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Bridging Gaps in Disability Justice: Comparative Study of International Standards and National Implementation in India

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Abstract:

The article examines the evolving concept, scope, and legal recognition of the rights of persons with disabilities within international and national frameworks. It traces the transformation of societal attitudes from viewing disability through a lens of charity and medical deficiency to recognising it as a human rights issue grounded in dignity, equality, and inclusion. The study highlights how disability is not merely an individual impairment but a socially constructed phenomenon shaped by environmental barriers, stigma, and systemic discrimination. The paper critically analyses various models of disability, including the medical, social, bio-psychosocial, human rights, and economic-vocational models, demonstrating how each framework contributes to understanding the lived experiences of persons with disabilities. Particular emphasis is placed on the shift towards the human rights model, which positions individuals with disabilities as rights-holders rather than passive recipients of welfare. At the international level, the article explores key developments such as the Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities (CRPD), which mark a paradigm shift in global disability discourse. These instruments establish principles of non- discrimination, accessibility, participation, and equality before the law. The role of the United Nations and its mechanisms in promoting and monitoring disability rights is also examined. In the Indian context, the study discusses legislative measures such as the Persons with Disabilities Act, 1995, and related frameworks that aim to ensure equal opportunities and social inclusion. Despite significant progress, the article identifies persistent challenges, including inadequate implementation, social stigma, and structural inequalities. The article concludes that achieving substantive equality for persons with disabilities requires a holistic approach that integrates legal reforms, policy interventions, and societal transformation. It underscores the need for stronger enforcement mechanisms, inclusive governance, and awareness-building to realise the full potential of disability rights as an integral part of human rights.

Keywords:

Disability Rights, Human Rights Model, Social Inclusion, CRPD, Equality, Legal Framework

1.1 Introduction

"Obviously, because of my disability, I need assistance. But I have always tried to overcome the limitations of my condition and lead as full a life as possible. I have traveled the world, from the Antarctic to zero gravity." STEPHEN HAWKING

When we label individuals as "other," we group them together as objects of our experience rather than seeing them as subjects of experience with whom we may relate, and we view them primarily as symbols of something else, generally, but not always, something we reject and dread and project onto them. Persons with disabilities and people who have hazardous and incurable illnesses represent, among other things, imperfection, a lack of control over one's body, and everyone's susceptibility to weakness, agony, and death to non-disabled people.[1]

As a result, one of the most difficult barriers to overcome is other people's views about persons with disabilities. Because of society's long-standing prejudice towards people with disabilities, there is a significant restriction to the amount of time that can be spent to a sympathetic understanding of the issues that affect them.[2] Every day, people with disabilities confront a variety of difficulties, ranging from physical to structural to entrenched discrimination. As a result, disability is viewed as a social construct. The words "disability," "handicap," and "impairment" have always elicited a reaction from society. The manner in which civilisations have responded to disability are always reflected in the terms or terminology chosen to address it. This demonstrates our mental process, attitude, and views of disabled people.[3] Individuals with disabilities have seen a shift in the way they are treated and the manner in which they are allowed to engage in society during the last two decades as a consequence of changes in the legislation, in the attitudes of persons with disabilities, and in society.

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1 "Sebastien Lorion" and "Stephanie Lagoutte," "What are Governmental Human Rights Focal Points", (2021) Netherlands Quarterly of Human Rights, Section 2.

2 "Sebastien Lorion", "Defining Governmental Human Rights Focal Points": "Practice, Guidance and Concept" (Danish Institute for Human Rights, 2021) Chapter 2, 28 April 2021.

3 Ibid.

It was formerly socially acceptable to refer to a disabled person as lame, crippled, retarded, handicapped, or even defective. When considering the ramifications of using the terms "disabled person" vs "person with a disability," the importance of language becomes clear. The first word emphasises the impairment, but the second term emphasises "the person," which translates to "person first" terms. The use of person-

first terms underscores that the person is more important than the impairment on a linguistic level. The overall move toward more humanitarian terminology to describe the situation of having a handicap reflects a shift in public perception and cultural attitudes. Changes in frequently used phrases may not appear revolutionary, but they reflect and reinforce social views toward people with disabilities that have been quietly changing.[4]

Impairment is a constant in any community, as well as a cultural and social construct. This indicates that social and cultural factors influence how disability is viewed and dealt with. They also have an impact on how a person with a disability reacts in any given society. As a result, the identification, definition, and social responses to impairments are influenced by common representations of the individual, society, and environment. Impairment gives rise to specific phrases or terminology, such as 'abnormality,' 'disability,' 'handicap,' or 'defective,' depending on those qualities, which represent society's attitude toward people with disabilities. A 'person with an impairment' was previously regarded as a freak or monster in ancient Greek civilisation, or as 'crippled' or 'infirm' un ancient Western society. Today, he or she is referred to as "a disabled person1" or "a person with a disability" in modern Anglo-Saxon language, or "a handicapped person" in modern French usage, and their treatment varies. It can be social, political, medical, religious, ethical, or other. [5] People with disabilities, on the other hand, continue to confront significant discrimination in many aspects of daily life, as illustrated by a variety of everyday experiences. The true cause of disability is prejudice and societal stigma. It is a cross-cultural phenomena that has existed in every human society and is part of the "natural physical, social, and cultural variety of human species."[6]

Over the last two decades, governments, social institutions, and civil society around the world have made sustained progress in achieving socioeconomic development, encouraging broader support for democratic norms, and developing collaborative connections. Inequality and exclusion, on the other hand, not only remain, but are growing in many regions of the world, both inside and across countries. Many cultures, both horizontally and vertically, are experiencing poor social circumstances, such as growing inequalities and marginalisation of some groups or communities. To avoid further escalation of social tensions among their members, societies must be equipped with strategies and tools for adequately assessing realities and addressing existing challenges in a more proactive, constructive, and holistic manner, so that they can become better prepared for new challenges, more resilient in confronting them, and better able to adjust to emerging imbalances and adjust more quickly, less violently, and morbidly.

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4 "Meredith Raley", "The Drafting of Article 33 of the Convention on the Rights of Persons with Disabilities: The Creation of a Novel Mechanism" (2016) 20(1),"The International Journal of Human Rights", 138.

5 "Gerard Quinn", "Resisting the ''Temptation of Elegance'': "Can the Convention on the Rights of Persons with Disabilities Socialise States to Right Behaviour?" in Oddny Mjoll Arnardottir and Gerard Quinn (eds), "The Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives", (Martinus Nijhoff 2009).

6 Ibid.

1.2 Meaning and definition of Person with Disability

The Declaration on the Rights of Differently-abled Persons defines "Differently-abled Persons" as any person unable to ensure himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or otherwise, in his or her physical or mental capabilities. The World Health Organization, in its International Classification of Impairments, Disabilities and Handicaps, makes a distinction between impairment, disability and handicap (International Classification of Impairment, Disabilities and Handicap—ICIDH).

The Americans with Disabilities Act, 1990[7] defines disability as physical or mental impairment that substantially limits one or more of the major life activities of the individual. The disability rights movement in India started only in the early 1990s. The need for a comprehensive legislation for safeguarding the rights of persons with disabilities and enabling them to enjoy equal opportunities and to help them to fully participate in national life was felt for a long time. To realise the objective that people with disabilities should have equal opportunities and keeping their hopes and aspirations in view, a meeting called the "Meet to Launch the Asian and Pacific Decades of Differently-abled Persons" was held in Beijing in the first week of December 1992 by the Asian and Pacific Countries in order to ensure "full participation and equality of people with disabilities in the Asian and Pacific Regions". This meeting was held by the Economic and Social Commission for Asia and Pacific. A proclamation was adopted in the said meeting. India was signatory to the said proclamation and agreed to give effect to the same. Pursuant thereto, **The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995**,[8] was enacted, and it came into force on 1st of January, 1996. This Act provides some sort of succour to the differently abled persons. According to **Persons with Disabilities Act 1995**, disabilities include blindness, low vision, leprosy, hearing impairment, locomotor disability and mental retardation and "person with disability" means a person suffering from not less than forty per cent of any disability as certified by a medical authority.10 Severe disabilities mean disability with 80% or more of one or more of multiple disabilities. **National Trust Act, 1999**,[9] defines "person with disability" means a person suffering from any of the conditions relating to Autism, Cerebral Palsy, Mental Retardation or a combination of any two or more of such conditions and includes a person suffering from severe multiple disability.

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7 "Gerard Quinn", "Bringing the UN Convention on Rights for Persons with Disabilities to Life in Ireland" (2009) 37(4) British Journal of Learning Disabilities 245, 249.

8 "International Disability Alliance's Forum for the CRPD", "Contribution to the OHCHR Thematic Study" (policy recommendations by IDA 2009).

The Rehabilitation Council of India Act, 1992[10] defines "handicapped" as a person who is (i) visually handicapped; (ii) hearing handicapped; (iii) suffering from i -j locomotor disability; (iv) suffering from mental retardation and "rehabilitation professional" means (i) audiologists and speech therapists; (ii) clinical psychologists; (iii) hearing aid and ear mould technicians; (iv) rehabilitation engineers and

technicians; (v) special teachers for educating and training the handicapped; (vi) vocational counsellors, employment officers and placement officers dealing with handicapped; (vii) multipurpose rehabilitation therapists, technicians; or (viii) such other category of professionals as the Central Government may, in consultation with the Council, notify from time to time. Disability embraces "a great number of functional limitations" of individuals. "There is growing recognition, reflecting the United Nations (UN) Declaration on the Rights ofDifferently- abled Persons, that persons with disabilities must enjoy exactly the same rights and opportunities that are taken for granted by abled members of society - the right to work, the right to enjoy a full social life, and to realise their potential as individuals. But quite often, consideration remains at the level of compassion, and provisions made for differently-abled people are seen more as welfare and charity than as the restoration of rights that disability takes away.[11]

People with disabilities are not a homogeneous group. For example, the intellectually retarded, the visually, hearing, and speech impaired, those with limited mobility, or those with so-called "medical impairments" all face different types of hurdles that must be addressed in different ways.

The term "disability" refers to a wide range of functional restrictions that can exist in any population in any region throughout the world. Physical, intellectual, or sensory disability, medical issues, or mental illness can all render somebody incapacitated. Such limitations, diseases, or illnesses might be permanent or temporary.

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9 "Marc Limon" and "Ellis Paterson", "The Emergence and Coming of Age of NMRFs" (Universal Rights Group Blog 27 March 2019) accessed 9 November 2020.

10 "Sarah Arduin", "Taking Metaregulation to the United Nations Human Rights Treaty Regime: The Case of the Convention on the Rights of Persons with Disabilities" (2019) 41(4) Law & Policy 411, 419.

11 "Norway Ministry of Foreign Affairs, 'Global Human Rights Implementation Agenda': The Role of International Development Partners" (Oslo, 20 April 2018) para.

The term "handicap" refers to the loss or limiting of possibilities to participate in communal life on an equal footing with others.[12] It depicts the interaction between a disabled person and their surroundings. The goal of this word is to draw attention to the flaws in the environment and many structured activities in society, such as information, communication, and education, that prohibit people with disabilities from participating on equal terms.

During the 1970s, there was a significant backlash from leaders of disability groups and disability specialists against the nomenclature of the period.[13] The terms "disability" and "handicap" were frequently employed in an ambiguous and confusing manner, providing inadequate guidance for policymaking and political action. The nomenclature indicated a medical and diagnostic approach that overlooked the flaws and shortcomings of the surrounding society.

The World Health Organization approved an International categorisation of impairments, disabilities, and handicaps in 1980, implying a more accurate and relativistic approach. The International Classification of Impairments, Disabilities, and Handicaps distinguishes between the terms "impairment," "disability,"

and "handicap." It has been widely applied in rehabilitation, education, statistics, policy, law, demography, sociology, economics, and anthropology. Some users have raised concern that the Classification's definition of "handicap" may still be deemed overly medical and too focused on the person, and that it may not fully describe the relationship between societal conditions or expectations and the individual's skills.[14] As a consequence of the experience acquired in implementing the World Programme of Action and the broader debate that took place during the United Nations Decade of Disabled Persons, there was a strengthening of knowledge and expansion of awareness about disability issues and language utilised. Current terminology emphasises the need of addressing both human requirements such as rehabilitation and technical aids as well as societal flaws that generate diverse barriers to participation.

12 "Jeremy Sarkin", "The 2020 United Nations Human Rights Treaty Body Review Process: Prioritising Resources, Independence and the Domestic State Reporting Process over Rationalising and Streamlining Treaty Bodies" (2020). The International Journal of Human Rights.

13 "Anne Waldschmidt", "Andreas Sturm", "Anemari Karaˇcic´" and "Timo Dins", "Implementing the UN CRPD in European Countries' in Rune Halvorsen, Bjørn Hvinden, Jerome Bickenbach, Delia Ferri, Ana Marta Guill´en Rodriguez (eds) The Changing Disability Policy System Active Citizenship and Disability in Europe (Routledge 2017) 178.

14 "Meyer and Tarrow", "The Social Movement Society (Rowman & Littlefield", Publishers 1997) 21.

Models of Disability

Disability has been seen and examined via several frameworks. In the following section, different disability models have been evaluated in order to determine the situation of people with disabilities.

The Individual or the Medical Model: Individual approaches to disability based on medical knowledge were largely accepted in Western industrialised cultures by the late nineteenth century. It concentrated on physiological 'abnormality, disorder, or deficiency and how it 'causes' functional restriction or 'disability.' Professional diagnosis, treatment, and recovery measurement lay the groundwork, while the distinguishing feature f'chronic' disorders emphasises rehabilitation rather than 'cure.' The level of impairment was determined by asking a series of questions concerning an individual's ability to do important personal tasks such as toileting, eating and drinking, and zipping and buttoning.[15] The medical model of disability is a sociopolitical concept in which disease or disability, as a result of a physical condition inherent in the individual's own body, can diminish the individual's quality of life and produce apparent disadvantages.[16] The medical model focuses on healing or controlling sickness, as well as diagnosing the illness or impairment from a clinical standpoint. By extension, the medical model thinks that a "compassionate" or "just" society spends resources in health care and related services in an attempt to medically cure impairments, increase functionality and/or enhance functioning, and provide handicapped people with a more "normal" existence. The medical profession's role and potential in this field are seen as crucial. Based on the 'Medical Model of Disability,' the WHO definition of disability (1980) described disability using terminology such as impairments, handicap, and disability. The medical model of disability focuses

on the individual's limits and strategies to decrease or apply adaptive technologies to adapt to society.[17] Current definitions of disability acknowledge biomedical aid but place a greater emphasis on variables that contribute to environmental and social exclusion. Unwanted outcomes result from uncritical dependence on the medical model.

Looking beyond Individual Solutions and the Social Model: The social model of disability is a response to the medical model of disability, which is based on a functional description of the body as a machine that must be fixed in order to adhere to normative ideals. The social model of disability highlights structural hurdles, negative attitudes, and societal exclusion, implying that society is the primary contributory cause in individuals being disabled. While physical, sensory, intellectual, or psychological differences may result in individual functional limitations or impairments, they do not have to result in disability unless society fails to take into consideration and integrate people regardless of their unique distinctions.[18] The approach's beginnings may be traced back to the 1960s, with the particular phrase emerging from the United Kingdom in the 1980s. Equality is a basic feature of the social model. The fight for equality is frequently contrasted with the efforts of other socially oppressed groups. Equal rights are stated to provide empowerment and the "capacity" to make decisions, as well as the chance to live life fully. The social model of disability focuses on societal changes that are necessary. These might include attitudes, such as having a more favourable attitude about specific mental features or behaviours, or not underestimating the potential quality of life of persons with disabilities. Social support, such as assistance in overcoming hurdles; resources, aids, or positive discrimination to overcome them; for example, giving a buddy to explain work culture to an employee with autism. Information, for example, in appropriate forms; Physical infrastructure, such as buildings with slanted access and elevators, or employment, such as flexible work hours and a disabled-friendly work environment.[19] According to the social model of disability, "disability is a social construct since it is the result of social arrangements that attempt to limit the activities of persons with disabilities by placing social barriers in their way." According to the social perspective, a disability is the outcome of how a physical or mental trait impacts functioning in a given environment and the expectations for functioning. The social model is also connected to economics. It suggests that a lack of resources to satisfy people's needs might handicap them.[20] It covers concerns such as the underestimate of people's potential to contribute to society and provide economic value to society if they are given similar rights, facilities, and chances as others. As a result, the social view allows us to perceive disability as the result of an environment that is hostile to certain bodies but not others, necessitating gains in social justice rather than in medicine.

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15 "George Anderson", "The New Focus on the Policy Capacity of the Federal Government" (1996) 39(4) Canadian Public Administration, 469.

16 "Tony Bovaird", "Beyond Engagement and Participation: User and Community Coproduction of Public Services" (2007) 67(5) Public Administration Review 846.

17 "Special Rapporteur, Report of the Special Rapporteur on the Rights of Persons with Disabilities: Thirty-first Session of the Human Rights Council (UN Doc A/HRC/31/62, 2016) para. 63; R. Kayess and P. French, "Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities", (2008) 8(1) Human Rights Law Review 1.

In response to these ideological advances, the handicapped scholar Mike Oliver created the phrase "social model of disability" in 1983. Oliver emphasised on the concept of an individual model against a societal model, which was taken from the UPIAS's original difference between impairment and disability.

18 Special Rapporteur (n 83), para. 63.

19 "Stacy Clifford", "Making Disability Public in Deliberative Democracy" (2012) 11 Contemporary Political Theory 211, 220.

20 "George Anderson", "The New Focus on the Policy Capacity of the Federal Government" (1996) 39(4) Canadian Public Administration, 469.

Bio-psychological Model: Disability is no longer defined by the effects of disease, but rather by health, functioning, and disability. This is a significant shift. The two sides (positive and negative) of health are studied and assessed as functioning and disability. They are characterised as the interplay of a health condition and environmental variables. This approach is portrayed as combining the medical and social models into what is known as a bio-psychosocial model. The current World Health Organization (WHO) definition of disability (2001), for example, the International Classification of Functioning, Disability, and Health (IGF), defines disability as an umbrella word for impairments, activity limits, and participation restrictions.[21] The interplay between persons with a health condition and personal and environmental variables such as unfavourable attitudes, inaccessible transportation and public buildings, and restricted social supports is referred to as disability. The revised terminology and phrases used demonstrate a significant shift in focus from discussing sickness or disability to discussing degrees of health and functioning. This shift corresponds to the broad adoption of the 'social model of disability.'[22]

It is a synthesis of the several components of health: biological, individual, and social. It strives to offer a general account of human functioning and engagement, not only a description of shortcomings. In other words, it purports to offer a global and transcultural paradigm and language that transcends cultural and socioeconomic differences and can be implemented in any place.

Human Rights Model: Through the worldwide disability rights movement, a paradigm change in the way disability is understood has recently occurred. A more inclusive approach has been introduced by including human rights perspectives in disabilities, which argue that every person is entitled to equal chance to develop and express his or her own unique potential. This paradigm requires civilisations to recognise the value of individuals based on innate human worth rather than an individual's assessed functional capacity to contribute to society.[23]

[21] "Grainne de Burca", "Human Rights Experimentalism" (2017) 111(2) American Journal of International Law 277, 283.

[22] "Lisa Vanhala", "The Diffusion of Disability Rights in Europe" (2015) 37 Human Rights Quarterly 833.

[23] "Per Lægreid", "Tina Ranma-Liiv", "Lise H. Rykja" and "Kulli Sarapuu" "Emerging Coordination Practices of European Central Governments" (2015) 81(2) International Review of Administrative Sciences 346

The recognition of the inherent dignity and equal and inalienable rights of all members of the human family is the cornerstone of global freedom, justice, and peace. All people are born free and equal in dignity and rights. According to this perspective, handicapped people are first and foremost human beings with the same basic human needs as the rest of humankind. Physiological requirements such as food, clothing, housing, and sex, as well as those that contribute to self-fulfilment, safety, security, love, a feeling of belonging, self-esteem, opportunities for new experiences, personal growth, creativity, or mastery.

The rights-based concept of disability emphasises on the intrinsic dignity of human beings and asserts that disability is the product of the State and civil society's failure to respond to the difference that disability symbolises.[24] A right-based approach incorporates the international human rights system's rules, standards, and principles into development plans, policies, and processes. To put it another way, the human rights approach denotes legal thinking. The work entails identifying authoritative grounds to support the imposition of an obligation on some agency capable of meeting the demand using a logical procedure. As a result, the occurrence of disability is more than a personal sorrow; it is a human rights issue. According to this viewpoint, a person is recognised by law as having rights and obligations, as someone who has special legal protection, but the level of this protection is dependent on economic, social, and political situations.[25]

According to this viewpoint, legislative measures form the essential framework within which mechanisms for equality of opportunity can be enforced. Seeing persons with disabilities as subjects rather than objects means providing them with full access to the advantages of fundamental freedoms that most people take for granted, but also being respectful and tolerant of their differences. It entails renouncing the inclination to see individuals with disabilities as problems and instead considering them in terms of their rights. Using a disability paradigm exposes the impact of social exclusion and emphasises the importance of protecting the human rights of all socially excluded groups.[26] It prioritises the individual in all decisions that impact him or her and, most crucially, locates the major "issue" outside the person and in society. According to this perspective, the "issue" or "cause" of disability arises from the State's and civil society's insensitivity to the difference that disability implies. As a result, the State bears duty for removing socially imposed barriers in order to provide full respect for the dignity and equal rights of people with disabilities.

[24] "World Health Organization." World Report on Disability Geneva: World Health Organization; 2011.

[25] "National Mental Health Survey of India , 20 15 -2 01 6 Prevalence, Patterns and Outcomes, Supported by Ministry of Health and Family Welfare, Government of India, and Implemented by National Institute of Mental Health and Neurosciences (NIMHANS)." Bengaluru: In Collaboration with Partner Institutions; 2015-2016.

[26] Ibid.

Economic and Vocational Model: Economic disability is defined as a diminished capacity to work, the associated loss of productivity, and the economic implications on the person, employer, and society as a whole. This concept is inextricably linked to the charity/tragedy model. These authors' economic vocational paradigm is directed toward the construction of an economy focused on physical labour rather than the supply of services. As a result, vocational rehabilitation or income maintenance programmes are recommended as the primary answer to the challenges that handicapped individuals encounter.[27] These policies contribute to the relegation of handicapped men and women to a life of lifelong reliance or to a secondary labour market, resulting in low-paying, boring job and limited chances for 11-round growth. The economic-vocational approach, like the medical/clinical approach, suggests that changing the person rather than changing the environment and the work site or changes in employee perception are the most desirable means of meeting the social and economic needs of the disadvantaged strata of society. In this approach, two criteria are pursued: benefit determination and selective placement. In terms of benefit determination criteria, it focuses largely on the causal reason of disability. It assesses impairment on a percentage basis. The selected placement criteria, on the other hand, is more concerned with the impacts of handicap.[28] As a result, both of these criteria are focused on the causes and consequences of impairment.

The International Labour Organization (ILO) is a staunch supporter of the economic- vocational model. The ILO defines disabled as an individual whose prospects of securing, retaining, and advancing in suitable employment are significantly reduced as a result of a duly recognised physical or mental impairment, as defined in the international Labour Vocational Rehabilitation and Employment (Disabled Persons) Convention 1983 (N o. 159) and Recommendation 1983 (No. 168).[29] As a result, the economic-vocational strategy is primarily focused on modifying the physical capabilities and vocational skills of handicapped people rather than the environment and worksite. As a result of this focus, much attention has been redirected from the struggle to prevent prejudice and discrimination against handicapped persons in the workplace to giving a restricted choice of Livelihood Avenue with the goal of making them productive members of society.

[27] "Math SB", "Nirmala MC". "Stigma haunts persons with mental illness who seek relief as per Disability Act 1995." Indian J Med Res 2011;134:128-30.

[28] "The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act", 1995. Available from: http://www.disabilityaffairs.gov.in/upload/uploadfiles/files/PWD_Act.pdf. [Last accessed on 2018 Sep 2021.

[29] The Mental Healthcare Act 2017. Available from: http://www.prsin dia.org/up loads/media/ Mental% Health/ Mental%20Healthcare%20Act,%202017.pdf. [Last accessed on 2021 sep 10].

Systems Analysis Model: This approach suggests that the design, management, and evaluation of services for handicapped people and their families must take into account the changing developmental requirements of such disadvantaged people. Only through evolving the cyclic politics of their families and societal environments at various periods of a person's life span could such a system be formed. The systems analysis perspective evolved around two fundamental assumptions.[30] First, it seeks to adopt a systems perspective, that is, through developmental/ecological perspectives, to analyse the phenomenon of disability because disabled individuals cannot exist in a social vacuum; they all exist in a society with its specific system of sub-cultures, and a social system where disability is defined according to prevailing public policy towards the disadvantaged. As a result, this demonstrates how 'valued' persons with disabilities are in the community. Second, it is founded on a life cycle development concept. The handicapped people, their families, and their social environment change with time. Thus, the systems analysis approach proposes that any assessment of disabled people's or other disadvantaged groups' skills must be viewed in light of the culture- or -subculture in which the individual is nurtured. The way a person with a disability interacts with his or her family members, or vice versa, the way a person with a disability interacts with his or her family in the micro-system of the socio-cultural environment, shapes society's attitude toward people with disabilities.[31] As a result, understanding the connections between these many social components in the context of disability is critical for understanding disability and disability-related issues.

Minority Group Model: The notion of minority group has also been used to characterise the position of disabled people, as well as to develop legal and regulatory measures to achieve equality and non-discrimination for PwDs, with the goal of mainstreaming the handicapped. It is evident that there are many similarities between the disabled and other minority groups— such as women, the elderly, black people, the poor, and other vulnerable portions of society— in that they are all viewed and reacted to as a demographic category. They are all from poor socioeconomic backgrounds, are politically weak to the point of oppression, and are negatively stigmatised and discriminated against.[32] The phrase, minority group with reference to disability, refers to the issue that persons with disabilities have not yet formed a group for individuals in order to defend or safeguard their rights. Disability is becoming a minority group due to non-acceptance, stigma and stereotypes, social deprivation, discrimination, non- participation, lack of control, and unequal status.

[30] The Amended Rules for Persons with Disabilities. Available from: http:/ /ay jnihh.nic.i n/A mended_PWDRules1996_accessible.pdf. [Last accessed on 2021 Sep 09]

[31] Narayan CL, John T. The Rights of Persons with Disabilities Act, 2016: Does it address the needs of the persons with mental illness and their families. Indian J Psychiatry.

1.3 Human Rights of persons with disability

The human rights approach to disability is a component of the human rights movement that emerged in the later half of the twentieth century. The growing international focus on human rights concerns has resulted in a number of major international human rights commitments in a wide range of disability-related sectors.[33] Samples of these accomplishments are explored, as are some recently proposed tactics for enforcing human rights on individuals with disabilities in order to guarantee that international commitments are upheld and made effective at the implementation level.

The human rights approach to disability originated as part of the human rights movement in the latter half of the twentieth century. The increased international attention on human rights issues has resulted in a number of significant international human rights commitments in a variety of disability-related fields. Examples of these achievements are examined, as are some recently proposed strategies for enforcing human rights on people with disabilities in order to ensure that international commitments are respected and made effective at the implementation level. Disability is increasingly being considered as a social disease, that is, as a result of environmental and sociological factors connected to a society's success or inability to be inclusive. This new human rights framework lays the groundwork for governments to promote social well-being for all of their residents.[34]

This occurred with the United Nations' recognition of the rights of people with disabilities and the adoption of a number of agreements and declarations, which fueled the disability rights movement. According to the treaties ratified by the General Assembly, many nations incorporated the disability rights movement in the human rights movement and implemented legislation that forbade disability discrimination and encouraged the inclusion of people with disabilities in all sectors of life.

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32 Institute for Health Metrics and Evaluation, 2017. Available from: www.healthdata.org/India. [Last accessed on 2021 Jan 02]

33 Right of Children to Free and Compulsory Education Act, 2009. Available from: eoc.du.ac.in/RTE%20-%20notify.pdf. [Last accessed on 2021 Sep 09]

34 Government of India, Ministry of Hu ma n Resource Development, Department of School, Education and Literacy, Lok Sabha, 2016. Available from: http://164.100.47.190/loksabhaquestions/annex/10/AS265.pdf. [Last accessed on 2021 Sep 09

The problem of disability rights is not so much about the enjoyment of specific rights as it is about ensuring that persons with disabilities have equal and effective access to all human rights, without discrimination. The non-discrimination principle contributes to the relevance of human rights in general in the situation of disability, just as it does in the settings of age, gender, and children. Non- discrimination and the equal and effective enjoyment of all human rights by individuals with disabilities are thus the major problems of disability worldwide.[35] The process of ensuring that persons with disabilities have access to their human rights continues to be delayed and inconsistent. It is motivated by the values that underpin human rights: the inestimable dignity of each and every human being, the concept of autonomy or self determination, which requires that the person be at the centre of all decisions that affect him or her,

the inherent equality of all people regardless of differences, and the ethic of solidarity, which requires society to maintain the person's freedom through appropriate social supports. Over the last two decades, the United Nations has authoritatively approved the change to a human rights orientation.

Human rights are transnational problems that are implemented locally. Governments across the world are increasingly evaluating their people' rights in accordance with international human rights laws, and international human rights efforts are beginning to treat disability in the framework of human rights. Disability is included in the human rights concept, which has been evolving since the 1948 United Nations Universal Declaration of Human Rights. Despite individual variations, this proclamation acknowledged that all people have certain civil, political, economic, social, cultural, and development rights. A rights model of disability, from this perspective, considers variance in human qualities linked with impairment, whether in cognitive, sensory, or motor capacity, to be a natural part of the human condition.[36] In the case of persons with disabilities, a rights-based approach assumes that society is obligated to provide whatever mechanisms are necessary for individuals to realise their rights, which may include the provision of supports, services, and aids to enable social and economic integration, self-determination, and the enjoyment of legal and social rights. The underlying idea is that all individuals have the right to participate in society as equals and to exercise self-determination.

The Universal Declaration of Human Rights was the first important step toward establishing a human rights framework at the United Nations. To clarify the rights described in the Declaration, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights, both legally binding human rights treaties, were adopted in 1966.[37] Following that, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention against Torture and Other Inhuman or Degrading Treatment or Punishment, and the Convention on the Rights of the Child were all created to protect and promote the rights of specific vulnerable groups.

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35 Ramaa S. Two decades of research on learning disabilities in India. Dyslexia 2000;6:268-83

36 Government of India, Ministry of Social Justice & Empowerment, Department of Empowerment of Persons with Dis abilities s, 2018 . Available from: http ://www.ccdisabilities.nic.in/content/en/docs/Newguideline.pdf. [Last accessed on 2021 Sep 08]

As a result, a more inclusive approach has been taken to integrate the human rights paradigm in disability, which asserts that every person is entitled to the resources necessary to develop and express his or her own unique talent as a moral imperative. This paradigm forces civilisations to recognise the value of all people based on their intrinsic human worth, rather than on their measurable functional capacity to contribute to society.[38] Rather than being an anomaly, disability is a universal variation. Civil and political ("first-generation") rights, as well as economic, social, and cultural ("second-generation") rights, are inextricably linked with disability-based human rights.

Human rights practitioners and activists are primarily concerned with the rights of the first generation. These rights are interpreted as fostering individual equality and include restrictions against government involvement. These rights are also referred to as "negative rights." The rights to life, mobility, opinion, speech, association, religion, and political involvement are examples of first- generation rights. Development agencies have typically been in charge of second-generation rights. These rights are typically referred to as "positive rights" since they are regarded to provide equal opportunity. Second generation rights are typically concerned with living conditions, covering concerns such as housing and education.

1.4 Right of person with Disability: International perspective

Disabled people face discrimination as a result of prejudice and ignorance in society. Furthermore, because to a lack of access to basic services, they frequently do not have the same opportunities as other individuals. According to international human rights legislation, everyone has the following rights:

a) equality before the law;

b) nondiscrimination;

c) equal opportunity;

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37 Government of India, Ministry of Social Justice & Empowerment, Simplification and Streamlining the Procedure for Issue of Disability Certificates to the Persons with Disabilities, 2011. Available from: http://pib.nic.in/newsite/PrintRelease.aspx? relid=68913. [Last accessed on 2021 Sep 12].

38 Ibid.

d) the right to self-sufficiency;

e) the right to full integration; and

f) the right to security.

The UN has undertaken a number of accords, declarations, international conferences, and other events focusing on disability rights in response to the human rights crises faced by persons with disabilities. States are increasingly moving toward a human rights viewpoint on disability, with 39 nations enacting disability-related non-discrimination or equal opportunity laws. International instruments such as the World Programme of Action for Disabled Persons, the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, and related UN resolutions not only serve as guidelines for states, but they also impose obligations on governments to reform their policies and practises in order to ensure that all citizens have access to human rights.[39]

Persons with disabilities have grown increasingly proactive in demonstrating strength and confidence in their own ability to lead self-reliant and independent lives throughout the first half- century of the United Nations. The United Nations' attempts to assist their efforts are highlighted in the following brief history.[40]

The UN was created on the premise of equality for all people. The Preamble to the United Nations Charter emphasises every human being's dignity and value, and places a premium on promoting social justice.

Persons with disabilities are de facto entitled to all of the Charter's and other human rights treaties' fundamental human rights. When the United Nations General Assembly adopted the Universal Declaration of Human Rights in 1948, it laid the groundwork for the promotion and preservation of human rights. Each individual has "the right to security in the case of unemployment, disease, disability, widowhood, old age, or other lack of livelihood under circumstances beyond his control," according to Article 25 of the Declaration.

Human rights documents such as the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights, both of which entered into force in 1966, provided further anti-discrimination rules. Together, they make up the most complete international code of legally binding human rights standards. The two Covenants build on and enhance the contents of the Universal Declaration, and the three agreements collectively form the International Bill of Human Rights.[41]

Furthermore, a Special Rapporteur on Disability, originally appointed in 1984 by the Sub- Commission on Prevention of Discrimination and Protection of Minorities and tasked by the United

[39] Ibid.

[40] Ibid.

[41] Ibid.

Nations Commission for Social Development, has maintained a special focus on disability rights at the UN level. Leandro Despouy, as Special Rapporteur, documented numerous human rights violations in the domain of disability in a detailed study titled Human Rights and Disabled Persons, which was released in 1992.[42] He advocated for disability to be recognised as a human rights issue, and for UN treaty monitoring organisations to be more involved in addressing abuses of disability rights.

1.4.1 Convention on the Rights of Person with Disabilities

Contemporary mental health laws are based on fundamental human rights principles, and their progress is affected by current human rights debate, international declarations and treaties, and the European Court of Human Rights' authoritative jurisprudence (ECrtHR).[43] The Convention on the Rights of Persons with Disabilities (CRPD) is the most current international human rights treaty applicable to individuals with disabilities, including those suffering from mental illness. It establishes a new standard by which to judge the human rights compatibility of domestic mental health legislation.[44]

The CRPD places a strong focus on social entitlement and a positive right to "treatment," which is defined broadly to include all social determinants of health. This is a unique and impactful contribution. The obligations to respect the (negative) rights expressed in the International Covenant on Civil and Political Rights4were historically accepted as immediately realisable, whereas the obligations to respect the (positive) rights expressed in the International Covenant on Economic, Social, and Cultural Rights were

subject to the principle of progressive realisation. Arguments in favour of a positive right to psychiatric care have viewed it as a derivation of negative rights, emerging from the concept of reciprocity, or as an extension of the prohibition of torture and cruel, inhuman, or degrading treatment, all of which are based on this distinction. Despite these compelling reasons, the Courts' recognition of the artificial distinction between the two types of rights appears to have influenced their unwillingness to recognise positive rights and entitlements as justiciable subjects.[45]

The Convention on the Rights of Persons with Disabilities (CRPD) is the first to be created with the full participation of individuals with disabilities. The text takes on a new depth as a result of this. It gives the input of participating organisations and the ambitions of the larger disability community interpretative weight.[46] 'Nothing about us, without us,' is the tagline accompanying the CRD's implementation. The CRPD's guiding framework is stated in Article 3's broad principles. These are the following:

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42 Ibid.

43 "International Covenant on Civil and Political Rights," opened for signature Dec. 16, 1966, 999 U.N.T.S. 171(23 March, 1976).

44 "Henry Steiner" & "Philip Alston," "International Human Rights" in Context 275 (2d ed. 2000).

45 Ibid.

(a) Respect for people's inherent dignity, individual autonomy, including the freedom to make one's own decisions, and independence;
(b) Nondiscrimination;
(c) Full and effective participation and inclusion in society;
(d) Respect for difference and acceptance of people with disabilities as part of human diversity and humanity.
(e) Equality of opportunity;
(f) Accessibility;
(g) Equality of men and women;
(h) Respect for the increasing capacities of children with impairments, as well as respect for their right to maintain their identities.

The first value, most importantly, is respect for intrinsic dignity and human autonomy, which includes the right to make one's own decisions. This statement establishes a strong relationship between intrinsic human dignity, which is a cornerstone of human rights, and the freedom to make one's own decisions. The concept of non-discrimination is observed. These principles, taken together, highlight the strengths of persons with disabilities, their capacity for individual liberty, and the hardship that discriminatory surroundings and attitudes put on them. Discrimination in the field of mental health can take many forms, including erroneous findings of incompetence or the presumption that choices should be overruled on paternalistic 'best interests' grounds. It can be characterised as an arbitrary classification of persons with mental illnesses as either needing to be treated or being inherently harmful.[47] The structure and

organisation of mental health systems, the substance of mental health law, and the under-resourcing of hospitals and institutions may all be signs of this. It might take the form of unjustified intervention or neglect.

Recognising the importance of discrimination for persons with disabilities, the CRPD emphasises the responsibility of States parties to change hostile settings in which people with disabilities may find themselves. It urges States Parties to promote individuals with disabilities' capacities and to

46 Government of India, Ministry of Social Justice & Empowerment (Disabilities division), 2008. Available from: http://dis ability affairs.gov.in/upload/uploadfiles/files/incentive_rev.pdf. [Last accessed on 2021 Sep 12]

47 Ibid.

combat discriminatory attitudes and practises by promoting community awareness, adopting social inclusion initiatives, and establishing human rights-compliant health and legal systems.

Human rights legislation recognises an immediate need to restore equality when individuals with disabilities are treated differently as a result of discrimination, whether the rights in question are categorised as negative or positive rights.[48] The pervasiveness of prejudice against persons with mental illnesses necessitates a close review of many commonplace actions. The next sections address assisted decision making, the nature of the need to provide adequate health treatments, and the overall obligation to maintain the person's bodily and mental integrity, all with this requirement in mind.

People with disabilities are treated as equal legal subjects under the CRPD, with the right to benefit from changes in practises and systems that had previously excluded them. The CRPD addresses the content of decision-making processes when it establishes the need to promote equality before the law. Article 5 establishes a legal foundation for everyone to be "equal before and under the law" and to have "equal protection and benefit under the law." All people must be recognised before the law, according to Article 5(1). Article 5(2) demands that appropriate legal protection against discrimination be provided. Article 5(3) mandates that adequate actions be taken to ensure reasonable accommodation,' as specified in Article 2, and Article 5(4) prohibits discrimination in particular measures to attain or expedite equality. These conditions support Article 12's duties to allow individuals with disabilities to participate in judicial proceedings.[49]

Article 12(1) states that "people with disabilities have the right to be recognised as individuals before the law everywhere," and Article 12(2) states that people with disabilities "have legal ability on an equal footing with others in all aspects of life." People with disabilities, including those suffering from mental illness, complain of being denied legal capacity on erroneous or spurious grounds, either because a disability is automatically equated with incompetence and incapacity, or because the disability is not accommodated in a way that allows the person to exercise their legal capacity. Decision-making is a communication process, according to Article 12(3), and decision- making capacity is a fluctuating human quality.[50] The vast majority of people, whether or not they have a disability, are more or less able to reason

and understand the content and consequences of a course of action, depending on how much information they receive, in what form the information is

[48] "Altman, B. M." (2001). Disability definitions, models, classification schemes, and applications. In Albrecht, G. L., Seelman, K., & Bury, M. (Eds.), *Handbook of disability studies* (pp. 97–122). London, UK.

[49] "Vanhala, L". (2015). The diffusion of disability rights in Europe. *Human Rights Quarterly*, 37, 831–853

[50] "Üstün, T., Kostanjsek, N., Chatterji, S., & Rehm, J." (Eds.). (2010). Measuring Health and Disability, Manual for WHO Disability Assessment Schedule, WHODAS 2.0. Geneva, Switzerland: World Health Organization.

received, in what context the information is received, how much time they are given to process the information, and how much time they are given to discuss or test the information with trusted people. This is especially true when it comes to health-related information.[51] The effects or side effects of medicine and other therapies, as well as the cyclic or unstable character of the disease, can add to the complexity of communication processes in mental health. If their practise was informed by and directed toward the attainment of supported decision making, a variety of tactics, some of which are already common in established mental health systems, might readily promote a supported decision making approach. The following factors might help to foster a culture of supported decision-making:

• the education of mental health professionals around the concept of informed consent and their obligations in law

• the education of mental health professionals around the processes of reasoning

• the appointment and involvement of advocates in decision making

• the involvement of support persons

• the development of case managers as facilitators

• the effective use of treatment plans

• the effective use of psychiatric advance directives, or

• substituted decision making arrangements where the substituted decision maker is clearly bound by the wishes of the patient.

Given the complexity and ongoing nature of the decision-making process, as well as the importance of understanding the specific problems faced by a person seeking decision-making support, involving a person who has been nominated by and is acceptable to the person with a mental illness is frequently seen as the most practical and effective way of ensuring that the outcome of a supported decision-making process is acceptable to the person with a mental illness.[52] However, extending personal care arrangements to adults with reduced decision-making abilities has certain practical challenges. The legislation of informed consent, which establishes the legal framework for the provision of voluntary medical care, stipulates that the individual must be capable, knowledgeable, and willing to consent. When a person relies on others to make decisions for them, the presumption that they are rational, autonomous, and freely selecting persons, as the law requires, is readily supplanted.

[51] Stone, D. A. (1985). *The Disabled State*. London, UK: Macmillan.

[52] Stein, M. A., & Stein, P. J. (2006). Beyond disability civil rights. *Hastings Law Journal*, 58, 1203.

While doctors must be aware of the risk of excessive influence in any therapeutic circumstance, they must also be sure that the support person understands their facilitative function and is free of conflicting interests or objectives. Similarly, the person with a disability must comprehend the function and process of support.[53] The development of a culture of supported decision making in mental health is likely to necessitate a variety of strategies, such as the creation of training programmes and practise guidelines to ensure that people with disabilities, clinicians, and support people all play their roles in a supported, communicative process.

The type and quantity of assistance required will vary from person to person, and high levels of assistance may be required at times. Although it has yet to be tested, the notion of "reasonable accommodation" may act to restrict the quantity of help that may be fairly anticipated to be supplied to people with disabilities. The provision of reasonable accommodation is also essential in determining whether or not the action in question was discriminatory.[54] Finally, the expected standard will be determined by the widespread availability of medical treatment. It is not uncommon in developed western health systems to give extremely high levels of communicative support to persons who, for example, have severe communication difficulties. Nondiscrimination necessitates that people with mental illnesses receive the same high level of support as people without mental illnesses.

The purpose of assisted decision making in health choices, according to the CRPD, is to acquire complete and informed consent. People with mental illnesses say that when they want to refuse medical treatment or voice a desire for an alternative medical therapy, the readiness to assign ability to them vanishes, typically on the grounds that they 'lack insight' into their disease and the advantages of treatment. Uneven capacity decisions are referred to as a 'Catch 22' by McSherry. In areas where mental health legislation leave treatment choices to the clinician's discretion, the circularity of thinking connected with capacity judgments in mental health is encouraged. In these jurisdictions, a person's lawful exercise of legal capacity may be overcome unless the physician recognises the legality of the person's rejection of treatment.[55] As evidenced by health research, a person's treatment choices are more likely to be honoured when the individual and the doctor communicate well. Legal frameworks that obstruct the lawful exercise of ability are unacceptable, according to the CPRD.

[53] Rioux, M., & Carbert, A. (2003). Human rights and disability: The international context. *Journal on Developmental Disabilities*, 10, 1–13.

[54] Priestley, M. (1998). Discourse and resistance in care assessment: Integrated living and community care. *The British Journal of Social Work*, 28(5), 659–673

[55] Pozzo, C. D., Haines, H., Laroche, Y., Fratello, F., & Scorretti, C. (2002). *Assessing Disability in Europe – Similarities and Differences* Strasbourg, France: Council of Europe Publishing.

People who are unable to acquire capacity, even with help, may benefit from substituted decision- making arrangements that are precisely suited to their circumstances, according to the CRPD. Article 12(4) stipulates that any "measures relating to the exercise of legal competence" must be implemented.[56]

- be free of conflict of interest and undue influence,
- be proportional and tailored to the person's circumstances,
- apply for the shortest time possible, and
- be subject to regular review by a competent, independent, and impartial authority or judicial body; and
- be subject to regular review by a competent, independent, and impartial authority or judicial body.

State parties are obligated under Article 12 to fulfil an individual's need for assistance. When a person is unable to make decisions for themselves, including medical decisions, Article 12(4) establishes a clearly articulated process that balances the need to intervene with a range of safeguards that are guided by respect for the person's rights, will, and preferences, are proportionate to the degree to which such measures affect the person's rights and interests, and are sensitive to the deeply embedded discriminatory attitudes that can colour determinations for caesarean sections. [57]Article 25 expresses the duty of State Parties to address systemic weaknesses using comparable principles.

According to Articles 5 and 12, decision-making processes must always take into account the unique abilities and needs of the person at the centre of the process. In the case of mental health, this shows that standard legal safeguards such as second medical opinion, review, or appeal are useful but insufficient measures to assure CRPD compliance in the absence of an investigation of the substance of the decision-making process.

Article 17 preserves the "right to respect for his or her bodily and mental integrity on an equal footing with others" and is based on the concept of non-discrimination. Its abbreviated phrasing is the result of a'negotiated quiet' during the CRPD's writing, which was intended to reinforce the CRPD's implied prohibition on involuntary treatment.[58] Article 17 highlights a number of commonly accepted procedures in psychiatric treatment that jeopardise a person's bodily and mental well-being. These are described by the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment as:

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56 Ibid.

57 Ibid.

58 Ibid.

- Poor conditions of detention;
- The use of restraints, including the use of medication as a form of chemical restraint;
- Drugs administered as punishment or restraint;
- The use of seclusion and isolation;

- Experimentation or experimental treatment without consent;
- Forced treatments that are intended to correct and alleviate particular impairments;
- Intrusive or irreversible treatment, such as lobotomy and psychosurgery;
- Forced abortion or sterilisation without free informed consent;
- Modified electroconvulsive therapy without free and informed consent. (Informed consent must include information about 'the secondary effects and related risks such as heart complications, confusion, loss of memory and even death');
- Forced psychiatric interventions that amount to political or social repression;
- Forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics,
- for the treatment of a mental conditions especially in the presence of extreme and debilitating side effects;
- Involuntary commitment to psychiatric institutions on an arbitrary basis. Involuntary detention may be arbitrary where the criteria for involuntary admission includes only the diagnosis of- mental disability coupled with additional arbitrary criteria such as being a 'danger to oneself and others' or in 'need of treatment'; and
- Violence, including sexual violence.

Although developed western nations may regard their mental health systems as free from the worst instances of abuse, some of the practices listed above remain common. At the very least, Article 17 works to confine these practices.[59]

It's possible that Article 17 includes a positive entitlement to have one's treatment options acknowledged. As previously mentioned, the circular thinking connected with capacity decisions may make a person with mental illness vulnerable to a judgement of incapacity based on their failure to comprehend the advantages of treatment. While there may be good grounds to deny all medical care, denial is generally coupled with a preference for one type of therapy over another. In these cases, the right to respect for a person's bodily and mental integrity, as well as the importance of autonomy and non-discrimination in the CRPD framework, necessitates adequate consideration of the person's opinions.[60] These should take precedence over the objectively determined 'best interests' norm if they are relevant and sufficiently conveyed. Giving Article 17 scope enables for the subjectively decided decisions of the person who is being treated to be taken into account. This logic might have unexpected outcomes. For example, a person who has clearly indicated a desire to stay medication-free, even if doing so will result in a restriction of bodily liberty based on public safety concerns, would be able to do so. A person who has not expressed a treatment choice or is unable to do so is entitled to the best available care, including active intervention, as long as the intervention is adequately circumscribed by respect for the individual's bodily and mental integrity.[61]

[59] Oliver, M. (1995). *Understanding Disability: From Theory to Practice*. London, UK: Macmillan International Higher Education.

1.4.2 UN Disability Rights Committee

Despite its vast reach, the CRPD provides no advice on disability evaluation as a means of obtaining state assistance, save for a requirement that rehabilitation programmes be "based on multidisciplinary assessment of individual needs and strengths" (Article 26). States parties are required to "provide access...to social protection and poverty reduction programmes," but there is no guidance on how "disability-related needs" or "disability-related costs" should be calculated (Article 28). As a result, it is important to look beyond the language of the CRPD to its interpretation.[62]

The UN Committee on the Rights of Persons with Disabilities, which is in charge of reviewing State parties' progress in implementing the CRPD, does so on a regular basis. States provide reports, which are frequently complemented by shadow reports from civil society and national human rights institutions. Before participating in discourse at public hearings and delivering Concluding Observations and recommendations, the Committee presents topics to which States react. The Committee's document trail is available in the UN human rights treaty database, and it provides a wealth of information on the Committee's growing concerns and interpretations over the last decade (Office of the High Commissioner for Human Rights, n.d.). In its Concluding Observations, the Committee has voiced concerns concerning disability assessment, both in terms of the criteria of disability utilised and the assessment techniques used. In regard to European nations, we go through these two basic problems below. Unless otherwise stated, all citations relate to the Committee.

[60] Ibid.

[61] "Oliver, M., & Barnes, C." (2012). *The New Politics of Disablement*. London, UK: Macmillan.

[62] Office of the High Commissioner for Human Rights. (n.d.). *Treaty body database*. Retrieved from https://tbinternet.ohchr.org

1.4.3 OHCHR Human Rights Indicators on the Convention of Rights of Persons with Disabilities (2020)

A focal point will be selected for "matters relevant to the implementation of the present Convention," according to Article 33(1). The Office of the High Commissioner for Human Rights defines implementation as "the process by which States Parties take steps to ensure that the rights specified in a specific treaty are realised within their jurisdiction." While the OHCHR expects a CRPD focal point to help with reporting on the Convention, it also says that the focal point should "clearly focus on formulating and coordinating a cohesive national strategy on the Convention." Because of the CRPD's vast reach, a national policy on the CRPD is invariably synonymous with a national disability policy.[63]

NMRFs are primarily concerned with reporting to the international and regional human rights systems, as

well as coordinating 'follow-up' to ensure that recommendations are implemented effectively. In principle, all ratified treaties, including the CRPD, are covered by NMRFs. The implementation phase is intertwined with international reporting and follow-up. They are, however, two separate processes. While implementation is based on domestic circumstances, reporting and follow-up are based on international standards. The OHCHR's Guide outlines four sorts of NMRF roles: interaction with UN machinery, coordination among domestic executive actors involved in reporting and follow-up, consultation with all national stakeholders, and information management, which is organised around planning and measuring actions.

The main motivation for the creation of NMRFs is to make timely reporting to the international human rights system easier. While coordinating State reporting on the CRPD is one of the roles of a CRPD focal point, its installation does not appear to have resulted in an improvement in compliance with reporting obligations. The CRPD was the treaty with the second greatest number of non- reporting States, according to the OHCHR, with 29 percent of parties identified as non-reporting States parties in 2018.[64]

The facilitation of expert visits is one of the recommended tasks of an NMRF. The overlap between the duties of NMRFs and CRPD focus points may be seen here. While the Spanish government has

63 "Mabbett, D. (2005)." Some are more equal than others: Definitions of disability in social policy and discrimination law in Europe. *Journal of Social Policy*, 34(2), 215–233

64 "Madden, R., Glozier, N., Mpofu, E., & Llewellyn, G." (2011). Eligibility, the ICF and the UN Convention: Australian perspectives. *BMC Public Health*, 11, S6.

a CRPD focal point, the Spanish NMRF, which is part of the Ministry of Foreign Affairs, was in charge of assisting and enabling the CRPD Committee's visit for the purposes of an inquiry. When the Committee undertook an inquiry into the United Kingdom, on the other hand, the UK CRPD focal point was in charge of communicating with the Committee and organising its visit. The Committee expressed its thanks to the relevant State for aiding its visit in both inquiry reports. In terms of reporting and follow-up, the focus points' responsibilities mostly overlap. Learning opportunities might be found in the production of a State report and follow-up actions. Participation in the international human rights system strengthens States' and officials' ability to become "discursively competent" in human rights and create their "internal value framework," according to Harold Koh. Bureaucrats in charge of the assessment and follow-up procedures can enhance human rights knowledge among fellow policymakers and emphasise how their job links to the State's human rights commitments.[65]

Furthermore, treaty investigations can set in motion bureaucratic protocols to obtain, authenticate, and analyse material that may not have occurred in the absence of the requirement to report,' according to Creamer and Simmons. The importance of such process-based innovations, according to CRPD proponents, is critical to effective adoption.[66] If treaty exams and follow-up actions give possibilities for learning and procedural innovation, it is necessary to evaluate whether bureaucrats operating within a CRPD focus point or those working within an NMRF are more likely to take advantage of these

opportunities.

One of the stated roles of an NMRF is 'data collection and information gathering' for inclusion in reports. On the face of it, this role appears straightforward. However, treaty bodies have become more exacting in their requests for information in preparation for an examination, and will increasingly recommend that States Parties develop their data collection capacity. This includes the CRPD Committee, which has repeatedly encouraged States to develop human rights based indicators. The OHCHR has similarly emphasised the utilisation of indicators within Recommendation Implementation Plans ('RIPs'), elaborated by NMRFs to serve as information management tools.[67] Data collection plays a comprehensive role that goes beyond tracking implementation. The development of indicators is central to implementation planning. Eilion´oir Flynn has highlighted that 'the CRPD implicitly requires the development of future indicators and sets the contours for measuring success in improving the lives of persons with disabilities'. The process of developing human rights indicators is a complex exercise which requires technical expertise and knowledge of the inner workings of government. Gauthier De Beco notes that whilst States often invest significant time in the development of human rights indicators, the indicators often prove unworkable in practice. The process of developing indicators must be open and transparent. Indicators frame problems and if the process for their development is not robust and inclusive, they may be manipulated to present narratives of success. There is also a risk that the utilisation of indicators will privilege those with technical expertise over the views of rights- holders. State actors responsible for the development of indicators must overcome these obstacles if they are to develop indicators which go beyond tracking 'technical' implementation and reflect the realisation of human rights in practice. In 2020, the OHCHR published a resource package including a set of human rights indicators on the CRPD presented article by article, with an accompanying guide to data sources. This resource provides practical guidance for States on the development of indicators which they can adapt to reflect their national contexts.[68]

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65 Ibid.

66 Ibid.

67 Ibid.

Data collection serves the dual roles of implementation and monitoring. Given the emphasis on reducing the burden which reporting places on States, it would appear most appropriate for monitoring activities emerging from the treaty process to be integrated into domestic monitoring systems. As set out above, this is an issue which the CRPD Committee has highlighted in guidance on focal points.[69] A CRPD focal point which has knowledge and expertise in national policy and established processes of engagement with rights-holders can perform a constructive role in engaging with statistical offices to bring together the science of indicators with the values and principles of the CRPD. These are attributes which an NMRF may not exhibit.

During the negotiation of the CRPD, the Australian NHRI proposed the incorporation of an obligation on ratifying States to develop a National Disability Action Plan (NDAP) on implementation of the CRPD. Whilst this proposal was not adopted, interest in the utility of NDAPs remains.[70] Jerome Bickenbach highlights that to be effective, rights must be 'operationalizable' into policy goals, which should then be broken down into 'challenging yet feasible' targets. An NDAP provides a policy instrument for the collection of these goals and targets.

68 "Kanter, A. S." (2003). The globalisation of disability rights law. *Syracuse Journal of International Law and Commerce*, 30, 241.

69 "Kakoullis, E., & Ikehara, Y." (2018). Article 1 purpose. In Bantekas, I., Stein, M., & Anastasiou, D. (Eds.), *The Convention on the Rights of Persons with Disabilities A Commentary*. Oxford, UK: Oxford University Press.

70 "Fleischer, D. Z., & Zames, F." (2005). Disability rights: The overlooked civil rights issue. *Disability Studies Quarterly*, 25(4). Retrieved from https://dsq-sds.org/article/view/629/806

The OHCHR guide suggests that focal points should be tasked with the development and implementation of an NDAP. Eilion´oir Flynn highlights that NDAPs can play a valuable role in facilitating cross-departmental collaboration on the implementation of the CRPD, and can be used as a policy framework for holding relevant authorities to account. The development and assessment of goals relating to the CRPD requires technical knowledge of the CRPD, political perceptiveness and interpersonal skills. The OHCHR's interest in national action plans has given way to interest in RIPs, which the OHCHR considers that NMRFs are well placed to coordinate. Advocates consider that a RIP coordinated by an NMRF overcomes many of the drawbacks of a national action plan and sectoral plans through using recommendations from the international system as the principal guide rather than a baseline assessment. We again see here the difference of approaches to compliance which underpin a CRPD focal point and NMRFs. Advocates of NMRFs consider that recommendations from the international system provide a blueprint for implementation efforts. CRPD advocates see the CRPD and the international system as providing a normative framework, the translation of which takes place at the domestic level through inclusive processes which harness the transformative potential of participation. Such processes draw on local knowledge, capacity and creativity.[71] In contrast, the RIP process seeks to restrict domestic processes which may taint or water down recommendations from the international system. A CRPD focal point embedded in the domestic policy framework is well-placed to grow expertise and foster the establishment of rational capacities to facilitate the development of national plans and the application of workable indicators.

1.4.4 **OHCHR guidelines on Covid-19 and the rights of persons with disabilities (2020)** Human rights scrutiny in the COVID-19 pandemic has largely focused on limitations of individual freedoms to protect public health, yet it is essential to look at the broader relevance of realising human rights to promote public health in the COVID-19 response.

The human right to the enjoyment of the highest attainable standard of physical and mental health provides binding normative guidance for health-care systems, broader social responses, and global solidarity. As recognised in the International Covenant on Economic, Social and Cultural Rights, the right to health requires that states take steps for the "prevention, treatment and control of epidemic, endemic, occupational and other diseases" and to assure "medical service and medical attention in the event of sickness". The right to health requires that health goods, services, and facilities are available in adequate numbers; accessible on a financial, geographical, and non-discriminatory

[71] "Diels, V., & Van Puyenbroeck, J." (2015). *Onderzoek naar de validiteit van het IZIKA en IZIIK instrument voor de doelgroep kinderen en jongeren met een handicap*. Retrieved from https://praktijkgerichtonderzoek.odisee.be/sites/default/files/mediabestanden/izika_rapport_251115.pdfGoogle Scholar

basis; acceptable, including culturally appropriate and respectful of gender and medical ethics; and of good quality.[72]

Many states, however, have struggled to ensure the availability and accessibility of COVID-19- related health coverage, resulting in shortages of critical medical care, such as diagnostic tests, ventilators, and oxygen, as well as personal protective equipment for health-care workers and other front-line workers. Austerity policies, structural adjustment programmes, and user fees have made crucial services unavailable to some vulnerable people in various nations.[73] Treatment must be based on medical evidence; testing and care must not be denied on the basis of disability, age, or inability to pay; and states must commit maximum resources to health care and rehabilitation. These emergency responses must ensure that other essential health-care services, such as sexual and reproductive health care, antiretrovirals for people living with HIV, immunisation campaigns, and community-based care and support, including mental health care, are not disrupted while providing this care in the context of COVID-19.

In addition to implementing urgent and progressive efforts to avoid COVID-19's escalating public health hazard, states must also "take measures to prevent, or at least lessen" the disease's effect, based on "the best available scientific data to safeguard public health," according to WHO recommendations. Even as states restrict individual freedoms to address this public health emergency—ensuring that such restrictions are reasonable, proportionate, nondiscriminatory, and law-based—it is critical to consider the disease's population-level effects and pay special attention to the disproportionate risks faced by marginalised and disadvantaged people. Lessons learnt from the HIV response emphasise the significance of including and prioritising vulnerable people in disease prevention efforts, rather than further marginalising them.[74]

Social determinants of health, such as appropriate housing, safe drinking water and sanitation, food, social security, and safety from violence, are key parts of the right to health and are protected as interrelated rights under international law. Inequalities in socioeconomic factors translate into varied risks of infection and mortality, and physical separation measures have an influence on these fundamental rights. Women, children, racial and ethnic minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ) people,

refugees, migrants, displaced persons, people with disabilities, the elderly, incarcerated populations, and those living in poverty, working in the These public health risks underscore the imperative for a coordinated human rights-based response to COVID-19 that protects health by realising rights. Human rights provide the necessary principles for effective COVID-19 responses. Equality and non-discrimination require disaggregated data and attention to the rights of vulnerable groups. The participation of all affected communities supports equitable responses, facilitating community-led action and targeted interventions that respect rights. Participation of civil society in the COVID-19 response supports the contextualisation of responses to national and local circumstances. Further, responses must be transparent, clearly communicated, and subject to accountability, including monitoring, independent review, and appropriate remedies. Independent review allows for the assessment of responses and improvement of health systems, with courts, national human rights institutions, parliamentary procedures, and regional and international human rights bodies providing a web of accountability to assure the realisation of health throughout the pandemic response.

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72 "Degener, T." (2016). Disability in a human rights context. *Laws*, 5(3), 35.

73 "David, H., & Duggan, M. G." (2006). The growth in the social security disability rolls: A fiscal crisis unfolding. *Journal of Economic Perspectives*, 20(3), 71–96.

74 "Brage, S., Donceel, P., & Falez, F." (2008). Development of ICF core set for disability evaluation in social security. *Disability and Rehabilitation*, 30(18), 1392–1396.

informal economy, or lacking stable housing are among those most at risk, as seen in the HIV response. Aligned with the UN Secretary-General's call for global solidarity, the right to health recognises international assistance and cooperation as central to the COVID-19 response. This international obligation requires that all states in a position to assist: share research, medical equipment, supplies, and best practices; coordinate to reduce the economic and social impacts of the pandemic; limit economic sanctions, debt obligations, and intellectual property regimes that impede access to needed resources; and, in all this, focus on vulnerable and disadvantaged groups, fragile countries, and conflict and post-conflict situations. However, despite repeated pleas from WHO for global solidarity in the COVID-19 response, many states have failed to provide sufficient international assistance and cooperation, threatening the health and human rights of the most marginalised populations.

WHO governance provides a path for shared responsibility to realise global solidarity. With WHO holding a vital role in coordinating the international response, states must not take deliberately divisive actions that seek to undermine global health governance. State support for WHO remains essential through contributions to the WHO budget and adherence to WHO guidelines. Beyond WHO, these international obligations require support for global governance through the UN's COVID-19 Global Humanitarian Response Plan and the UN Framework for the Immediate Socio- Economic Response to COVID-19; coordination in the development and, if successful, distribution of a "people's vaccine" that is accessible throughout the world; and engagement with the UN human rights system to facilitate accountability for

human rights in global health.[75]

The COVID-19 pandemic has been exacerbated by human rights failures, yet the right to health can provide a framework for assuring that the COVID-19 response serves to realise the right to the highest attainable standard of physical and mental health for all.

1.5 Rights of Person with Disability: National Perspective

Law and life has to go hand in hand. "Man, in society, has had to move from feudal life, through industrial and technological changes, to the modern atomic age. Village communities have had, life- wise, to evolve into Nations and sovereign States and to develop into a world community with closer international relationships. Each stage and change has challenged and out- model existing socio-economic patterns and new relations have been forged. Law, which in one sense expresses the property relations of a given society, has also undergone corresponding transformations and whenever law has lacked behind social change, it has become a drag, generating in its wake violence, violations and upheavals. In short, life and law have marched together history and must do so hereafter also." It is the demand of the society that now we have to deliver to the development of every strata and constituent of society. The best for the differently abled persons can only be achieved with the help of the positive implementation of the legislative intents in practice. And that can be achieved by the positive and healthy interpretation of the statutes.[76]

The description of the subject matter in the earlier chapters reveals that the world, standing in the threshold of 21st century is bent upon restructuring the world society where every person is to be made accountable towards the other. Nations, collectively and individually are finding ways and means, based upon their resources to bring all the members of the society on equipedestal in the nation's mainstream in the long term interest of the nation.

Typically, the pride and honour of Indian families is linked to its capacity of addressing the needs of all its members in the manner suiting to each one's need. Member with disability, is all nobody's concern but that of the 'family'. Social, emotional, financial or other problems of these disabled and/or dependent members are kept within the proviso of the family. Not only because of a 'stigma' attached to it but, also because the family's pride relies on its ability to manage these problems within its own means and capacity.[77]

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[75] Ibid.

[76] Ibid.

On one hand, the credit goes to the family system and its ability to manage a variety of challenges and disabilities of its members by itself; but on the other hand, this very quality of the family has kept the common concerns of the 10% of India's population who are disabled at the level of'Individual problems'. The upper and middle class Indian family and their individualistic approach to this type of common

challenge, have prevented transformation of 'Individual issues' from becoming 'Social issues'. Disability has long been perceived as an 'individual problem', therefore, resulting in the indifference of the society and the state.

In two cases of child abuse reflecting negative attitude of people towards people with disabilities it was reported that a 12-year-old boy and a 19-year-old woman were found imprisoned by their own families in their homes in New Delhi. The boy suffered from mental disability, and a hole had been made in his room to pass food to him. The girl, physically disabled from birth, had spent her whole life in solitary confinement and now had a phobia of light and people.[78]

Recently, Praveen Manjhi, a mentally challenged youth of 28 years, suffering from mental-illness for the last nine months was kept in an iron cage of six feet length and four feet width, in Muthu village in Jharkhand. This shows that the attitude of people towards the disabled has been more or less pathetic. They consider disabled persons to be poor people or a weaker section, who are not able to live on their own, or who always need some help or some support from others. Indian society doesn't think of them being independent and self sufficient in their own right and thus look at the entire issue from the point of view of charity. The same thinking reflects in the attitude of the lawmakers. The Person with Disabilities Act, 1995 is more a policy than an Act. The pragmatic approach of judiciary in this regard is appreciable.[79]

In the words of Will Durant, "Human Conduct and belief are now undergoing transformations profounder and more disturbing than any since the appearance of wealth and philosophy put an end to the traditional religion of the Greeks. It is the age of Socrates again: our moral life is threatened, and our intellectual life is quickened and enlarged, by the disintegration of ancient customs and beliefs. Everything is new and experimental in our ideas and our actions; nothing is established or certain any more. The rate, complexity, and variety of change in our time are without precedent,

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77 "Bezzina, L., Camilleri-Zahra, A., & Gauci, V." (2018). *Task 2017–18 Disability assessment – Country report, Malta*. Retrieved from Utrecht/Leeds: https://www.disability-europe.net/downloads/905-country-report-on-disability-assessment-malta

78 "Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N." (2015). Assessing Disability in Working Age Population: A Paradigm Shift from Impairment and Functional Limitation to the Disability Approach. Washington, DC: World Bank.

79 Ibid.

even in Porcelain days; all forms about us are altered, from the tools that complicate our toil, and the wheels that whirl us restlessly about the earth, to the innovations in our sexual relationships, and the hard disillusionment of our souls.[80] The passage from agriculture to industry, from the village to the town, and from the town to the city, has elevated science, debased art, liberated thought, ended monarchy and aristocracy, generated democracy and socialism, emancipated woman, disrupted marriage, broken down the old moral code, destroyed asceticism above content, made war less frequent and more terrible, taken from us many of our most cherished religious beliefs, and given us in exchange a mechanical and fatalistic philosophy of life. All things flow, and we are at a loss to find some mooring and stability in the flux." This is time, when human deliverance needs holistic jurisprudence so as to provide right based justice

delivery system for every strata of society. Persons with different abilities also need not only protection of society but also their rights needs to be delivered to them.

Poverty has been adjudged as the biggest obstacle in the development of the disabled population. Due to the lack of fundamental needs such as food, shelter, clothing, medicine etc., the rate of disabled population is increasing day by day in the world and particularly in India. In India, each person has to work for his existence and live with the governing principle of 'survival of the fittest'. Under such circumstances, the disabled members are often left to their own fate or at best, institutional confinement is resorted to as a solution.[81] Due to lack of financial support, both from Family and the Government, the disabled children are abandoned completely. Often, it is found that due to poverty the disability, which can be avoided or cured earlier, are neglected and as a result it leads to permanent disability. Lack of nutritional food and no proper care of the health by the poverty ridden community, leads to the increase in the population of the disabled persons.

In general, the severity of disability is described in terms of how much that disability limits one's daily activities. Women are more likely than men to be limited in the amount or kind of major activity they can perform, and more stigmatised owing to the huge demands that the activity makes on their time and energy. Some of the challenges faced by women with disabilities include: physical barriers, such as architectural barriers and lack of adequate transportation and support services to keep appointments, run errands, or receive medical care; financial restraints; and lack of reliable health information and services that address their needs.

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80 "Brage, S., Donceel, P., & Falez, F." (2008). Development of ICF core set for disability evaluation in social security. *Disability and Rehabilitation*, 30(18), 1392–1396

81 Ibid.

Indian society is essentially a patriarchal society. The birth of sons is always celebrated; the birth of a girl is often mourned. And the birth of a disabled girl is adjectives and say, 'a girl, and to top it off, disabled!' A disabled boy is still more acceptable than a disabled girl. If a poor family has a disabled son, they will do their best to give him a decent living. Whereas, when it comes to a girl, they say, "Why should we do anything? There are residential schools, mostly for visually impaired girls. Otherwise girls are with their families, but what happens is that they are left in a comer, not given enough food, and left to die.[82] Opportunities are very-very limited, because education is not there. Of 35 million children, half of the children in the country are not going to school, and two thirds of them are girls, including disabled girls who can only do unskilled labour - if the family lets them go out. Also, as we have arranged marriages in India, a cultural context whereby the parents find a boy, and a certain dowry accompanies the girl. In the case of disabled girls, it means that they would have to give extra dowry, if the girl were to marry a nonnal boy. The women need more attention of policy makers because of the traditional stigma of society i.e, exploitation and suppression from times immemorial.

Disabled children face different sorts of problems in the schools for the reason of their disability and suffer from an inferiority complex of being disabled.It remains futile in the absence of its proper implementation. It is also true that because of the unawareness on the part of the parents of the rights of their children, they are unable to derive benefit from these schemes. No doubt, the Government Schools play an important role in imparting education to a large stratum of the society especially to those who cannot afford the costly education of the private schools. These schools are maintained out of the funds of the State and are important paraphernalia to implement the policies of the State.[83] Hence, it is essential to know how many of them are committed to implement the disabled friendly policies and schemes and to what extent are they helping and encouraging the disabled students to integrate with the normal students in the school. Section 30 of Persons With Disability Act 1995 gives direction to the appropriate government to prepare comprehensive education scheme, which shall make provisions for - (a) Transport facilities to the children with disabilities; (b) Removal of architectural barriers from schools; (c) Supply of books and other materials to children with disabilities; (d) Grant of scholarship to children with disabilities; (e) Setting up of apt forum for redressal of grievance; (f) Modification in examination system for

82 Committee on the Rights of Persons with Disabilities. (2012). *Concluding observations on the initial report of Hungary, CRPD/C/ HUN/CO/1*. Retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/HUN/CO/1.

83 Citizens Advice. (2017). *Written evidence to the Parliamentary Work and Pensions Committee PIP and ESA Assessments inquiry (PEA0369)*. Retrieved from http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/work-and-pensions-committee/pip-and-esa-assessments/written/73556.pdf.

children with disabilities; and (g) Restructuring of curriculum for the benefit of children with disabilities. Media is the fourth powerful pillar of Democracy. It is a very-very powerful tool, especially the print media, the television media and now, the Internet, which has entered the world, coming on in a very big way. Media has many aspects. Films are considered as one of the most powerful mode of conveying a message because of their effective audio-visual propinquity. India produces the largest number of feature films in the world but few and far between the subjects of disability. To fill the gap, Brotherhood, a Delhi based NGO organised two special film festivals in the capital in the year 2004. The use of media as a means of improving the conditions of the disabled is praiseworthy. By using the Hypnotic nature of the audio-visual media, we can send positive message to both the disabled persons and the able-bodied persons. The positive aspect of media has boosted the community-based programmes. In an attempt, to promote public awareness and consciousness, around 26 films and documentaries, both Indian and foreign, were screened during the Second International Special Film Festival organised by the Brotherhood and Action Aid India from September 8-19, 2004, in Delhi. Indian films screened included - Anjali, Koshish; Koi Mil Gaya, Tera Mere Saath Rahe, Sparsh, and Khamoshi. The films in foreign category comprised - Children of Lesser God, Born on the Fourth of July, Merciuy Rising (USA), When you Shine, This is Noriko (Japan), Colours of Blind, For there be Love (China), Rivka and Yoram, My Mother's First Olympics (Israel), Every Little Thing, In the Land ofDeaf(French), andA Heart Else Where (Italy)12. The audio - visual media is the best source of spreading not only messages for the disabled

persons but it can also be useful for community as a whole to understand the problem of the disabled persons and the strategy there of to integrate disabled persons in the society.[84]

The media occasionally blows out of proportion the achievements of the disabled persons as performed by super human beings or always gives the attribute or the idea that the disabled person is a special person - a person with special needs, care and everything special. Therefore, they are often treated in segregation. The disabled person is never treated as part of the mainstream society. By changing the perspective, by looking at the disabled person as a potential rather than as a problem, not special but ordinary in every way -that is where the media can step in. Though media can be a most useful source of promoting third generation rights yet, it is not showing any sort of positive responsibility towards the disabled persons as a whole. During the Stephen Hawking's visit to India, Media reported the problems of the disabled persons whole-heartedly, and also reported the impact of Persons with Disability Act, 1995 in India.[85] The problem of accessibility of disabled persons to Historic Monuments had been highlighted, but very soon media forgot everything. Due to the lack of the follow up by the media, the matter remains cold for another few years.

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84 Ibid.

In fact, the media, be it visual or audio-visual or audio, should devote time and space for projecting recent development, research orientation, achievements in this field, follow-up action to the earlier ones and summing up all of this statistically at local, national, regional, and international levels. Over and above all, the issue has to reach the public. The Government has several programmes, companies like the Tata Group, which have several policies - but how does the person with disability know, about them? How do we know about their implementation? What is being done? What is not being done? And who is being open, democratic, and who is not? The media has to be transparent in regard to all these before the public. The disabled do read and get news from the newspapers too.[86] The print media has improved marginally and definitely, in a sense, that a lot of things pertaining to these get exposition these days. But even then, it's not enough at all, in general and particularly for the economically weaker sections and worst of-the worst are gregarious in numbers. Media has to understand its role and responsibilities in the making and moulding of-social awareness. A responsible media can serve as a tool and become useful in spreading a responsible message related with disabled issues in the society.

1.5.1 Fundamental Rights of Person with Disability

In Chapter III of the Indian Constitution, all people are guaranteed fundamental human rights. The right to equality is guaranteed by Article 14 of the Constitution, which states that all people are equal in the eyes of the law. Persons with disabilities are entitled to this promise that they will not be discriminated against in any way and will be treated equally, which may include the need for special treatment. Similarly, Articles 15 and 16 ban discrimination based on "religion, race, caste, sex, place of birth, or any

of them," and ensure equal opportunity in public employment. The State can create provisions for the reserve of appointments or posts in favour of any backward class of persons who, in the view of the State, is not sufficiently represented in the services, according to Article 16 (3) and (4). Under the PWD Act, promises of reservation and equal opportunity in public employment are granted on the basis of Article 16. The right to equality has been preserved, ensuring that people with disabilities are not discriminated against and are given equal opportunities in civil service recruitment. The right to life is guaranteed to all people by Article 21 of the Constitution, which the Supreme Court has defined to encompass the right to live in dignity, the right to a livelihood, and the right to an education. Article 21A provides all children between the ages of 6 and 14 the right to freedom and compulsory education.[87]

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85 David, H., & Duggan, M. G. (2006). The growth in the social security disability rolls: A fiscal crisis unfolding. *Journal of Economic Perspectives*, 20(3), 71–96.

86 De Bruycker, S. (2018). *Task 2017–18 Disability assessment – Country report, Belgium*. Retrieved from Utrecht/Leeds: https://www.disability-europe.net/downloads/905-country-report-on-disability-assessment-belgium

The Directive Principles of State Policy, which are also goals for the state to meet, are found in Chapter IV of the constitution. According to Article 38 of the DPSPs, state policy should be focused on minimising disparities, ensuring the right to an adequate means of subsistence, and ensuring that the legal system functions in a way that promotes justice. Article 41 states that the state must establish preparations to ensure the right to labour, education, and public assistance in the event of unemployment, old age, disease, or disability, as well as other unjustified poverty.[88] The State shall make every effort to offer free and obligatory education to all children until they reach the age of fourteen, and under Article 46, the State is also responsible for supporting the educational and economic interests of the poorer parts of the population with special care. All of these provisions apply equally to people with impairments.

If no other alternative or equally effective remedy is available, any individual may approach the High Courts or the Supreme Court in their writ authorities under Articles 226 and 32, respectively, if any of these rights are denied or violated.[89]

The PWD Act

The PWD Act came into force on 1st January 1996, and was enacted in pursuance of India's obligation under the Proclamation on the Full Participation and Equality of People with Disabilities in the Asian and Pacific Region, which it adopted in December 1992. The Act provides for various measures for persons with disabilities to facilitate their access to education, employment, basic infrastructure and social welfare measures.[90]

Under the PWD Act, a 'person with disability' has been defined as any person having 40% or more of any of the following disabilities:

(i) Blindness;

(ii) Low vision;

(iii) Leprosy cured;

87 de Wind, A. E.,Dekkers -Sánchez, P. M., & Godderis, L. (2016). The role of European physicians in the assessment of work disability: A comparative study. *Edorium Journal of Disability and Rehabilitation*, 2, 78–87.

88 Degener, T. (2017). A new human rights model of disability. In Finna, V. D., Cera, R., & Palmisano, G. (Eds.), *The United Nations Convention on the Rights of Persons with Disabilities: A Commentary* (pp. 41–59). Oxford, UK: Oxford University Press.

89 Ibid.

90 Ibid.

(iv) Hearing impairment;

(v) Locomotor disability;

(vi) Mental retardation; and

(vii) Mental illness.

This is a limited definition, as only persons who fall within this definition as having 40% or more of the above 7 disabilities would be categorised as person's with disabilities and would be entitled to get the benefits of the rights and schemes under the PWD Act.

The main rights available to persons with disabilities are in the field of education in public schools, public employment, infrastructure on the roads and in public transport and access to public buildings and a grievance redressal procedure for protection of their rights.[91]

Education

Under the PWD Act, all children with disabilities below the age of 18 have the right to free and compulsory education that is accessible. This goes even beyond the mandate of the *Right of Children to Free* and *Compulsory Education* Act, 2009 that calls for free education to be provided to children up to the age of 14. The further obligations placed on the government by the PWD Act with respect to formal education are that efforts must be made to see that these children with disabilities are integrated into regular schools that they attend, and that the setting up of special schools with vocational training facilities should be encouraged at the local level in the Government and private sectors, so that children across the country who require special education have access to such schools in their areas. Section 39 of the PWD Act also requires that 3% of all seats in Government and Government-aided educational institutions be earmarked for children or students with disabilities.[92] The PWD Act also requires that the government formulate and implement schemes pertaining to non-formal, functional education, in respect of the following matters:

(a) Conducting part-time classes in respect of children with disabilities who have completed the fifth grade and could not continue full-time studies thereafter;

(b) Conducting special part-time classes to provide functional literacy for children with disabilities in the age group of sixteen and above;

(c) Imparting non-formal education after an appropriate orientation;

(d) Imparting education through open schools or open universities;

(e) Conducting class and discussions through interactive electronic or other media; and

[91] Frueh BC, Elhai JD, Gold PB, Monnier J, Magruder KM, Keane TM, et al. Disability compensation seeking among veterans evaluated for post-traumatic stress disorder. *Psychiatr Serv.* 2003;54:84–91.

[92] Ibid.

(f) Providing every child with disability the requisite books and equipments, at no cost. Additionally, to facilitate equal opportunities in education for children with disabilities, the government is obligated to promote research on assistive devices, teaching aids and special teaching materials, and establish and assist special teachers' training institutions. Educational institutions are required to ensure that children with visual disabilities are provided with scribes when required. To further facilitate the mainstreaming of children with disabilities, the government is required to prepare a comprehensive scheme providing for facilities or financial support for transport to and from school, making school supplies available, scholarships, grievance redressal fora, modification of examinations and restructuring of the curriculum.[93]

Employment

Chapter VI of the PWD Act, containing Sections 32 to 40, addresses the affirmative action measures with respect to the employment of persons with disabilities. It requires that at least 3% of all posts in all jobs under the government are required to be reserved for persons with disabilities, with 1% each being reserved for persons with blindness / low vision, persons with hearing disabilities and persons with locomotor disabilities / cerebral palsy.[94]

To ensure that reservations have meaning, the government is required to identify posts in all public establishments that shall be reserved for persons with disability, based on the suitability of such posts to each category of disability. The list of identified posts so prepared is required to be revised in light of technological developments, at regular intervals of a maximum of 3 years.

Under Section 34, vacancies are required to be advertised, with the details of the reservations for the persons with disabilities, in the Special Employment Exchange and, if not filled, shall be carried forward to the next recruitment year.[95]

There are also many requirements of reasonable accommodations to be provided by the Government under Article 38 of the PWD Act and to formulate schemes for the following:

(a) relaxations of age limit,

(b) training,

(c) creation of an enabling environment and providing incentives to employers.

[93] Chaudhury PK, Deka K, Chetia D. Disability associated with mental disorders. Indian J Psychiatry. 2006;48:95–101.

[94] Math SB, Gupta A, Yadav R, Shukla D. The rights of persons with disability bill, 2014: Implications for neurological disability. Ann Indian Acad Neurol. 2016;19:S28–33.

[95] Ibid.

(d) The government is also required to frame an insurance scheme for its employees with disabilities, and is expressly prohibited from discriminating against employees who acquire disabilities over the course of their employment as well as employees with disabilities in the matter of promotions.

(e) Finally, for those persons with disabilities who are registered with the Special Employment Exchange and have not been able to find gainful employment for over 2 years, the government is required to frame a reasonable scheme for unemployment allowance.

Accessibility

Accessing public spaces and infrastructure are addressed in Sections 44 to 47 of the PWD Act. Such measures include adapting public transport facilities for easy access to persons with disabilities, installing auditory and tactile indicators on public roads and pavements to aid those with auditory and visual disabilities, and installing ramps, Braille symbols and auditory signals in facilities in public buildings and medical institutions.

Statutory Authorities and Grievance Redressal

The PWD Act provides for the appointment of a Chief Commissioner for Persons with Disabilities at the central level under section 57 and Commissioners for Persons with Disabilities at the state level under Section 60 of the PWD Act. The Commissioners have the powers to

(i) Co-ordinate with the departments of the State Government for the programmes and schemes for the benefit of persons with disabilities;[96]

(ii) Monitor the utilization of funds disbursed by the State Government;

(iii) Take steps to safeguard the rights and facilities made available to persons with disabilities;

(iv) Submit reports to the State Government on the implementation of the Act at such intervals as that Government may prescribe and forward a copy thereof to the Chief Commissioner.

In addition to these powers, the Chief Commissioner and Commissioners may of their own motion or on the application of any aggrieved person or otherwise look into complaints relating to deprivation of rights of persons with disabilities or the non-implementation of laws, rules, bye-laws, regulations, executive orders, guidelines or instructions made or issued by the appropriate Governments and the local authorities for the welfare and protection of rights of persons with disabilities, and take up the matter with the appropriate authorities. In order to enquire and adjudicate into these complaints, the Chief Commissioner and the State Commissioners have certain powers of civil court such as summoning of documents, etc.[97]

96 Maj M. The rights of people with mental disorders: WPA perspective. Lancet. 2011;378:1534–5.

97 Ibid.

Thus any matter of discrimination or denial by public authorities in matters of recruitment, promotion, benefits that person's with disabilities are entitled to may be brought before the Commissioners for adjudication and under Section 62 of the PWD Act, , and they can recommend appropriate action to be taken by the offending body.[98]

The central government and many State governments have enacted rules under the PWD Act which include rules on the procedure for filing complaints before the Commissioners. The complainants do not require legal representation during the proceedings, and generally, they may institute a complaint by submitting complete details of their complaint and facts to the relevant Commissioner. In accordance with the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1996, complaints are ideally to be disposed of within 3 months from the date of notifying the opposite party.[99]

In the event that any party is not satisfied with the decision of the Chief Commissioner or the State Commissioner, the said decision can be challenged in a writ petition in the respective state Hogh Court by the aggrieved party.

1.5.2 Rights of Persons with Disability Act, 2016

The 2016 Act has been able to provide greater clarity into hitherto undefined constructs. For example, the definitions of discrimination, barrier, mental illness, and benchmark disability have been elucidated. In the 1995 Act, a person with disability meant "a person suffering from not less than forty per cent of any disability as certified by a medical authority." In the 2016 Act, this definition has been replaced by the following: A person with disability "means a person with long- term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others."[100]The former definition typifies a person based purely on the degree of disability. The latter, in contrast, provides a holistic view of what the person's disability could comprise, emphasising not only on biological determinants but also on social, environmental, and relational ones.

The concept of disability itself has been altered in the new Act that views the concept on a continuum. This is a broader and more inclusive understanding of disability, in comparison with the 1995 Act which recognized PwD as only those with a disability equal to or higher than40%.[101]

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98 Olatunji BO, Cisler JM, Tolin DF. Quality of life in the anxiety disorders: A meta-analytic review. Clin Psychol Rev. 2007;27:572– 81.

99 Judd LL, Akiskal HS, Zeller PJ, Paulus M, Leon AC, Maser JD, et al. Psychosocial disability during the long-term course of unipolar major depressive disorder. Arch Gen Psychiatry. 2000;57:375–80

100 Ibid

Similarly, in the PwD Act, mental illness was defined as "any mental disorder other than mental retardation." The new Act provides a broader definition of mental illness "Mental illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence."

1.5.3 Rights of Persons with Disability Rule, 2017

India's new disability law, The Rights of Persons with Disabilities Act, 2016 and the Rights of Persons with Disabilities Rules, 2017 was notified by the Indian Government on 19th April, 2017 and 15th June, 2017 respectively (collectively the "**RPD Act**").[102] The RPD Act is in line with the principles of the United Nations Convention on the Rights of Persons with Disabilities and repeals the erstwhile The Rights of Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. While the old law was applicable only to the public sector in India, the RPD Act has for the first time brought the private sector into its ambit by providing a statutory framework to ensure equal opportunities are provided to persons with disabilities (**"PwD"**) in all organisations.

The RPD Act covers PwD suffering from various disabilities, including cerebral palsy, dwarfism, muscular dystrophy, acid attack victims, hard of hearing, speech and language disability, specific learning disabilities, autism spectrum disorders, chronic neurological disorders, Parkinson's disease, blood disorders such as haemophilia, thalassemia, sickle cell anaemia, etc., and encourages all establishments to develop an amiable work environment for PwD. The RPD Act also prohibits discrimination against PwD on the ground of disability, except where it can be established that the alleged act of discrimination was a proportionate means of achieving a legitimate aim.[103]

While most obligations under the RPD Act are imposed on the public sector, there are some obligations on private establishments as well. The definition of a private establishment under the RPD Act is quite broad and includes a company, firm, cooperative or other society, association,

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101 Ibid

102 Simon GE. Social and economic burden of mood disorders. *Biol Psychiatry.* 2003;54:208–15.

103 Noale M, Maggi S, Minicuci N, Marzari C, Destro C, Farchi G, et al. Dementia and disability: Impact on mortality. Dement Geriatr Cogn Disord. 2003;16:7–14.

trust, union and factories. While it is not compulsory for private companies to hire PwD under the new law, the private sector has to comply with the following obligations under the RPD Act.

Obligations of private establishments in India

Equal Opportunity Policy: Every entity has to draft an Equal Opportunity Policy (**"Policy"**) which enumerates the facilities and amenities to be provided to the PwD to enable them to discharge their duties in the entity. This Policy has to be displayed on the entity's website or at conspicuous places on the premises of the entity.

Additional Compliances*:* Entities having 20 or more employees have to comply with the following:

- **Specific Policy inclusions:** The Policy should include:

  i) the facilities and amenities to be provided to PwD to enable them to effectively discharge their duties in the entity;

  ii) list of suitable posts/roles identified for PwD;

  iii) manner of selection of PwD for various posts, post-recruitment and pre-promotion training, preference in transfer and posting, special leave, preference in allotment of residential accommodation, if any, and other facilities to be provided to the PwD; and

  (iv) provisions for assistive devices, barrier-free accessibility and other facilities provided or to be provided to PwD by the entity.

- **Liaison Officer:**A liaison officer has to be appointed to oversee the recruitment of PwD and make the necessary provisions and facilities for such employees.
- **Maintenance of Records:** The entity has to maintain records of the number of PwD employed by it, their date of joining, name, gender, address, nature of their disability, nature of work performed by them and nature of facilities provided to them.[104] Record retention is an important requirement, as the RPD Act empowers concerned authorities to seek records/ specific information from an establishment for inspection on demand to ascertain their compliance level with the law. Further, failure to comply with such demand is an offence under the RPD Act and may result in penalty of prescribed fines.

Compliance with Accessibility Norms: Every entity has to comply with the accessibility standards relating to physical environment, transport and information and communication technology as per the standards prescribed in the RPD Act. These include barrier free built environment having elevators/ramps for the benefit of wheelchairs for PwD; ensuring the

[104] The Voice of FOD, Volume XII No. 1, Jan -June, 2004.

documents uploaded on the website are in Electronic Publication (ePUB) or Optical Character Reader (OCR) based PDF format.[105] No entity shall be granted permission to build for new construction projects or certification of completion for under-construction buildings, unless it has adhered to the accessibility norms formulated by the Central Government. The existing buildings are required to adhere to these norms within 5 years from the notification of The Rights of Persons

with Disabilities Rules, 2017 (i.e., by June 2022). While these compliances are primarily the responsibility of the building developer/owner of the establishment premises, it is important for entities acquiring/leasing out office space in such premises to note the related compliances.

Handling complaints of discrimination: The RPD Act also requires heads of private establishments having 20 or more employees to handle complaints of discrimination received from PwD by either taking necessary action as provided under the RPD Act or informing the complainant in writing as to how the alleged act of discrimination was a proportionate means of achieving a legitimate aim.[106] However, the action to be taken by private establishment for handling such complaint is not prescribed under the RPD Act.

Penalty for non-compliance

Non- compliance of the above mentioned obligations (other than maintenance of records of PwD employees) will amount to an offence under the RPD Act and shall be fined with INR 10,000 for the first contravention and for any subsequent contravention with fine up to INR 50,000, which may be extended to INR 500,000. There is some ambiguity on the authority that would be responsible for implementation of the provisions of RPD Act and monitoring compliances by private establishments as the "appropriate government" (state or central) for private establishments is yet to be ascertained.[107]

2.5.3 National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999

In 1999, the National Trust for the Welfare of Persons with Autism Cerebral Palsy, Mental Retardation and Multiple Disabilities Act was passed. This legislation is applicable to those suffering from autism, cerebral palsy, mental retardation or multiple disabilities.[108] The Act provides for establishment of the Board of the National Trust, Local Level Committees, Accountability and Monitoring of the Trust. It also includes provisions for legal guardianship of the four categories of the persons with disabilities mentioned above and seek creation of enabling environment for their independent living. In nutshell the act envisages to work for affirmative action for categories of persons whose disability may render them incapable of self-care in daily life and independent living (Addlakha, 2005). The specific objectives of the Act included:

105 Ibid.

106 Hershey, Laura , "An Interview With Dr. Anita Ghai, One OfIndia's Advocates For Rights OfDisabled Women" available at http:// www.disabilityworld.org,, May-June 2001, (Last accessed on 13* April 2021)

107 Ibid.

- Enabling and empowering PWDs to live as independently and as fully as possible within and as close to the community to which they belong;

- Promoting measures for the care and protection of persons with disabilities in the event of death of their parent or guardian; and
- Extending support to registered organizations to provide need based services during the period of crisis in the family of disabled.

However, the act has been criticised a lot for having limited scope. The primary focus of the act had been towards providing enabling environment for independent living of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities.[109] There are certain bits and parts of the act that can be expanded to include sexual and reproductive health and rights. For instance, the health aspects can be expanded to include sexual and reproductive health services and information. The act remains silent when it comes to direct mention of sexual and reproductive rights of person with disabilities.

1.5.4 Department of Empowerment of Persons with Disabilities (Divyangjan)

In India, 2.21% of population has one or other type of disability and 80% of them live in rural India. The Rights for Persons with Disability Act 2016 with its schedule of 21 types of disabilities, definitions, assessment for 21 types disability, bench mark disability, disability certification procedures require participation of all key stakeholders such as government departments, NGOs, rehabilitation professionals, teachers, special educators, psychologists and families, disability experts, doctors, lawyers, PWD towards its standardisation. The professionals under each type of disability are working in a highly specialised manner and there is need to dialogue regarding diverse category of disabilities by understanding multidisciplinary approaches, intervention strategies in collaborative manner. This will facilitate to develop best intervention strategies for future needs of persons with disability to develop roadmap and policy interventions. This conference will focus on scope of convergence of various dimensions of disability, accessibility, with a larger goal of inclusion for all and facilitating benchmark practices at national level in context of RPWD Act 2016 and sustainable development as per United Nation's Sustainable Development Goals with larger goal of "No One Leaving Behind".[110]

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108 Ibid.

109 "Radhakrishnan, Chitra," "Body As Bane: Women And Disabilities In Indian Patriarchy" available at http:// www.womeninaction.org, no.2, (Last accessed on 24Ib April 2021)

This is the fourth conference organised by Centre for Disability Studies and Action at TISS on issue of Inclusion and Accessibility. We started our journey with first 'International Conference on Disability Rights, Accessibility and Inclusion in India' at TISS in collaboration with HRLN and ISLP UK, where more than 150 disability rights activists participated from all over India and renowned Disability Rights advocates from ISLP UK. This was instrumental to start series of National Conference on Disability, Accessibility, Inclusion and Wellbeing 2017, 2018 and 2019 is upcoming which was organised in December every year on the day RPWD Act 2016 was passed by parliament.

The current law RPWD Act 2016 were passed after a decade of struggles of the persons with disability, disability advocates, experts, disability specific organisations and policymakers with 21 categories of disabilities. With effect to that various supreme court judgements were passed to protect the rights of persons with disability however there is hardly any awareness on those.[111] It's essential to understand the scenario after the judgements and initiatives taken by government, NGOs towards protecting the rights of persons with disability. Hence the conference is a collective effort to build capacity and highlight the rights-based perspective and disability models together i.e. medical model, social model, a rights-based model in the light of bio-psycho-social-cultural- geographical legal perspective to facilitate inclusion of persons with disability.

The conference will provide a forum for dialogue and learning to build capacity on the use of each disciplinary knowledge and share best practices to comprehend the same in light of current law to further realise the needs-based interventions and rights of persons with disability in India.[112] The Conference aims to bring best practices in the disability sector and reimagining disability in the context of the current legislation and policy framework to understand the diverse needs of the population of persons with disability. This will enable professionals to empower PWD as well as design intervention strategies for them with a rights-based approach. The idea is to converge all the aspects of education, higher education, well-being, health, and disability with a larger goal of inclusion of all and accessibility. This is an effort to acknowledge all the disability models together with bio-psycho-social-cultural-legal aspects in understanding the needs of persons with disability to facilitate inclusive development in the country.[113] The current law RPWD Act 2016 has raised the expectation of the PWD across India to get quality benefits, provisions and need-based interventions under the 21 types of disability. In current scenario of disability sector, professionals and practitioners are working in a highly specialised manner and they may be lack of awareness about knowledge generated and diverse practices of other categories of disability, Hence there is urgent need to discuss, dialogue and deliberate regarding each category of disability, rehabilitation and its inclusion process with its multidisciplinary knowledge and practices. This will enlarge the work of the multidisciplinary team to work together in a collaborative manner for understanding future needs of Persons with Disability.

110 As reported in Success and Ability - Newsletter of the Ability Foundation, April-June 2021

111 The Hindu, Monday, April 27, 2021, p. 12, City Edition Delhi

112 Sorabjee, Soli J., "Law and Justice", 2003, p.4

1.5.5 Rehabilitation Council of India Act, 1992

Rehabilitation Council of India Act was passed by the parliament in 1992. The Act provides for formation of the Rehabilitation Council of India for regulating the training of rehabilitation professionals, and preservation of a Central Rehabilitation Register. It aimed at standardising manpower training and service delivery, through regulating organizations and institutions working in the disability sector in the country

(Addlakha, 2005).[114] Some of the salient features of the Act included:

1.5.5.1 Standardising training courses for professionals dealing with people with disabilities;
1.5.5.2 Prescribing minimum standards of education and training of various categories of professionals dealing with people with disabilities;
1.5.5.3 Regulating these standards in all training institutions uniformly throughout the country;
1.5.5.4 Promoting research in rehabilitation and special education; and
1.5.5.5 Maintaining Central Rehabilitation Register for registration of professionals. The Act regulates training standards for sixteen categories of rehabilitation professionals.

The Act strives to proactively promote training and research initiatives utilising experience of specialised as well as mainstream academic institutions. The act remains silent of the reproductive and sexual health issues of persons with disabilities.[115] Neither does it recognise any professional training program for catering to the sexuality needs of persons with disabilities let's say sexual counsellor's for persons with disabilities and therefore negating the importance of sexual rights in the lives of persons with disabilities.

113 "Mohit, Anuradha", "Disability In India: Family Responsibility Or Social Issue? Signs Of A Gradual Paradigm Shift," available at http://www.disabilityworld.org,, (last accessed on 23rd April 2021)

114 Ibid.

1.5.6 The National Policy for persons with Disabilities, 2006

National Policy for Persons with Disabilities was announced in February, 2006.[116] The Policy Statement for Person with Disabilities recognized persons with disabilities as valuable human resource for the country and seeks to create an environment that provides them equal opportunities, protection of their rights and full participation in society.[117] The policy seeks to achieve the physical, economic and educational rehabilitation of persons with disabilities through various mechanisms as defined in the policy paper along with the focus on prevention of diseases. The salient feature of the National Policy includes:

1.5.6.1 Physical Rehabilitation, which includes early detection and intervention, counselling & medical interventions and provision of aids & appliances. It also includes the development of rehabilitation professionals.
1.5.6.2 Educational Rehabilitation including vocational training and
1.5.6.3 Economic Rehabilitation for a dignified life in society.

Even the National Policy for Person with Disability where the stress is on improving the quality of life of PWDs nowhere talks explicitly about improving the quality of life by providing PWDs with their Reproductive and sexual rights. The policy does not talk in great detail about sexual and reproductive health and rights of PWDs and direct provisions for them though they can be expanded to include them

115 Ibid.

116 "Diels, V., & Van Puyenbroeck, J." (2015). *Onderzoek naar de validiteit van het IZIKA en IZIIK instrument voor de doelgroep kinderen en jongeren met een handicap*. Retrieved from https://praktijkgerichtonderzoek.odisee.be/sites/default/files/mediabestanden/izika_rapport_251115.pdf

117 Ibid.