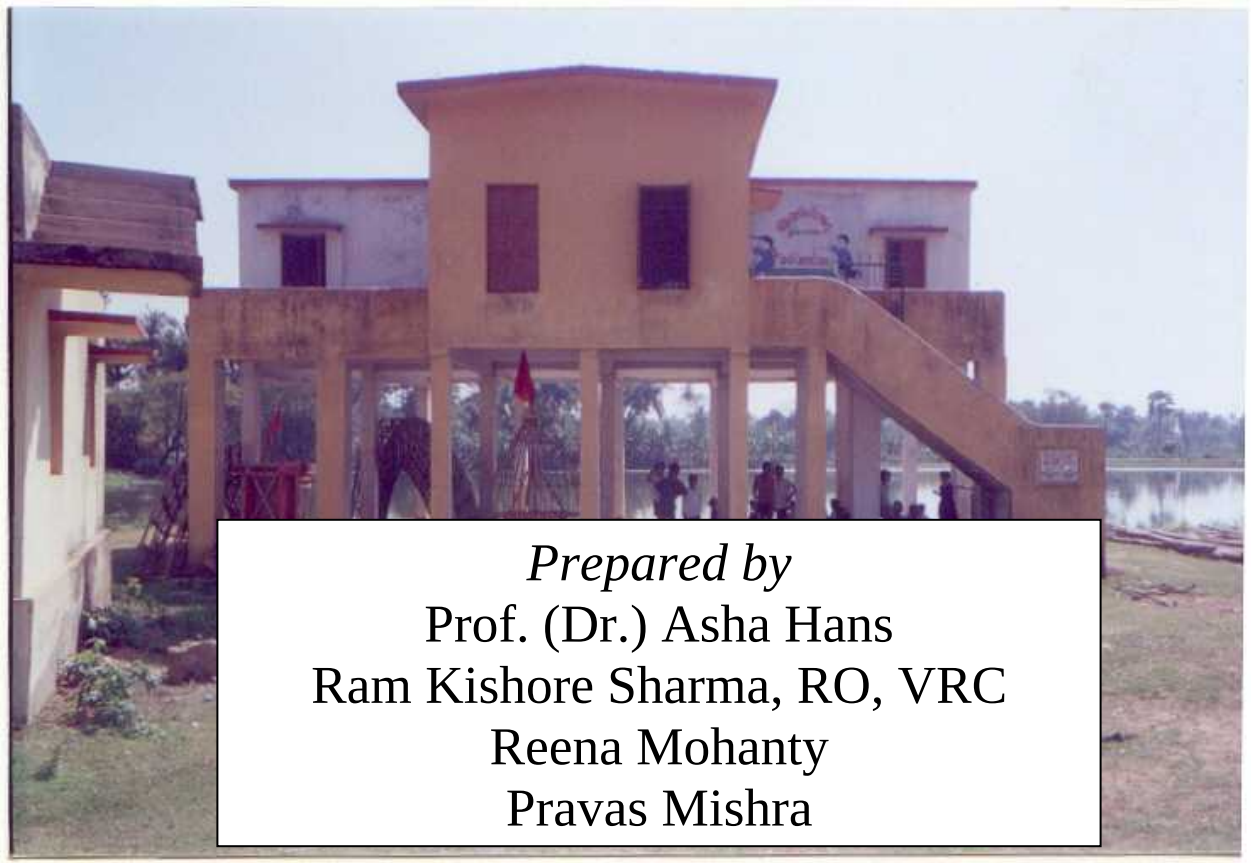
TRAINING MANUAL
FOR
INCLUSION OF DISABILITY IN DISASTER RESPONSE



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Ashok Hans
Executive Vice-president

17th September'2005
Bhubaneswar

PREFACE

In 1999 a super cyclone struck the coast of Orissa. Despite every effort disability did not become a core issue in Disaster Management policy and implementation .It was found that the vulnerability of the severally disabled was two folds. On one hand their families and community members left them behind and on the other hand Government or Non-Government personnel could not evacuate them. They spent several weeks in isolation and a majority without food, shelter or a means of treatment. The fate and the loss of lives amongst this target group will never be known.

The available Cyclone shelters were ill designed to enable persons with disabilities to use the same. Some other aspects of the poor outcome were inaccessible conditions for the use of mobility aids, inadequate resources within the community to evacuate these people, lack of trained manpower to recognize their immediate needs and the ability to tackle the trauma.

Disturbing reports were received through the media and some voluntary organizations that, the severely injured & disabled were being turned away by and from the District and major Hospitals. These traumatized and poverty stricken persons were sent home to die. This, SMRC felt was not acceptable, as it was an abuse of human rights and dignity.

As Government, UN and other donor agencies began coordination meetings to tackle the problems, SMRC raised the issues of prioritizing relief and rehabilitation measures for persons with disabilities. It seemed that there was a singular lack of concern or understanding hence, no steps were taken or any action plan drawn up by the State Government to provide intervention or assistance to this vulnerable section of the population. This issue was taken up repeatedly with the state Government and finally inadequate circular was issued to all district collectors to provide relief. This was limited to a small population who could reach the destination points of relief distribution. But no rehabilitation process was taken up.

SMRC then decided to take the task up and to go into the field. The objectives were to locate the severely disabled, evacuate those who needed immediate treatment, provide on the spot treatment, counseling, medicine etc. The follow up objective was to assess the long term needs in the area of reconstruction of houses, provision of loans for livelihood, mobility aids and assistive devices and other special needs to prevent destituteness and mortality.

DanChurchAid stepped in to assist in the above to provide on the spot initial intervention by a team of multidisciplinary parapetic and rehabilitation personnel. Further assistance was provided in the form of building for the O & P fabrication workshop and space for housing the very severely injured persons who needed extended stay for other rehabilitation assistance. This was a welcome gesture considering that, the State Government and International donors working in the field of disability did not come forward.

With limited resources at its disposal SMRC organized a multi collaborative action plan by utilizing the network of the central government agencies like the Artificial Limbs Manufacturing Corporation (ALIMCO), which provides free of cost mobility aids and assistive devices and the Vocational Rehabilitation Center for the Handicapped (VRCH), which conducts vocational assessment and caters Vocational need of the PWDs. The district level NGOs joined this team in their respective districts. It was inevitable that all the cases could not be possible to be covered and hence, it takes two years before SMRC was able to reach each and every person in the remotest of villages before SMRC could complete the job.

In response to the cooperation SMRC received it was able to identify 2838 persons, provide 2727 mobility aids, loans were processed from the National Handicapped Finance Development Corporation (NHFDC). In addition one model vocational training center was set up in the village Hajipur, Ersama block the most affected block in the entire 14 districts. In addition number of items were provided to the severely disabled during the home visits.

In addition a medical parapetic team with rehabilitation professional personal visited the homes of the 124 persons with severe disabilities especially those with spinal cord injury to provide them not only medical treatment but most importantly psychosocial counseling to enable their families to cope with and to overcome their traumatic experiences. This exercise has been equally traumatic and the states the team who witnessed first hand the plight of these persons and those who shared their concerns for the future.

The outcome of the work has manifested into future needs that would be necessary to ensure safety and better preparedness and hence management to confront natural disasters and prevent severe disabilities as well as the avoidable loss of life.

One way to sustain the efforts of SMRC was to 1) Train the community so that it becomes independent 2) Pass on this knowledge to others and therefore this manual is being put on our web page.

Based on the past intervention in the disaster area and looking into the need of the disable community, I am pleased to introduce this manual in the hope that it will help to raise awareness and orient the community to protect the disabled during disaster.

Ashok Hans
Executive Vice-President

17th September'2005
Bhubaneswar

CHAPTER ONE

In this section brief discussions are made about the center and its area of functions. This section also gives an idea about the incidence and status of disability and disasters. The statistical figures on the disability also give an idea about the variation of intensity of disability in the state as well as in the disaster prone area of Jagatsinghpur district.

1 INTRODUCTION

This manual intends to focus on issues that are critical to the needs of people with disabilities. Identifying these issues will make management efforts easier and more effective when disaster arrives. The management includes mitigation, preparedness, response, and recovery. The aim of this manual is not to run parallel to other Disaster Management and Mitigation efforts but to find a space for the disabled in the general process with inclusion of their specific needs

1.2 ABOUT THE CENTER

Name of the center: **Shanta Memorial Rehabilitation Centre (SMRC), Orissa, India**

Vision:
A world of equal opportunities, full participation and protection of rights for the people with disabilities (PWDs).

Mission:
The mission of SMRC is to support change aimed at the creation of an environment where the socio-economically marginalized including women, aged and especially, the disabled can enjoy equal rights in all spheres.

Area of Activity and Functions

The area of activity is to enable the Persons with Disabilities (PWDs) to access their basic entitlements of their life with special focus on women, children, adolescents, and the elderly. It functions in the field of health, literacy, human resource development, medical training, Vocational rehabilitation, Economic empowerment and disaster management and preparedness.

The Objectives of the Centre:

- To assist in the change of the existing environment to include the visions of excluded people's needs especially the disabled

- To assist in change by bringing together these people affected by discrimination, human rights abuse and neglect with activists and agencies involved in this process of change.

- To assist in the creation of an atmosphere where this group will enjoy their rights in all spheres.

- To enable the voluntary sector in playing a more committed and meaningful role in developmental activities of the marginalized people.

- To reduce the incidence of disability

The above are carried through an integrated process of advocacy, training, research, and activities in the field.

1.2.1 DISASTER MANAGEMENT

SMRC's Earlier Programmes in Disaster Management during the Super Cyclone of 1999:

It was found that the vulnerability of the severally disabled was two folds. On one hand their families and community members left them behind and on the other hand government or non-government personnel could not evacuate them. They spent several weeks in isolation and a majority without food, shelter or a means of treatment. The fate and the loss of lives amongst this target group will never be known.

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stricken persons were sent home to die. This, SMRC felt was not acceptable, as it was an abuse of human rights and dignity.

As Government, UN and other donor agencies began coordination meetings to tackle the problems, SMRC raised the issues of prioritizing relief and rehabilitation measures for persons with disabilities. It seemed that there was a singular lack of concern or understanding hence, no steps were taken or any action plan drawn up by the State Government to provide intervention or assistance to this vulnerable section of the population. This issue was taken up repeatedly with the state Government and finally inadequate circular was issued to all district collectors to provide relief. This was limited to a small population who could reach the destination points of relief distribution. But no rehabilitation process was taken up.

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The outcome of the work has manifested into future needs that would be necessary to ensure safety and better preparedness and hence management to confront natural disasters and prevent severe disabilities as well as the avoidable loss of life.

In addition SMRC successfully completed a project in partnership with CORDAID wherein, 100 beneficiaries of the Super Cyclone in 1999 affected with severe disabilities were rehabilitated through comprehensive and multi disciplinary health care and components of rehabilitation and provided with a package to continue their activities of daily living. The project was jointly monitored and reviewed by CORDAID's designated monitoring agency CENDRET of the Xavier's Institute of Business Management in Bhubaneswar.

1.3 DISABILITY DEFINITION

Owing to improved health services disabled people are living longer, their presence in society is becoming more visible and their numbers are growing. Defining disability is difficult because there are dozens of definitions - each with a purpose to it. These range from the very narrow to the very broad, from the medical to the social, from the cultural to the local, from the one intended to integrate them in society to the one for exclusion and segregation. People are labeled as disabled or handicapped because they look different from the rest of the society on account of their appearance, behaviour or capacity to learn.

The **WHO** Manual gives the following definitions: A disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. The **ILO** defines a disabled person as an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment.

'According to the Standard rules on the Equalization of Opportunities for Persons with Disabilities, United Nations, 1994 the term 'disability' summarizes a great number of different functional limitations occurring in any population in any country of the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness.

The person with disabilities (Equal opportunities, protection of rights and full participation) Act, 1995 of India defines disability in the specific context of a person suffering from not less than forty per cent of any disability as certified by a medical authority.

It identifies the following seven categories of disability which will now be used in India:

- Blindness
- Low Vision
- Leprosy Cured
- Locomotor Handicapped
- Hearing Impairment
- Mental Retardation
- Mental Illness

The term 'handicap' is sometimes used in the place of disability means the loss or limitation of opportunities to take part in the life of the community on an equal level with others. It describes the encounter between the persons with a disability and the environment. The purpose of this term is to emphasize the focus on the shortcomings in the environment and in many organized activities in society, e.g. Information, communication and education, which prevent persons with disabilities from participating on equal terms.

Medical and social Models: There are two major models, which explain disability and suggest approaches to deal with it in practical ways, the medical model and social model.

The medical model views disability as a personal tragedy. Disability such as the impairment of limb, organ or function has traumatic physical and psychological effects on a disabled person. Disabled people, in this model, are regarded as people with limitations who cannot ensure a reasonable quality of life because of their impairment. The medical model expects individuals to find ways of adapting to society. It puts the duty of adjusting and adapting to the society of able-bodied people and their environment on the disabled.

The social model presents disability as a consequence of oppression, prejudice and discrimination by the society against disabled people. It is the society, which constructs economic, social, health, architectural, legal, and cultural and other barriers in order to deliberately prevent people with impairments from enjoying full benefits of the society. The social model shifts the emphasis from a disabled individual to the society and its disabling attitudes and environment.

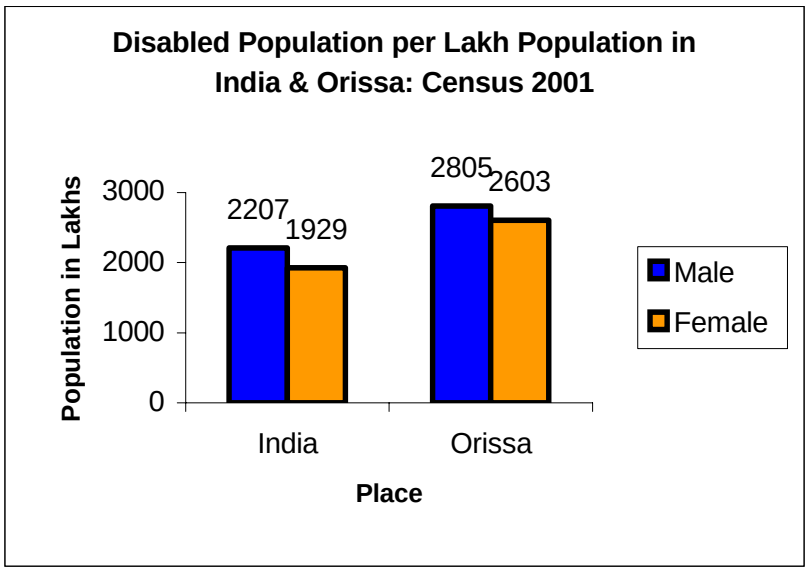
1.3.1 DISABLED STATUS IN THE WORLD

Unfortunately data is lacking on many aspects of disability. According to estimates of the United Nations, about 10% of the world's population are disabled. Looking only at developing countries, the numbers are expected to be much higher. Difficult conceptual issue as well as social and cultural differences have inhibited the collection of the data needed to properly estimate the prevalence of disability in the world. Fortunately, international efforts are now underway to improve the quality and availability of data.

1.3.2 DISABILITY IN INDIA AND ORISSA

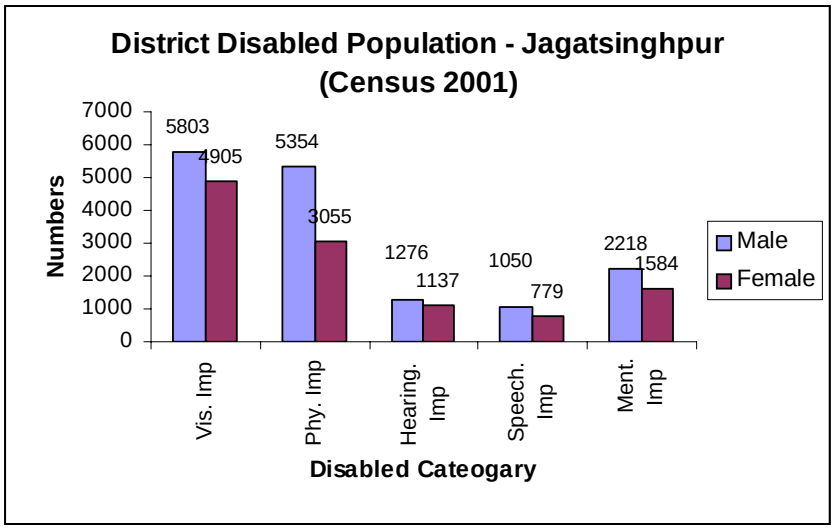
Unlike the UN estimates, according to one of the WHO estimates, there are 5% of people with disabilities in developing countries and accordingly it is estimated that there will be five crore disabled people in our country. Moreover the WHO report also says that 10% of a nation's population constitutes disabled people which in turn would make Orissa in India have at least a four million population of disabled. Keeping in mind the impact of natural calamities on people, the number would keep increasing. According to the census on India 2001 total persons with disabilities is 21906769(Male: 12605635 and Female: 9301134) which is 3 % of the total India's population. Orissa has disabled population of 1021335(Male: 568914 and Female: 452421) and the Jagatsinghpur district has total population of 27161(Male: 15701 and Female: 11460).

Three to five per cent of India's population suffers from various degrees of mental retardation. The majority of these are children (Building Abilities a handbook to work with people with disability, 2001 page 20). The NSSO sample survey of 1991 says that in India over 90 million people are physically, mentally or sensory challenged.



Orissa was the region where survey was done and provided the basis of the manual. The Census 2001 shows that the total number of disabled person per 10Million population in Orissa is 2775(2805 males and 2603 females). The specific area of research was Jagtsinghpur a district of Orissa where all have disasters either taken place such as cyclone, flood and fire or fall in the area of disaster.

If we take a look at the Census 2001 data on the break up of the various types of disabilities in Jagatsinghpur district, it would be evident that the highest number of persons with disabilities in Jagatsinghpur district are visually impaired- 10708 (5803 males and 4905 females), followed by the physically challenged- 8409 (males-5354 and females- 3055), then the mentally challenged- 3802(2218- males and 1584- females), hearing impaired- 2413



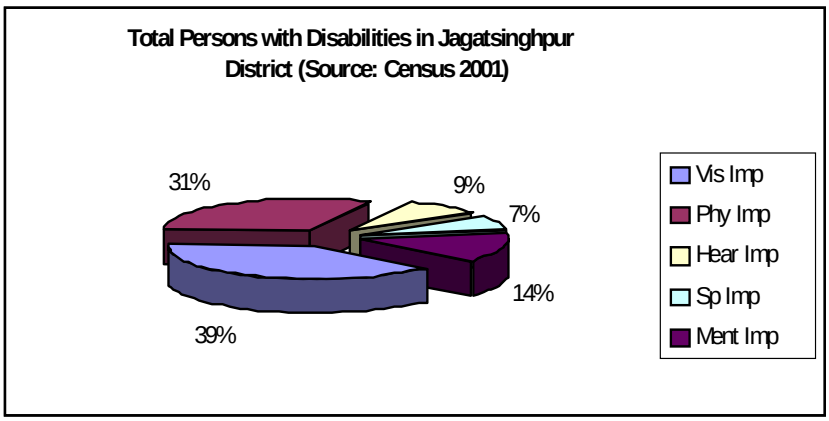
(males-1276 and females-1137), and finally the speech impaired- 1829 (males-1050 and females-779).

The manual therefore takes in account all these disabilities

DISASTER

1.4 IDEAS ABOUT DISASTERS

Modernization and Development strategies have not been able to eradicate poverty and inequality in the developing world. Despite efforts by the people themselves to acquire a better quality of life it is becoming increasingly difficult to do so. The greed of some people and nations, to corner most of the world's resources, usually with unfair means, creates not only inequality but also destruction of the environment, which produces disasters. These 'so called' natural disasters such as cyclones, and floods are usually the result of a skewed system of development. Consequently the poor and marginalized groups are being confronted by a spiral of disasters which can wipe out their efforts of decades of development in a few hours.



Disasters can occur because of climatic changes, deforestation or unsustainable methods of practices. So, despite achievements in public health, education, women's rights and literacy disasters are having an ever-deeper impact on those least equipped to deal with them - taking away any gains made - as well as impinging on the lives of those who might have felt themselves somehow safe.

1.4.1 DISASTERS IN INDIA AND PREPAREDNESS

India is the worst affected theatre of disaster in the South Asian region. Drought, floods, earthquakes and cyclones devastate the country with grim regularity. (Time line of disaster annexed)

In recent years there have been major disasters such as the earthquake that destroyed Latur in Gujarat, the Super Cyclone that, wiped out dozens of villages in the districts of Orissa. Besides this, every year various parts of the country face floods. Big dams such as Koyna in Maharashtra burst killing 100's of people. Land degradation, Natural grasslands, mangrove forests are disappearing because of overgrazing, water logging, Salinization, over fertilization and further, mining are degrading huge tracts of land.

Deforestation, mining and the decline of traditional irrigation and agricultural systems have caused land degradation on a large scale, leading to one of the worst drought conditions in the country. The 1987 drought, was one of the worst of the 20th century. In 2001, more than eight states suffered the impact of severe drought.

The states most exposed to cyclone-related hazards, including strong winds, floods and storm surges, are West Bengal, Orissa, Andhra Pradesh and Tamil Nadu along the Bay of Bengal. Along the Arabian Sea on the wet coast, the Gujarat and Maharashtra coasts are most vulnerable. Natural calamities have a more devastating impact in India than most countries because of inadequate policies relating to disaster preparedness and management and no institutional support systems.

To cope with these calamities, under the Indian Constitution, disaster management is the responsibility of state governments. However, there is a National Crisis Management Group headed by the cabinet secretary to assess the impact of major disasters. This Group consists of various nodal ministries makes the recommendation for assistance from the National Fund for Calamity Reduction and the Prime Minister's Relief Fund. At the same time the policy implementation is weak as there is no standardized disaster policy in India. Therefore more people die, more property is damaged and vulnerable communities become more vulnerable. Some states have rehabilitation policies most do not.

1.4.2 DISASTERS IN ORISSA

Orissa is one of the world's most disasters prone as well as the most poverty stricken region. Famine prone Kalahandi, water scarce Bolangir, cyclone and flood prone Jagatsingpur districts have become bywords in the vocabulary of underdevelopment. In these state there is a close correlation between poverty and disasters. The disasters being indexed are:

Flood: The Mahanadi causes regular floods in the state. In 1999, the super cyclone was followed by torrential rains leading to severe floods in the Baitarani, Budhabalanga and Salandi basins, which severely affected the districts of Jajpur, Bhadrak, Balasore and Mayurbhanj. After hitting the Paradeep coast, cyclonic storms with tidal waves 5 to 7 meters in height ravaged the coastal districts of Jagatsinghpur, Kendrapara, Puri , Khurda and Cuttack. This was followed by flood where 24 districts and 18,790 villages were affected. 99 lives were lost and 967 .8 Millions people affected.

Cyclone: The entire east coast of Orissa is vulnerable to cyclones of varying frequency and intensity. A super cyclonic storm of great intensity hit Orissa in October 1964. In 1971, a cyclone killed 10,000 people in Kendrapara.

Super Cyclone 1999: On 16th October 1999,five districts of the state of Orissa were hit by a cyclone, the brunt of it borne by the Ganjam District. On 29th and 30th October, another exceptional "super cyclone" devastated a vast region of the state. On early hours of 29th October wind blew at an unbelievable speed of 250 to 300 K.M. per hour. Such was the ravages of nature that nothing except concrete structures could survive. This super cyclone wrecked havoc in 14 of the 30 districts of Orissa. It is estimated that the super cyclone has affected up to 15 million people (more than 2 million households)

The super cyclone on October 29 and 30, 1999 left the state paralyzed, with its communication system and infrastructure totally wrecked. The super cyclone had a wind velocity between 270-300 kmph. It severely affected 97 blocks. 9, 885 people were killed as per official reports.

Drought: In Orissa, almost each year more than 10 million people reel under drought. 119,14 villages in various districts of the state have been declared drought-affected. The 1996 drought affected 26 districts and 2934.8 Million people. Orissa has faced drought several times in the past few decades but the drought in 2000 was the worst in current times. Bargarh, Nuapada and Bolangir were the worst affected districts. The recurrent annual droughts are caused by erratic rainfall and improper water harvesting systems.

Earthquake: The districts of Cuttack, Dhenkanal and Sambalpur lie in Zone III. Significant earthquakes were reported in 1963, 1964, 1988, 1996, with strong tremors in the districts of Dhenkanal, Puri, Sambalpur

and Rourkela.

Tsunamis — Tsunami, also called seismic sea waves generated by large, violent earthquakes occur in the ocean. The world's most powerful earthquake in 40 years in 2004 triggered massive tidal waves that slammed into villages and resorts across southern and southern east Asia killed 15,7,663 people in 12 countries including India. The Orissa coast received shock during the 2004 Tsunami disaster. This time no such dreadful effect was felt in the state. As the state is Lying on the Coastal region future disasters cannot be ruled out.

Fire — Fire is a common phenomenon all over Orissa. With thatched houses and bamboo supported structures whole villages get wiped out. In most of the cases fire is due to ignorance and negligence of the people living in the rural areas.

The Jagatsinghpur district is not left with occurrence of fire. During the year 2004 the district has lost 4 human lives and property of Rs. 441,0,700/- in 278 fire cases.

1.4.3 ISSUES IN DISASTERS AND DISABILITY IN JAGATSINGHPUR: SMRC'S EXPERIENCE

Jagatsinghpur is one of the few districts, which is ravaged by all the above disasters. While cyclones, Floods and fire are common disasters; the district falls under zone III of earthquakes and was shook by the tsunami/earthquake of 2004.

The district was ravaged by the super cyclone of 1999 followed by floods, what it left behind was a trail of cadavers and carcasses. Along with it remained a group of people shrouded in a mesh of poverty, vulnerability and disability. A survey done by SMRC highlighted the fact that the disabled had lost their voice and rights to a dignified living. Disability needs encompasses those of all the vulnerable groups- women, children, the aged and the disabled themselves. Thus by addressing the needs of the disabled one is actually addressing the needs of the entire vulnerable group too. Women with disabilities are among the poorest of all people, the most marginalized and the most abused- physically, mentally and socially. They have been subject to deliberate neglect, verbal abuse, physical assault and sexual harassment (Action Aid Disability news, Vol 10 No.1&2 1999 Pg. 12).

Natural Calamities and Disasters Create:

- Physical, visual, mental and psychological disabilities
- The inability to cope
- Disability among previously productive and active members of the society
- Trauma and psycho-socio disorders and Post Traumatic Stress Disorders
- Need of alternate livelihood support

Vulnerability

Disaster/Disabled Persons during Natural Calamities:

- Warning and dissemination of information is not disabled friendly.
- Requires specific technique of rescue and evacuation of disabled, which is not known to them as well as general people.
- Immediate medical care and first aid is not available for the disaster-affected disabled.
- Proper infrastructure and support for limiting extent of disability
- Limited options of livelihood become even more limited and nullified
- Limited access to information, institutions, entitlement become even more limited and nullified in the wake of calamities
- Decision making, access to social networks and dignity is blocked
- Vulnerability to social stigmas, insecurity, exploitation, verbal abuse and violence is increased

Vulnerability of Normal People to Disability at times of Natural Calamities:

- Individuals might become disabled
- Spinal, head injuries and trauma and post traumatic stress disorders are common
- Pregnant women, new born and unborn children are at risk
- Old people are vulnerable to fractures
- Disability coping and managing capacity is extremely taxing

***Health**:*

- Disabled persons health in particular, remains inadequate and disabled persons suffer disproportionately as a result.
- There are no emergency trauma care services or blood banks available locally to deal with their different disabilities including for those who are mentally traumatized.

- Epidemics such as typhoid, malaria and gastrointestinal diseases break out. Clean drinking water becomes unavailable for weeks or months together. Many die or are left severely physically and mentally challenged and are mostly left behind to die.
- Old people are left behind to fend for themselves. Sick and without economic and familial support they live only waiting for death to overtake them. Due to these old age diseases others become disabled with new ones.
- Women find it difficult to access RCH services those pregnant with disabled children due to the disaster find it more so.

Food Security

- Most disabled find it difficult to access relief and rehabilitation facilities.
- In cyclones and floods, salt-water contamination of land can lead to the loss of harvests for a number of years. For malnourished people, this could mean disability and a rise in mortality as a secondary result of disasters.
- In drought-affected Orissa, famine deaths have occurred because of acute food shortage. The food shortages are due to the nature of people's interaction with the market, and the exploitative work conditions. It has a lot more to do with the inadequacies of the government's public distribution system, lack of all weather storage facilities, the corruption in the system, the exploitation of an illiterate population, political indifference and red-tapism. Malnutrition is an important cause of disability especially among children and women.

Economic/ Livelihood Issues

- These groups are vulnerable to economic hardships in terms of loss of livelihood, infertile lands, lack of income, loss of water for drinking and irrigation, food and clothes and shelter.
- Have no access to resources like loan, credit, market etc.
- Disabled especially disabled women are victims of the gendered division of labour. They are in underpaid jobs with little security and no benefits such as health care or union representations. The informal sectors where these groups find work are usually the most impacted by natural disasters
- Because the disabled due to their disabled conditions do not have the liberty of migrating to look for work, following the disaster, their

visibility in society and governance remains low, and attention to their needs is in adequate.

- When disability occurs the persons economic resources are taken away their bargaining position in the household is adversely affected.

Housing

- Because housing is often destroyed in the disaster, many families are forced to relocate to architectural barrier free shelters.
- No cyclone shelters being built even recently are accessible to the disabled. Inadequate facilities for simple daily tasks prove burdensome for disabled with multiple barriers to access from housing to marketing to employment.

Social & Familial

- Disasters leave behind large number of disabled, widows and orphans, and older groups are left alone to cope with life.
- Most Disasters end in child labour, which include the very vulnerable disabled groups.
- Girls usually disabled are forced into marriages with older men (as old as 85 years) or to anti social elements by the relatives with a view to grab their property.
- Sexual abuse of girl children, especially disabled and those who have been orphaned increase.
- Disasters themselves lead to increase a person's vulnerability and an increase in levels of domestic and sexual violence following disaster.

1.5.1 WHY TRAINING MANUAL FOR DISABLED ON DISASTER MANAGEMENT

There is need to prepare training manual for the people with disabilities due to following reasons.

- People with disabilities often need more time than others to make necessary preparations in an emergency.
- The needs of older people often are similar to those of persons with disabilities.
- Disaster warnings are often given by audible means such as sirens and radio announcements, people who are deaf or hard of hearing may not receive early disaster warnings and emergency instructions. Be their source of emergency information as it comes over the radio or television.

- Some people who are blind or visually impaired, especially older people, may be extremely reluctant to leave familiar surroundings when the request for evacuation comes from a stranger.
- People who are blind or partially sighted may have to depend on others to lead them to safety during a disaster.
- People with impaired mobility are often concerned about being dropped when being lifted or carried.
- Some people with mental retardation may be unable to understand the emergency and could become disoriented or confused about the proper way to react.
- Many respiratory illnesses can be aggravated by stress. In an emergency, oxygen and respiratory equipment may not be readily available.
- People with epilepsy, Parkinson's disease and other conditions often have very individualized medication regime's that cannot be interrupted without serious consequences. Some may be unable to communicate this information in an emergency.

The intensity of vulnerability is more for the disabled people than that for the general people. There is a need to train the PWDs and the stakeholders so that the PWDs can be protected during disaster.

Specific Needs

Disabled people have expertise and they should be involved in all stages of development process starting from programme planning to evaluation. Involving the disabled people in the development process will certainly provide an opportunity and organization to access their rights of life. In addition to those efforts are to be made to ensure their representation in all types of community organizations.

- Involving and listening to people with disabilities assures that right needs are met.
- To plan for communities without excluding the disabled planning must:
- Identify those in the community who might have special needs before, during and after a disaster.
- Customize awareness and preparedness messages and materials for disabled, which will increase the ability of the group to plan and survive in the event of a disaster.
- Educate the disabled about realistic expectations of service during and after a disaster even while demonstrating a serious commitment to their special needs. This will result in integrating the disabled within the

community where they will not only remain subjects of disaster planning but become partners in the endeavor

- Their experience and knowledge inputs can serve to enhance the community's response and benefit the community in large.
- While we integrate we also realize that disabled people's needs differ as per their type of disability, together with gender, profession, class and caste. Therefore as their specific needs differ so do their capabilities

1.5.1 PARTNERSHIPS WITH DISABILITY COMMUNITY

Partnership for the Disabled can by specified in three layers of priorities:

i. The Community
ii. The Advocacy Groups
iii. The Government, Department of Health, WCD/ Department under whose purview Disability falls, local administration: The Collector, BDO, DM committees and officers in charge.

Involving the PWDs in the development process will assist them in developing plans that will take into account the needs of people with disabilities before, during and after a disaster strikes. The sharing sessions with the partner community will help the disabled to find out better ways to out of the following problems in the pre, during and post disaster period.

Locomotor: Traveling to nearby shelters and to access relief
Hearing: Inability to hear warning sirens and messages
Visual: Reading warnings and traveling to new unfamiliar places

In this context therefore questions that are found important and need to be raised are:

- What is it like to be a person with a disability during and after a disaster?
- Can one hear or understand the warnings?
- Can one quickly exit a home or workplace?
- Can one move about the community after the disaster?
- Are there special necessary or even vital daily items (medicines, candles (light in any form, medical devices) that are not likely to be available in shelters?
- Are basic services like toilets available and accessible to people with disabilities?

CHAPTER TWO

The section deals with the aims and objectives of the manual and also highlights on the methodology of training. This will help the trainers to get an idea about the learning to groups and also methods on management of training for the PWDs.

2.1 AIMS AND OBJECTIVES OF TRAINING

Before deciding whether training for disabled during disasters is the right course of action these key questions need to be asked:

- What is the problem? Do disabled have specific needs, which are overlooked during disasters?
- Is training part of the solution? If it is then should it involve the community and the disabled themselves to apply a social model of disability?
- How will training best be achieved? Is disabled community's participation necessary?
- What is the desired outcome of training? Will it enable the community to understand disability issues and in the context of this manual during disasters?
- How will you know if success is realized? Will community change and disabled participation and decision making be overtly obvious?
- The indicators for assessment of inclusion of disabled in plans and implementation programmes will be:
    i. Physical and psychosocial security
    ii. Disaster awareness
    iii. Community organizational preparedness
    iv. Household and PWD preparedness
    v. Accessible Infrastructure

It can be made clear what training can and cannot achieve so as to:

Avoid over – high expectations,
Inappropriate selection of trainees
Inappropriate content.

The programme is developed with the following specific objectives:

1. Raise awareness on Disability equality and human rights
2. Change attitudes of community towards the disabled

3. Raise awareness of community on disabled people's strengths and needs in general
4. Raise awareness of community on disabled people's strengths and needs during disasters
5. Help disabled people to gain self- esteem and confidence;
6. Include disabled in planning and decision making to meet disasters, prepare and mitigate them
7. Create support groups with knowledge of disability issues to further carry on the work of training other groups
8. Train disabled and non-disabled disability-rights activists;
9. Through these extended partners influence policy and implementation.
10. Include gender in the disability and disaster programme and encourage linkages such as disability in relation to violence against women
11. Engage in the work of reconstruction engineers, public-health workers, and other sectoral staff; to include Disability issues in their work

One way of deriving objectives is through learning-needs analysis. The basic assumption on which all training rests is that this is a powerful 'transforming' tool through which people learn new attitudes, knowledge or skills. They also build confidence by acknowledging existing knowledge. The results of training for disability show a clear agreement that the long-term goal of training is to achieve a "Disability Equality".

While many training courses combine a number of different objectives, it is useful, nevertheless, to start by distinguishing between four basic objectives.

- First there is training in sensitization or awareness rising to the importance of disabled and development and disability issues. The objective of this type of training is to introduce participants, who can be identified as 'insensitive to disability' as variables in the development process.

- Secondly, there is training in skill transfer in disability analysis and diagnosis. The objective is to impart the necessary skills to participants to enable them to understand disability and diagnose it so that they can understand the myths surrounding it. It will then perceive the disabled access to entitlements, control over resources, needs assessment and the under lying policy approaches of the social model of disability. These tools can be used inclusion of disabled in concrete development context. This knowledge can be used to appraise, to evaluate the ongoing policy,

programs and projects of many different agencies working in various sectors.

- Third objective of training is the translation of skills into disaster planning practices. This ensures that participants develop the capacity to translate their 'theoretical' knowledge into 'practice', through its implementation during disasters. It aims to achieve the integration of disability planning, methodology into the institutional structures and the operational procedures of disasters. By its very definition, disability-planning training places greatest emphasis on this objective.

The purpose of the training is, to provide tools, not only for identifying problems, but also for translation of capacities into practice. These relate to the nature of disabled person's subordination and the managing roles of disabled. The purpose of simplification is to translate these concerns into specific interventions in planning practice. Tools such as the vulnerability analysis, disability needs assessment, the Social Model matrix and disability friendly and participatory planning procedures help planners to undertake disability discriminations, define disability objectives and identify disability-entry points. In addition, it assists them to recognize the constraints and opportunities in institutionalizing and operationalizing disability planning during disasters.

- Finally, there is training in motivational factors. Its objective is to motivate participants to 'do the job'. The extent to which this is necessary varies. It depends on whether constraints in disability inclusion in planning and programmes relate to personal attitudes or lack of professional skills. Disability dynamics training identifies motivation as the primary constraint and focuses on this objective.

Training in Disability Dynamics:

Disability dynamics is a very different training approach. It differs fundamentally from others is that it comes mainly from the training experience of grass-root organizations. In addition, its constituency is the disabled and CBO's, rather than government. It comprises several local, highly participatory, innovative and flexible methodologies designed to 'empower' disabled and to recognize, analyze and address disability issues at the grass root level.

This method is based primarily on 'interactive' discussions, role-play and interpersonal dynamics.

2.2 LEARNING GROUPS

2.2.1 PARTICIPANTS

1. Disabled in the Community
2. Community level leaders such as WSHG members/ CBOs/ Local NGOs/ School teachers
3. GP and Village level functionaries such as Ward members/Nayab Sarpanch/Anganwadi workers/ Health workers

At least half the members should be PWDs representing gender and type.

2.2.2 SIZE OF GROUP AND DURATION

The size of the group should not exceed 20 – 25 participants at a time and the duration will depend on the timetable but not less than 3 days. This may be difficult to do in continuous mode if there are daily wagers or self-employed participants. In this case timing and duration may be changed as per needs.

If there are 20 participants the division could be:

3 disabled women
3 disabled men
3 non-disabled women
3 non-disabled men
6 community leaders (including youth)
2 GP/ village level functionaries

In each module timing should be kept flexible so that no one is bored or the training ends abruptly when it is interesting.

Language

Training has to be in local specific language. Important also is trainers understanding of disability issues and equality.

As for the hearing-impaired persons local schoolteachers with training or hearing impaired careers might be included. Besides attempts be made to utilize material which is pictorial.

Accessibility

The place where training takes. Must be physically accessible to PWDs. Some participants may even need a place to rest in between sessions and an accessible toilet. If there are steps a temporary ramp (permanent would of course be better) should be set up. Based on building guidelines (Module VI). A white line may be painted on the steps to increase visibility for less visual disabled. A handrail would be of help to those people with crutches.

Put up signs for hearing impaired
Paths leading to building be cleared
Put Braille signs where necessary
Provide reading partners for those with visual impairment and
Repeat instructions so that they can be understood.
When moving people see that those needing assistance are taken care of.
Allow more time than you would usually take,

Try to keep everyone on the same height not rugs for nondisabled, as wheel chair users will be at a different height. Carrying out activities on the ground may not be feasible. Some disabled participants may also have problems with too high heat or cold. When speaking speak clearly and face any hearing impaired person so that they can read your lips.

The seating should be in a circle with no barriers (Oxfam: p. 136)

2.3 HOW TO USE THIS MANUAL

The basic course content is elaborated in modules I on which training is to be imparted using any of the Training methods listed. The trainer is to devise a suitable linkage with the modules content and facilitation skills to conduct the training programme. A suggestive timetable listing the methods against the module is given though it may not be strictly followed. However it is suggested that the trainer should go through the timetable and the modules for best use of the manual. It should be changed considering the participants, their knowledge level etc. Duration of the training programmes is purposely kept flexible so that the trainer can adjust suiting to the local conditions and time available with participants.

2.4 TRAINER

Trainers such as resources persons/ experts/ NGOs/ Master Trainers

Roles and Responsibilities of a Trainer-

1. Provide a congenial atmosphere.
    - Be attentive to all group members
    - Model and encourage desired behaviour
    - Validate participants feelings and emotions
    - Encourage and respect voluntary participation
    - Offer referrals to support services when appropriate

2. Provide structure to the group
    - Manage the time and pace of each exercise
    - Encourage the group to set and follow ground rules
    - Intervene when required to help the process on track
    - Facilitate a variety of exercises

3. Allow every one to be heard
    - Solicit responses by invitation from quiet participants
    - Limit disruptive participation tactfully

2.5 TRAINING METHODS

2.6 INTRODUCTION AND STARTERS

Objects, photographs, cartoons, drawings, or newspaper articles, which may be provided by the facilitator or by each participant. The aim is to provide a focus for discussion. The facilitator should make sure the starter or the questions about it are related to the content of the workshop (e.g. ask participants to choose an object which represent their life as disabled/nondisabled).

2.7 ICEBREAKERS

These are short activities designed for the beginning of the workshop, or of each day in a long workshop, to help people relax, get to know each other, and gain confidence to speak in front of the group. They should encourage participation and mutual support among disabled and the others at the workshop. Most trainers have a number of tried and tested methods. In this Manual we present a few which also begin to introduce the idea of disability, to start people thinking about it.

It is important to select the icebreakers most suited to the group. This is likely to vary according to how well the participants know each other, their cultural backgrounds, their disability and so on. There is a list of icebreakers below.

Greeting

How you greet the following differently:
Older people
Younger people and Children
Men & women
Disabled- how disabled greet each others
Gods and Goddesses
Different community language

Ask the participants to move around the room greeting each other in the way indicated on their slip. This will assist the disabled to break out of their isolations. They might of course not be able to do everything, but their attempts will provide the icebreakers

Find Someone

Give a list of statements and hand out and read and ask the persons to find one person who fits the statement. They should write their name against a statement, which matches. They can later present a person in the list. If there are illiterate get a person to assist.

Statements

1. I like the music of (a particular singer)
2. Has attended a workshop on disaster before
3. Wants to participate in disaster mitigation work
4. Has worked for disabled in any way
5. Any other

Positive & Negative Identities

I am Vijay (victory) and I'm Sneha (affection) … Each person says their name and a positive word to describe themselves and goes on to introduce the preceding members of the group: I am Mala (string of flowers) and I'm Tara (star). A variation on this is for people to say their name and one thing about themselves (not necessarily starting with the same letter): 'I'm Maya (Wealth), I have three children'. In the same way they introduce the preceding members: 'I am Mohan and I like working in groups, this is Supriya , she is an Anganwadi worker, and so on.

2.8 ENERGIZERS

Energizers can be used at any time in the training when energy or attention is flagging: after lunch or an intensive session or theory. They can also be used to encourage group feeling – which is useful at the beginning of the training, after separate sessions for disabled, and others, or where there have been sharp differences of opinion. They are also great fun. One energizers, which always works, is singing - this encourages the feeling of group participation and a lift peoples spirits. Do not encourage too much physical or noisy activity as it may harm some participants.

Ask each person to write down or say about another person in the group what they like about that person. It raises self-esteem

2.8.1 CIRCLES OF CHANGE

This game can be used to get people to interact, it can also be used to build awareness and provide information on a topic: Keep a vacant seat and keep people moving in a circle to sit on the vacant place. Whoever is left out must narrate or act an incident. Be aware with this game that there may be certain areas that people do not feel comfortable to share in such a public way. Also be aware that some disabled may not be able to run. In this case it is possible to have other people act as 'runners' for them.

2.9 TECHNIQUES

2.9.1 LECTURE METHOD

- Prepare lecture note keeping view of objectives
- Experience and needs of trainee
- Arrange the points in logical sequences
- Arouse interest and illustrate
- Introduce the topic and objectives set for the session
- Outline the main points
- Use example
- Speak slowly and clearly
- Do not merely read out vita
- Encourage to ask questions

The Lecture method should not be a one way process but participatory

2.9.2 BRAIN STORM

Brainstorming is a general discussion is which trainees express their ideas freely. It is used for decision- making skills; help to find out number of solutions.

The aim of brainstorming is to collect from the workshop participants as many ideas as possible on a specific topic within a given time, in an uninhibited way. Once you have presented the topic to the group, invite them to call out ideas, comments, phrases or words connected. Write all the contributions on newsprint or flipchart as they come up, without comment or question. Participants should not comment on each other's suggestions. People should feel that what they say is not evaluated or judged. The list of ideas is then used as the basis for further work, which may involve discussion of them and categorizing them, rejecting some, prioritizing others, and so on. A brainstorm can be a good way of starting off an activity on a new topic.

Stage1. Define the problem for which solutions are needed.
Stage2. Carry out brainstorm itself:

- All ideas are recorded
- How silly or inappropriate it may be
- No trainee should pass any comment
- No discussion or clarifications is permitted

2.9.3 DISCUSSION

1. Determine the overall objectives
   - Why discussion
   - What result you want to achieve
2. Define the topic clearly and concisely
3. Consider the group
   - What they know, feel, think about the subject
   - Possible conflicts
4. Preparation of detail discussion
   - Which aspect of the subject
   - How much time
   - Prepare introductory remark
   - Frame appropriate question
5. Have every thing ready
   - Decide time, date, place of meeting
   - Accommodation

How to Lead a Discussion

Get off to a good start

- Start the meeting on time.
- Try to make the group feel at ease

Lead in the Discussion

- Explain purpose
- Mark topic clearly
- Explain discussion procedure
- Introduce the topic

Guide the Discussion

- Encourage all participants
- Control to talkative member
- Do not allow to monopolize
- Deal fact fully for relevant contribution
- Avoid personnel arguments
- Keep the discussion on the subject
- Summarise

2.9.4 GROUP FORMATION

Most of the activities in this Training Manual require the participants to be divided into smaller groups of three to six people for discussion or to complete a task. Often a spokesperson from the smaller group will report back to the full group, for further discussion. People can find it easier to share experiences in pairs or small numbers, and to relate the subject to their lives. In disability training, strong emotions are often aroused by examining relations between disabled and men, and sharing experiences in small groups is a less threatening way of doing this.

Speaking in a smaller group also enables less confident people to participate more fully in the programme, and to build up confidence for speaking in the plenary sessions.

Certain activities also require splitting the participants into single-sex groups. When it is done, it is important to follow up such activity with one, which brings the group together again.

There are a number of ways of working with small groups, depending on the training programme as well as the subject covered. One may, for example, wish to establish 'home groups' or groups whose membership does not change through training – although people may be split differently on other occasions. Home groups enable participants to build up trust and solidarity with one another. Or you may wish to make sure that people mix thoroughly by being in different groups in every activity. It is best if the trainer divides the participants into groups, through counting or some other method.

2.9.5 GROUP DISCUSSION

This is a very common discussion method, which can be combined with other methods in one activity. Discussion in a large group is useful for learning from the experiences of all the members of the group and allowing participants to draw conclusions from activities. Facilitators may need to encourage equal participation, and discussion between participants.

Group goes through the following steps

Each group selects its own chairperson and someone to record the discussions
Responsibility of chairperson

- Defining the problem.
- Gathering background information
- Developing alternative solutions
- Testing each solution
- Choosing best solution

Group discussion is important because

- As a democratic process
- As a problem solving process
- As a means of stimulating cooperative groups

What it is not- a debate a speech, an argument, conversations, a public opinion, and an opinion towards a prejudice.

2.9.6 ROLE PLAY

Role-plays or simulation games imitate reality by assigning roles to participation and giving them a situation to act out. Role-play is a training technique in which participants assume an identify other than own. Each

person in a role-play needs to have a clear idea of the role they have been assigned, and the objectives of the role-play should be well defined. The aim of a role-play is to make attitudes, situations and experiences come to life in a dramatic and enjoyable way: they aim to help to people learn through experiencing and feeling. They can also be used to practice skills e.g. of raising disability issues. They can be based on real-life cases, or carefully designed to bring out certain roles and attitudes. In disability training, role plays, can be a very effective way of enabling non-disabled to experience what it is like to feel powerless or invisible in a situation (when they play a disabled) and to put disabled in touch with their own feelings about their disability roles. A non-visual impaired person playing the role of a visually challenged.

Role Play is a fairly 'open' technique, allowing the situation to develop once people have their character roles and the basic setting established. If there is anxiety, it can be lessened by not using words 'role play' but 'drama' or 'acting out a situation'. They should be used after group trust has built. It is very important to allow sufficient time after role-plays for a thorough de-brief (for each player to say how they felt in role), de-role (for each player to come out of their role and realize that they are themselves), and for summarizing the lessons learned. Otherwise there is a danger that participants may be carrying on appropriate feelings and thoughts.

2.9.7 CASE STUDY METHOD

These may be based on real cases or be designed as hypothetical situations but based on real issues. They provide the material on which participants practice using analytical tools they have learned. They also stimulate participants ' critical faculties by presenting success and failures in development and relief work. Case studies should always be carefully designed with specific objectives in mind, and tailored to fit the concepts or problems they are intended to address. Case studies need careful preparation and testing out.

- A case study presents a case, analyses and debates, is a method of developing a systematic thinking and exposes the participants to a diverse situation writing a case.
- Select the type of project observe and collect the data write the case
- Objective, use films, videos
- Success failure

Questionnaires
These are usually used to test knowledge, but can examine attitudes too.

Rounds
A round is an exercise in which each participant has the opportunity to say something quickly, in turn, in answer to a question or to report an opinion of feeling. Rounds are a useful quick monitoring exercise to give a sense of individual and group learning. It is particularly useful if you have very uneven thoughts on certain topics to the group. However, some people may not want to their true thoughts on certain topics to the group. In this you can case you can use index cards or slips of paper, and ask each person to write a question or opinion on a card. The cards are then collected in, shuffled, and each person takes one card, which they read out. Thus everyone's feelings are obtained, anonymously. This is also known as the 'Ballot Box'.

Demonstration
Instructor actually performs an operation or does a job thereby showing the trainee what to do and how to do it.

Creative Work
This includes collage, drawing, painting, modeling, composing songs, poems, stories, or plays. These can be done individually or as a group effort to enable expression of issues in a different way. It is important to stress that these activities are a vehicle for ideas, not a test of people's talent or drawing ability.

Performance
Trainee is required to perform under controlled condition, the operation, skill or movement being taught

Guided Fantasy
The facilitator reads out a prepared fantasy, or one can be developed by the group. It can be used for private reflection or shared with the group. It is useful to start with general relaxation to enable individuals to let go and free their imaginations.

Study Visit
This can be particularly useful in a long training course, to break up the routine, and to enable people to put theory into practice. Study visits require a lot of careful preparation by the core group to set them up before the training.

A briefing session is necessary, so that participants know why they are going and what questions they will be researching on the visit; also a de-briefing session after the visit, so that full use can be made of the learning. E.g. Shelters, market place, office of DSW

Visit by a Disabled Activist

A visit by a disabled activist will create confidence in participants that disabled can do it.

Field Visit

Participants (trainees) are taken to visit for observation of similar type of project in which these people are being trained.

Field Placement

In field placement the trainee has to perform the duty in a place closely similar to his/her own tasks or job.

2.10 SUITABILITY OF TRAINING METHOD

2.11 CRITERIA FOR SELECTION

Trainer should ask the following questions:-

1. Will the method ensure to hold the attention of the trainee?
2. Will method ensure the information would reach to every trainee?
3. Will it make effective communication for achieving the objective set for session?
4. How big is the group?
5. Whether she/he has sufficient expertise of method to be used?
6. Will method ensure active participation?
7. Whether necessary facilities, arrangements and resources are available?

2.12 EXPECTATIONS AND PRIORITIES

Participants must be allowed to speak about their expectations. This will enable the facilitator to bring in issues of local concern. It will also make the workshop more contributory and fulfill the needs of the local region.

At the end of the workshop these expectations could be checked to assess the range of fulfillment.

2.13 COPING WITH PROBLEMS OF THE PARTICIPANTS

No	Problems	Possible Remedies
1	Hesitant, Shy, Reluctant, Silent	Socialize with hesitant participants, ask easy questions.
2	Monopoliser, Bigtalker	Ask "Would you mind if we got another opinion on this one?"
3	Voice of Victor, Seems to have tremendous need to be heard- (inputs are not necessarily offensive) -	Treat victor politically.
4	Arguer (Constantly disagree)	Ask, "Anyone want to respond? / I understand your position. You believe that…"
5	Non listener, Tend to interrupt, cut other off, leap into the fray before other have to say	Ask for restatement, ask for listening.
6	Idea Zapper-Deflate everyone's idea.. But it will never work,	Ask him/her to give a working idea
7	Complainer-Blaming, fault finding, gloomy observation problem magnifier.	Ask him/her- Do you have any idea which will encourage to search other side of thing
8	Rigid one: Tough, disagree	say other views do exist
9	Hostile one Questions designed to embarrass or influence	I see you have strong feeling on this issues, would you care for my opinion
10	Angry one Aggressive, unfriendly	Total silence to constant complaining.
11	Negative Nothing will work, people are impossible	Ask him anything positive
12	Clown Ill-fitting, irritating humor	- Tap and reward his/her serious side
13	Show off- Show off his/her knowledge, bigwords, funny phrases, unique experience,	Let group deal with him
14	Unwilling participant	Draw him in slowly

CHAPTER THREE

DISABILITY AND DISASTER - AN ANALYSIS OF A STUDY IN JAGATSINGHPUR DISTRICT

Present section tries to focus on the findings of the study conducted by the organization. To identify the need basing on the degree of the vulnerability of disabled people in the disaster prone area a study was conducted in the district of Jagatsinghpur, as it is one of the disaster prone areas of India. This section has two parts. In the first part there are detailed discussion on the problems faced by the disabled people during disaster. And the second part comes with suggestive strategies, which are needed to be followed by different stakeholders.

Part 1

3.0 WHOM DO DISASTERS AFFECT MOST?

Disasters affect the most vulnerable of groups in the community amongst them the women, children, elderly and the disabled. In disasters the special needs of communities are often isolated from services and this needs to be prevented. These groups are particularly vulnerable by virtue of their lower economic, social and political status and obstructed mobility, hearing, speech, vision and intellectual level. The vulnerability itself has economic and social manifestations as disasters leave behind diseases, disabilities and vulnerable group's inability to cope.

Disasters also result in large number of productive people becoming disabled. In cyclones, fire, flood and earthquakes, trauma and psychosocial disorders are the most common disabilities.

Challenges Facing in a Disaster

The disabled like all others lose their family members, neighbours, homes and belongings family disabled in a disaster. Like children what matters most are loss of careers and employers with whom they might have a good working relationship. Sometimes even the loss of local business owners who gives credit or send the goods home affects their quality of life.

The visually challenged may find it difficult to adjust to new terrains. With disasters leaving behind fallen trees, debris and even water they usually suffer severe injury.

In most disabled psychological disorders may set in early reminding them of the crisis situation when they became disabled and had to be hospitalized. This reliving experience of perhaps difficulty sleeping, flashbacks exposes the disabled to sever post-traumatic stress disorder (PTSD). Two months after the cyclone of 1999 in Orissa, NIMHANS found that the prevalence of PTSD and depression among adults in was twice the national average. And six months after the attacks, more than one-fourth of school children exhibited mental health problems severe enough to impair their normal functioning.

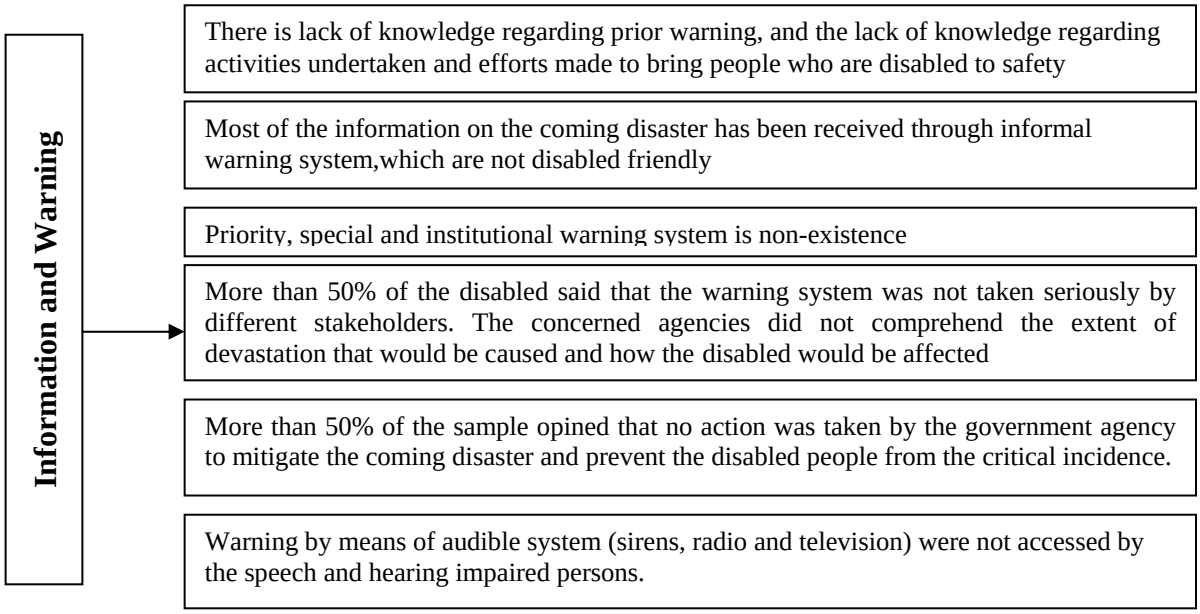
Access to medicines required by the disabled are not easily available. It is not be possible to repair broken wheelchairs, as shops are closed. This furthers restraints the mobility of disabled and their access to relief.

To meet these challenges each problem will be identified and recommendations provided. In this context the problems and recommendations will fall under the following:

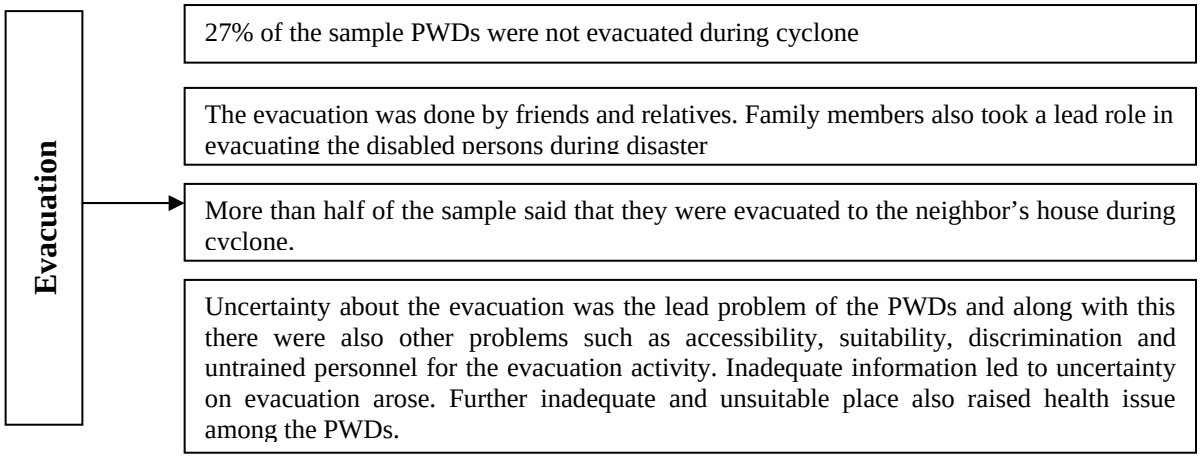
- General
- Disaster specific
- *Information and warning*
- *Evacuation*
- *Rescue*
- *Relief*
- *Rehabilitation*
- *Reconstruction*
- *Mitigation and*
- *Policy implication*

In order to identify the problems related to above a study was conducted by the organization (Study area and methodology annexed).

3.1 INFORMATION AND WARNING

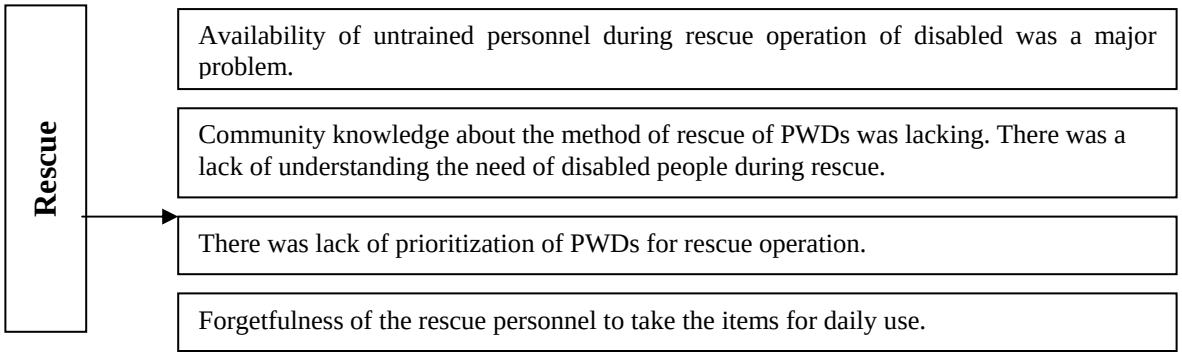


3.2 EVACUATION

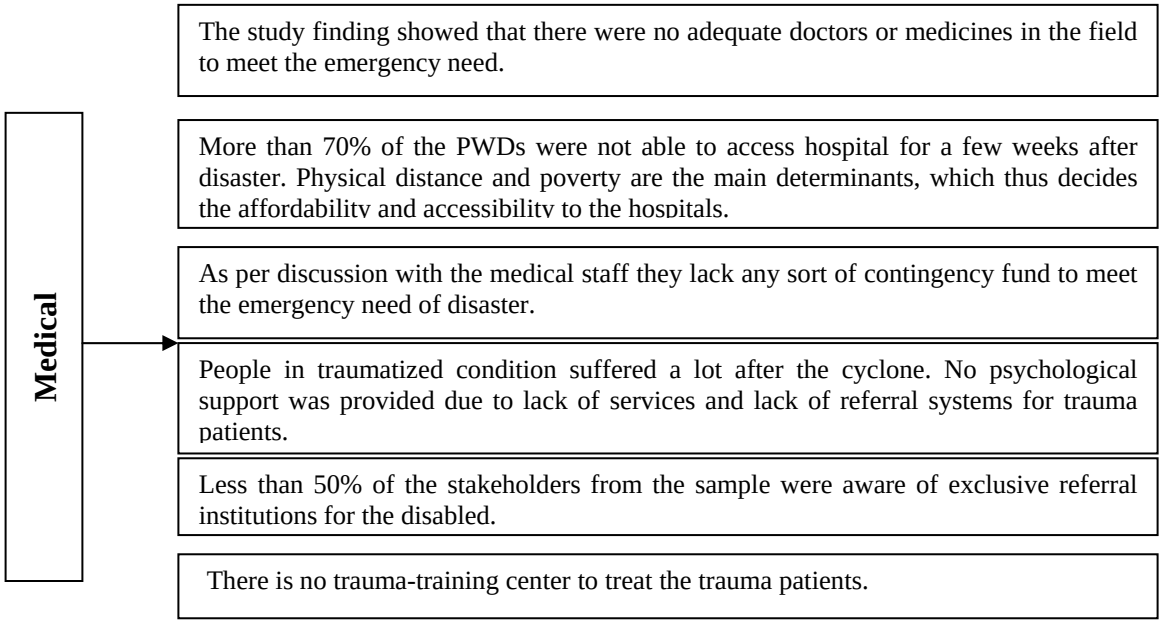


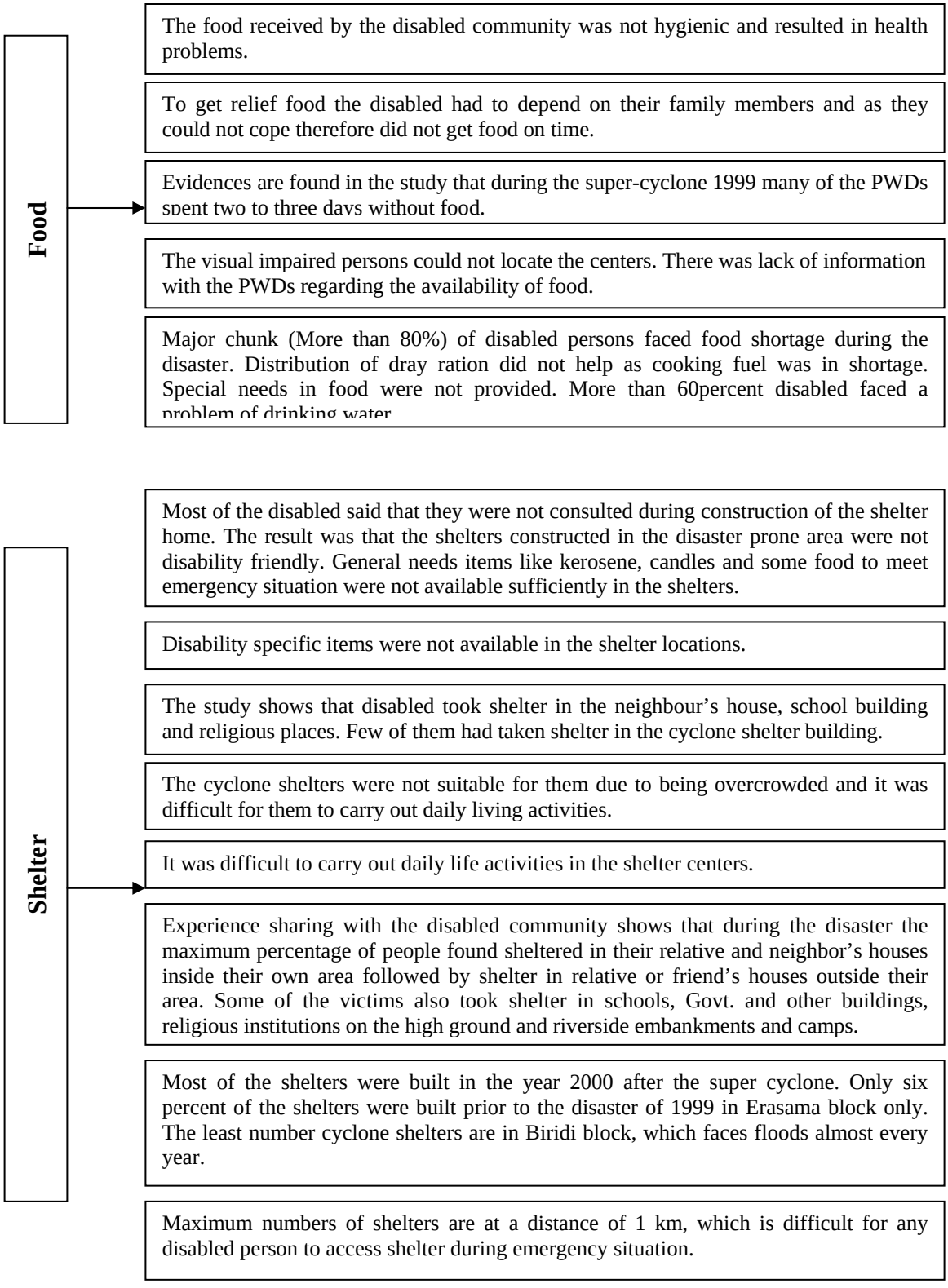
3.3 RESCUE

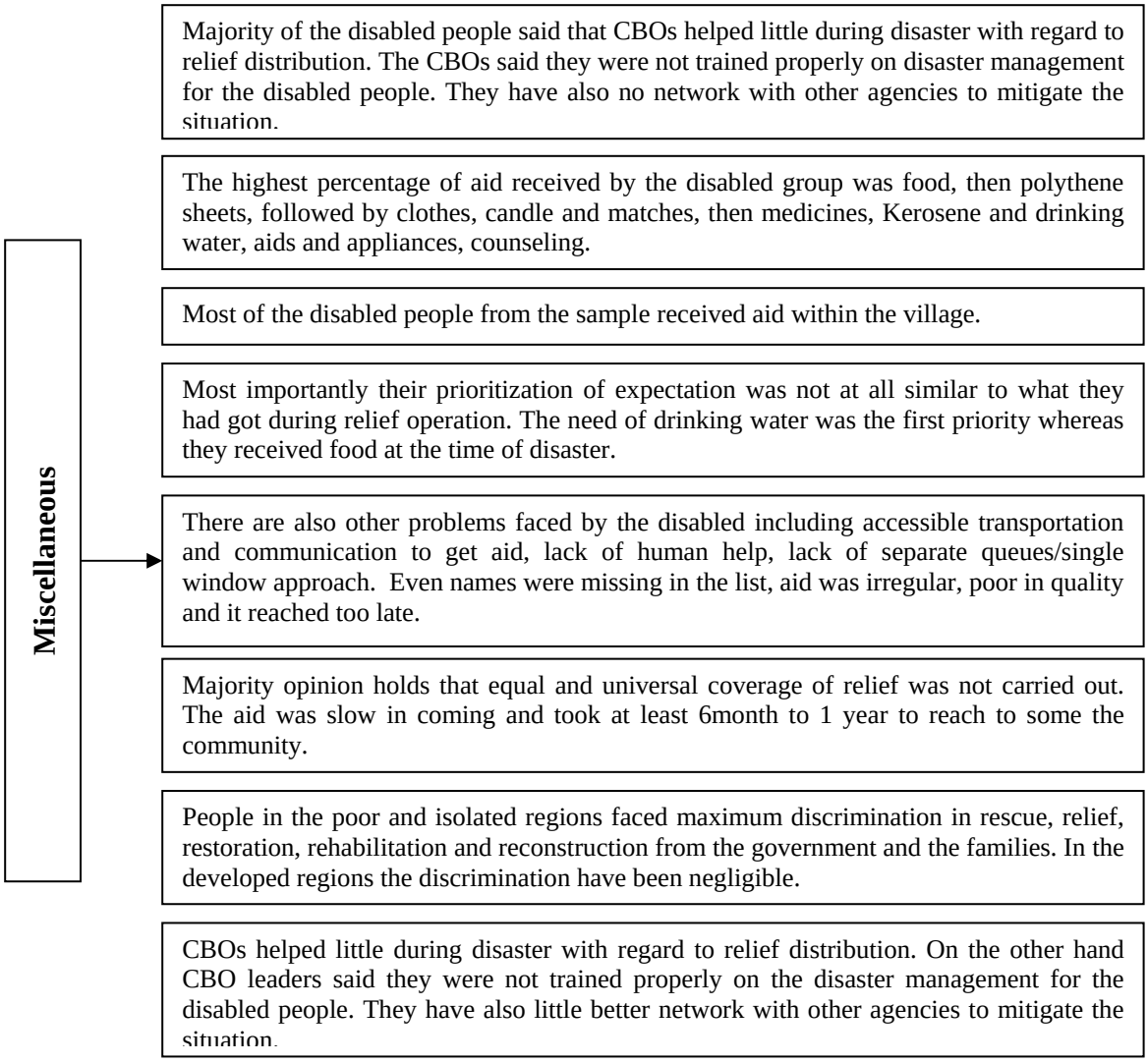
Rescue for cyclone, floods and tsunamis are different than fire and earthquake. Even if warning is carried out it is in recurrent or expected disasters. Very rarely is attention paid to disasters that may take place after a long period.



3.4 RELIEF




Food
The food received by the disabled community was not hygienic and resulted in health problems.
To get relief food the disabled had to depend on their family members and as they could not cope therefore did not get food on time.
Evidences are found in the study that during the super-cyclone 1999 many of the PWDs spent two to three days without food.
The visual impaired persons could not locate the centers. There was lack of information with the PWDs regarding the availability of food.
Major chunk (More than 80%) of disabled persons faced food shortage during the disaster. Distribution of dray ration did not help as cooking fuel was in shortage. Special needs in food were not provided. More than 60percent disabled faced a problem of drinking water
Shelter
Most of the disabled said that they were not consulted during construction of the shelter home. The result was that the shelters constructed in the disaster prone area were not disability friendly. General needs items like kerosene, candles and some food to meet emergency situation were not available sufficiently in the shelters.
Disability specific items were not available in the shelter locations.
The study shows that disabled took shelter in the neighbour's house, school building and religious places. Few of them had taken shelter in the cyclone shelter building.
The cyclone shelters were not suitable for them due to being overcrowded and it was difficult for them to carry out daily living activities.
It was difficult to carry out daily life activities in the shelter centers.
Experience sharing with the disabled community shows that during the disaster the maximum percentage of people found sheltered in their relative and neighbor's houses inside their own area followed by shelter in relative or friend's houses outside their area. Some of the victims also took shelter in schools, Govt. and other buildings, religious institutions on the high ground and riverside embankments and camps.
Most of the shelters were built in the year 2000 after the super cyclone. Only six percent of the shelters were built prior to the disaster of 1999 in Erasama block only. The least number cyclone shelters are in Biridi block, which faces floods almost every year.
Maximum numbers of shelters are at a distance of 1 km, which is difficult for any disabled person to access shelter during emergency situation.



3.5 REHABILITATION

Economic

- **BPL**: Below Poverty Line is an income line fixed by the Govt. of India for a person who earns below this amount and is therefore entitled to access welfare schemes meant for this category of people. In the study it is found that a major chunk of the sample PWDs do not belong to the BPL category, as they do not have BPL cards which indicates inaccessibility to economic schemes by the PWDs**.** In addition to the above it is found that these cards are mostly given to their family members and not the disabled person themselves.

- **PDS:** Public Distribution System is implemented by the Ministry of Civil Supplies, Govt. of India through State Govt. The system enables people to get the consumable items at subsidized price. The study reveals that items under PDS reach the disabled at irregular intervals. Besides to access items from the PDS they are dependent on family and others owing to their disability and distance of the PDS.

- **Self-employment Loans:** This is the scheme, which most PWDs would like to access. This would enable them to set up income generating activities. It was found that very low proportions of the disabled could avail the loan. There was both lack of awareness and entrepreneurial ability among the PWDs. The findings from group discussion with the disabled showed that the scheme is not being communicated effectively. Lack of bargaining power is another constraint, which debars disabled to take the risk in self-employment activities. It demonstrates *that a change in attitude is required from the family members to support the disabled in these schemes.*

- **Non-Government Schemes**: Apart from the govt. schemes there are also number of schemes implemented by Non-Govt. Organizations. Very small proportions of respondents have availed Non-Government Schemes. The reason is that though the schemes are implemented a negligible portion of those focuses on disables. They are not able to compete with the other people. Lack of information is also major constraint for not accessing the schemes by the disabled people.

- Priority is given to Financial Independence and a job is seen as the way to achieve self-reliance.

- The percentage of persons who felt that they are not capable of earning a living is higher than that who felt they could. This indicates that among the disabled a low level of earning a living exists. This could be attributed towards the attitude of people towards the disabled, which suppresses them, and the lack of awareness regarding their capacities and what they can achieve.

Govt. Schemes: General

Less than half of the respondents have received benefit from the **Employment Assurance Scheme**. Though the scheme is implemented it has not prioritized or targeted the PWDs.

None of the disabled have received any benefit from **SJGSY**, which indicates lack of accessibility to this scheme by the PWDs. (it also shows that the scheme has not been universally implemented in the District.)

The study shows that very few (38%) of the disabled have been benefited from IAY scheme.

Less than half of the PWD population have received benefits from the FFW scheme.

Prime Ministers Rojagar Yojana (PMRY) is a self-employment scheme target to the unemployed, which supports them in the form of finance and skill upgradation. But this vital scheme excludes majority of the PWD population as the study reveals. According to the study a very negligible proportion (2%) of the disabled have received benefits from the PMRY scheme. Thus exclusion from the Govt. Schemes meant for the upliftment of the poor is clearly visible from the study.

Besides above schemes, which are meant for rural poor there, are also other schemes, which are meant specifically for the disabled population. The study tried to find out some of the facts.

Government Schemes: Specific for Disabled

It has been observed that a low percentage of disabled people have availed the disability pension. Awareness or access to means for application and eligibility for the disability pension is not very clear to a majority of eligible disabled, which hinders them to access the scheme.

Travel Fare Concession was not used by any disabled person. Lack of information regarding the facility, the eligibility criteria and documentation process are the major constraints for not availing the benefit. Inability to travel by the PWDs is also another cause for which they do not avail the travel concession.

Vocational Training

None of the disabled in the study were found to have received benefits from any vocational training from the Government, which shows non-implementation of the scheme by the Govt. It is also clear in the study that there is lack of concentrated effort on the part of the implementing agencies to include the PWDs in the vocational training programme.

National Handicapped Finance Development Corporation is a government body established to assist the PWDs in setting up income generation activities. A very low proportion of the respondents has undertaken self employment activities with the assistance of NHFDC. This shows that the initiatives to strengthen the means of livelihood by the Govt are not reaching the disabled community.

Aids and Appliances

- Less than half of the disabled population had not received aids and appliances. As per discussion with the Govt. Officials shows that the aids and appliances have been distributed in other blocks in the post cyclone period.

Education: Special School

Majority of the disabled did not attend school and are illiterate. None of the respondents go to a Special School for the Disabled. Further investigation to the above fact shows a lack of infrastructure (Special Schools), Special Teachers, accessibility to Special schools are the important constraint for not accessing these schools by the disabled population. It may be noted that the special schools are not the answer for educating the disabled people. It is recommended that the Children be integrated in general schools.

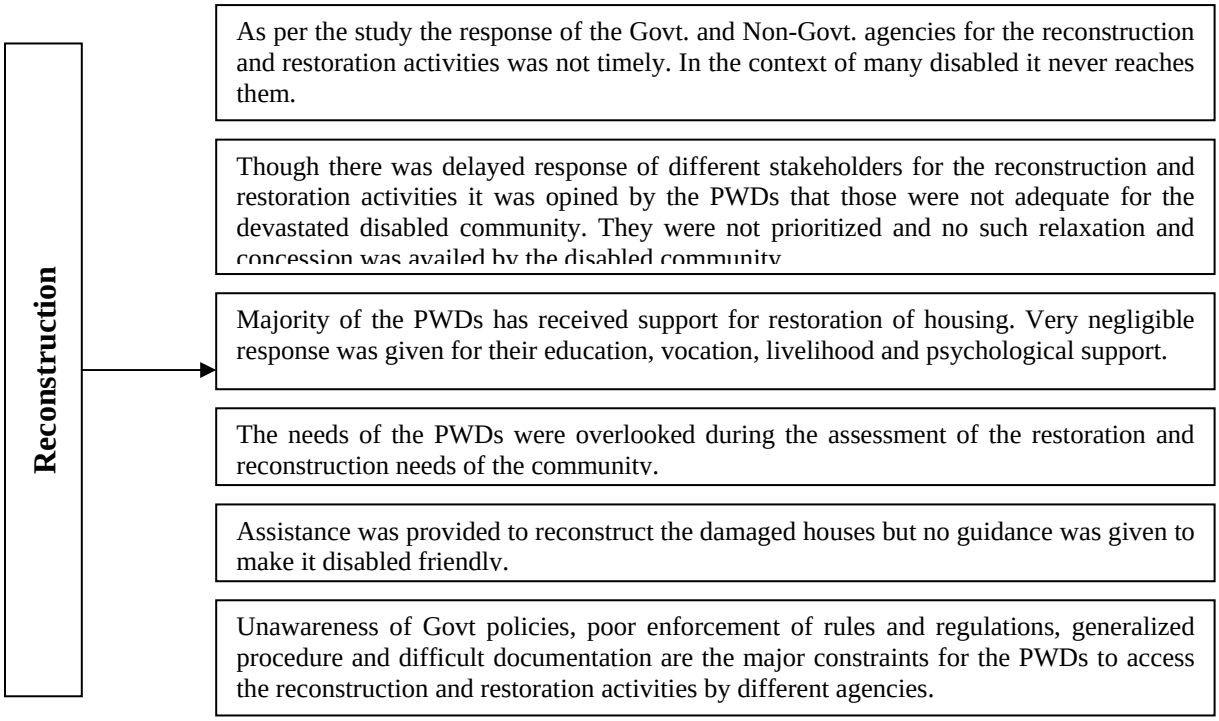
Accessibility to the schools is constrained for the physically impaired persons due to lack of barrier free access to the school building. Poverty of the disabled persons and there are no such special teachers to teach the blind and speech and hearing impaired persons are also major constraints which hinders them from going to schools for education.

Psychological

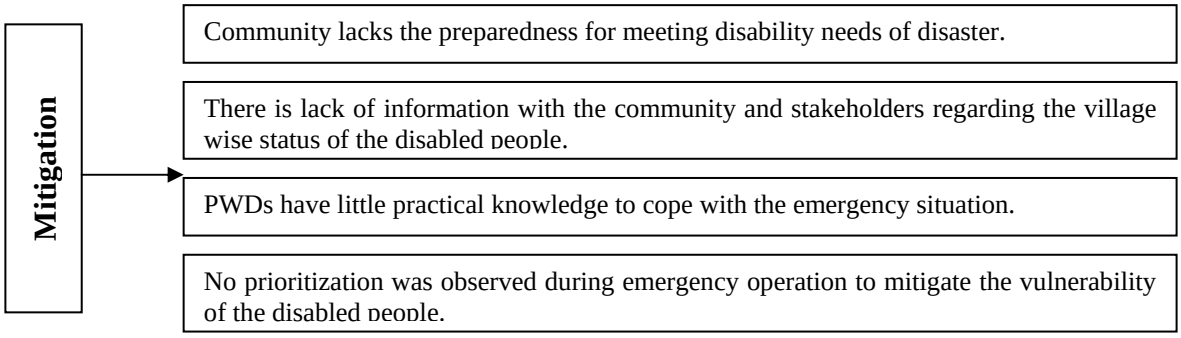
It is evident from the study that the highest proportion of the sample received psychological support from the family members and very negligible proportion of the sample received from Govt. Thus the study envisages that the institutional effort for the psychological support to the disabled is negligible for which there is lack of self-confidence and the dependence on the fellow family members is very high.

Very low percent of the sample population access the market for their daily needs. Some areas being the interior tract of the districts bring the picture of negligence in accessibility to the market in comparison to the other part of the district. The outcome of the focused group discussion shows that dependency of disabled on their family members is the main reason for which they are not able to access markets. They also do not prefer to go to the market as they are not brought into the mainstream of the society and thus feeling of inferiority prevents them to access the market. Further the narrow approach to market and crowded place is also another constraint for the blind people to go to the market. It is also found that due to lack of proper conversation ability with the mentally ill and speech-impaired persons they are not able to access the market for their daily consumption purpose.

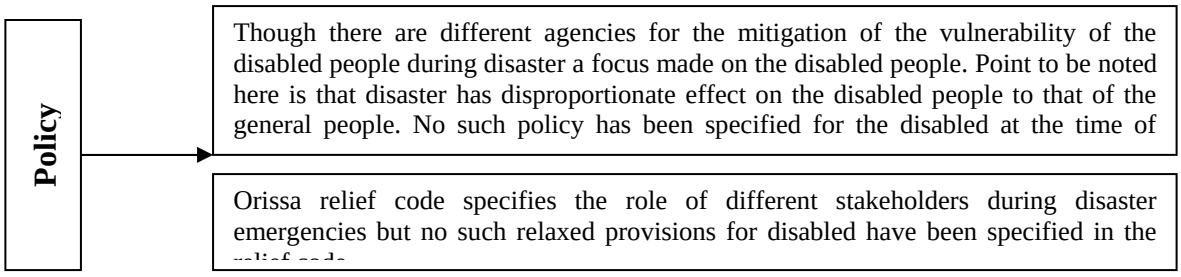
3.6 RECONSTRUCTION



3.7 MITIGATION



3.8 POLICY

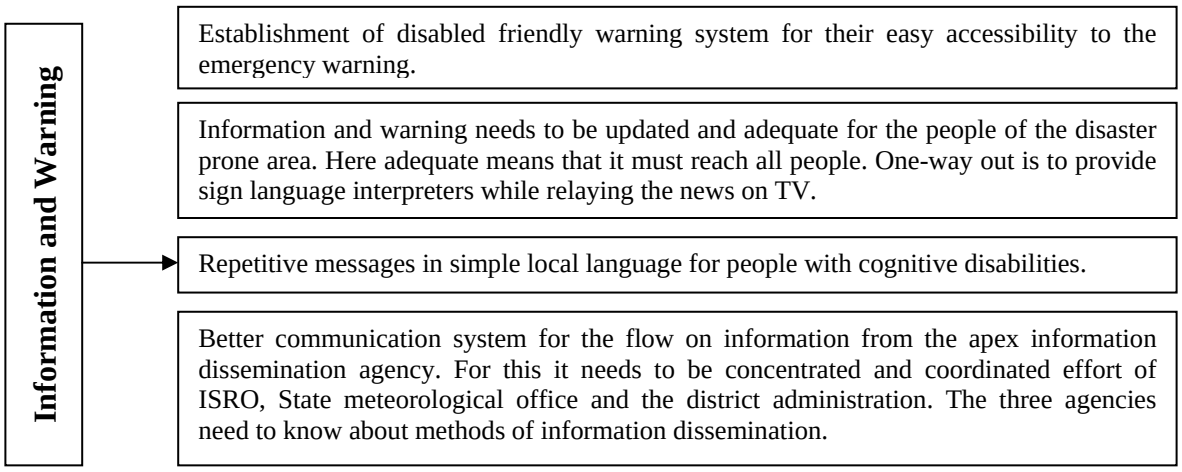


Part 2

Suggestive Outcomes of the Study

In the earlier part of this section were analyzed the problems faced by the PWDs during and after disaster. In this section efforts are being made to find the suggestive strategies to improve the status of the PWDs during disaster.

3.8 INFORMATION AND WARNING

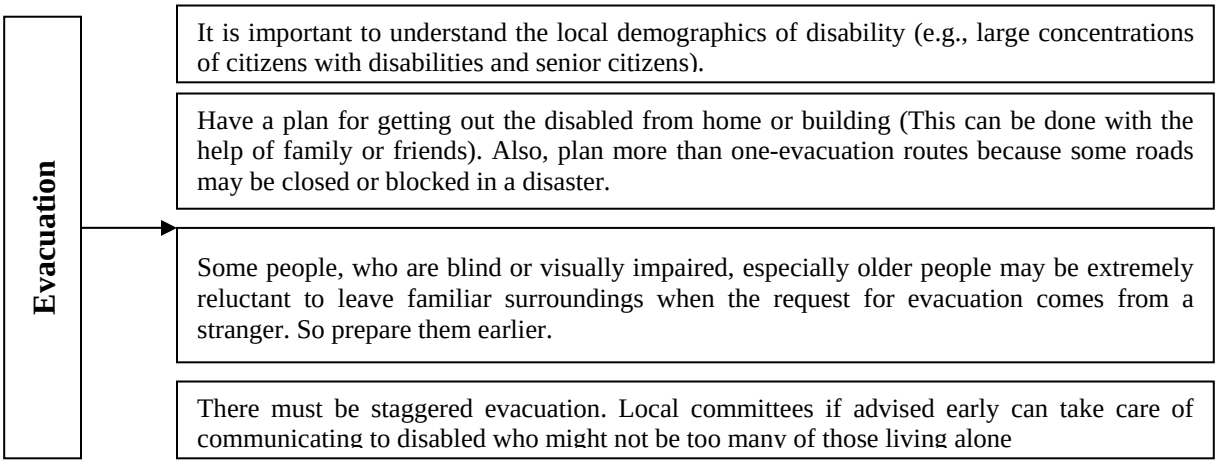


Special tips:

If a person has severe, speech, language or hearing disability…

- Store a writing pad and pencils to communicate with others.
- Keep a flashlight handy to signal whereabouts to other people and for illumination to aid in communication.
- Remind friends that you cannot completely hear sound warnings or emergency instructions. Ask them to be your source of emergency information as it comes over their radio.

3.9 EVACUATION



3.10 RESCUE

- Inspect the village and bring in stranded and injured people who might not be in the disability list but are disabled due to disaster.
- Maintain a 'missing persons' register and update it after each rescue trip.
- Attend to injuries and traumas of rescued people
- Practical training on rescue and evacuation should be imparted to all stakeholders
- Education regarding disability to all stakeholders
- Needed - rescue operation training of disabled person
- Villagers to participate in implementation of the programmes and public participation
- Prepare a rescue kit (See attachment).
- Also keep some tools handy such as cutting saw and blades, crowbar, hammer, nails etc. to cut the fallen trees, to rescue people stuck under the fallen houses and who may become disabled if not rescued immediately

Rescue of Wheelchair Users

- Discuss with the user of the wheelchair how to lift the user and the wheelchair ether together or separately. When circumstances necessitate separating the user and the wheelchair, keep the period of separation to a minimum.
- Some parts of a wheelchair are safe to lift from, while others will come off when lifted. Always ask the user to confirm where it is safe to lift. Also, ask the user what else about his or her wheelchair you should know in order to lift it safely.
- Wheelchairs with four wheels usually have handbrakes on each side of the chair. When the wheelchair is to remain stationary set both brakes.
- When more than one flight of stairs is traversed, helpers may need to switch positions since one person may be doing most of the lifting. Switch positions only on a level landing.
- When the lifting is complete, follow the instructions of the chair's user and restore the manual or motorized wheelchair to full operation; then direct the user to a safe area.
- Generally, the best way to lift the chair and user together is to position one helper behind the chair and the other helper in front. The helper behind the wheelchair tips it backward to a balance angle that is tolerable to the user. The other helper grasps the front of the wheelchair and guides its movement. The two helpers lower or raise the wheelchair one step. Television stations should

Para 103 (3) of ORC addresses the provision for drinking water in a situation of polluted water sources during cyclone/flood – Arrangements for stocking of disinfectants for disinfecting water sources should be made. Along with this some standby provisions made by the Panchayati Raj Dept. & Women & Child Welfare Dept. & Public Health Dept for sinking new wells and tube wells".

3.11 RELIEF

Medical

- Support of Red Cross is needed to improve the status of medical services at the field level to meet any sort of emergencies.
- First Aid need to be managed by the task force, emergency doctors, CDMO, pharmacist, CBOs, paramedical staff and attendants, special medical aid camps of the district, Local PHCs and block agencies, and medical teams.
- It is needed to have a trauma-training center at the district level.
- Adequate doctors with emergency oxygen, respiratory equipment and contingency funds with the medical should be readily available.
- Help other groups e.g. the relief and first aid group in chlorinating wells in the village, spraying bleaching powder, treating injuries and wounds etc.
- Many of the disabled have associated problems such as high diabetes, respiratory disease, urinary infection etc. Proper need should be given in food and medicine to those identified disabled.

Food

- Non-government agencies should devise Meals-on-Wheels service for shelters and the home-restricted persons or those who cannot negotiate the devastated terrain because of their disabilities, medical conditions, and/or are elderly. Disabled people need not follow the generalized procedure in relief distribution.
- Ensure that families do not cook individually but eat at the community kitchen and help with food distribution. Too many fires make the living area smoky and are a waste of fuelwood. Use of solar cooker to be encouraged.
- Ensure that the assessment and the concerned papers reach the govt. department responsible for compensation and ensure that timely assistance comes through from the government authorities
- Some people with mental retardation may be unable to understand the emergency and could become disoriented or confused about the proper way to react. So they should be taken care of.
- It can take up to for 3 days for emergency water to get to your area. Every person should store at least, and more for those people who need extra water. And still more if there were animals to be taken care of most households would have a cow or a ship. It is best to store filtered water because it will stay fresher during a long storage. (Replace the water every few months.)
- Shelters can act as centres for distributing relief materials so that supplies are not looted or hoarded by unscrupulous people and the materials can be given against identification slips. Ensure that the vulnerable sections are covered.

3.13 REHABILITATION

Livelihood

- After each disaster people have to cope with livelihood issues. As the State of Orissa is predominated with rural areas and most of its people depend on farming emphasis should be made to strengthen the base of agriculture. Along with this focus has to be made on fisheries, livestock and encouraging for small enterprise. In other states different livelihood patterns be identified (Module 5).
- The district /blocks administration should organize disability certification
- Assess the extent of damage done to the village
- Include disabled in Food for Work and targeting of families and related programme.
- A special employment cell can be set up to identify vacancy posts.
- A special drive for vocational training and livelihood identification.

Counseling

- Counseling and guidance cell for the PWDs in districts to be set up to provide psychophysical support during disasters. This center needs to work in coordination with the district administration
- Most victims of cyclone/floods suffer from trauma, grief and worry about losses to their families and property. Some can cope, some, totally breakdown. The disabled are under more stress than other is as they may not able to see or hear or more but are aware that there is disaster. The counseling team needs to identify such people and help them through their grief. Members of the group need to be trained in counseling techniques. They should be patient, sympathetic and good listeners and should have the necessary skills of tackling people's problems and put them at ease. Persons of repute with a matured and balanced outlook can be selected as members of this group. Special education would be needed to be made to the mental retarded who might not be ask to convey their feelings properly listen with patience to their worriers.

Certification & Compensation

Help disabled with the paperwork to follow compensation proceedings, especially relating to death certificates, insurance papers, disability certificate etc.

3.14 RECONSTRUCTION

Access

- Special access routes to be made in hospitals so that they don't have to climb staircases.
- Interior village road needs to be improved to access the disabled during disasters.
- Barrier free houses to be built for PWDs.
- Planning for accessible shelter and appropriate temporary housing needs

Medical

- Shelters must be accessible and stored with essential items to meet the needs of disabled. Drinking water earthen pots, wheelchair, staffs (canes), a toilet chairs urine pots and some wood
- Preparation in advance by the government and disaster management officials saves lives and morbidity. These training will also help saving lives of other community members and newly disabled due to disasters.
- Psychological support to the persons affected persons could be made by the NGOs in coordination with the district administration.

General

- Identifying the impact on the disabled of an interruption in utility services.
- Build on disabled's strength in communities, related to primary health care community literacy program, household safety etc.

Economic

- Planning for employment after a disaster

Training

Train volunteers in advance in dealing with people with disabilities. Besides the protection of their self-esteem disability specific needs may seem an extravagance when it is an important requirement sometimes live saving.

Housing

- Houses built on raised land or earthen platforms so that water cannot get inside during normal flooding.
- Housing for poor: thatch, bamboo and corrugated iron sheets
- Treated Bamboo posts: To increase resistance during submergence and insect attack.
- Improved bracing and fastener for walls and posts against strong winds
- Improvement of floor and plinth by a mixture of cement and concrete with clay: to increase resistance to water.
- Plantation of water-resistant plants like bamboo, banana, kolmi etc. next to the house so that erosion does not take place.

3.15 MITIGATION

Training

- Training should have better focus on the disabled community and should cover all categories of disaster unlike the earlier training programme, which focused on the cyclone only.
- Training programme should be informative with regard to the technical aspects of various categories of disaster, role and responsibilities of different stakeholders to mitigate the vulnerability.
- There should be detailed discussion on the eligibility and scope to access all types of govt. entitlements meant for the disabled and also general schemes.
- At block level medical and paramedical staff including doctor should be trained in detail about disability management
- Training programmes should be held in the accessible location so the disabled persons could attend. These meetings should be organised at Panchayat(Local Government) level.
- Training programme must identify the disabled community leaders and train them on advocacy issues and regular effort to be made to take the work forward.
- **Component of Disability in training:** It is the fact that some of the disabled have been trained for the disaster management but that training programme has little focus on the disability. Thus it is suggested that disability concept should be included in each of the training programme on disaster. Point to remember that the degree of intensity of vulnerability is higher than a general person during disaster.

Tips for Training:

- Train personnel to regard a disabled person as the best expert in his or her disability and to ask a disabled person for advice before lifting or moving that person.
- Train personnel to take extra time when communicating with people who are deaf, hearing impaired, or speech impaired.
- Train personnel to never separate a disabled person from his or her assistive aids: wheelchairs, canes, hearing aids, medications, special diet food, urinary supplies, etc.
- Train personnel to realize that a disabled person's equipment may not be working after a disaster occurs, or it may be insufficient for emergency circumstances.
- Train rescue workers to know that some individuals with emotional and developmental disabilities may be too unsettled to respond appropriately to instructions and directions, such as a public address announcement to evacuate a building. Some disabled individuals may need to be in a quiet place for a while to regain their composure; others may even try to hide from rescue workers.
- Train personnel to realize that some individuals with significant mental or learning disabilities might not understand the significance of "Keep Out" signs and barricade tape.

- It is suggested that trauma management should be a part of the disability training.
- Block level training of all medical and paramedical staff including doctors should be taken up with regard to disability and management
- Since 73% of persons with disabilities are helped by their family for coping with their day-to-day life we can conclude that dependence on family is very high, even so during a disaster situation, therefore training of family should be a high priority.

3.16 POLICY RECOMMENDATIONS

The PWD Act 1995 requires equal access for people with disabilities to all government programs. This includes programmatic inclusion in all disaster plans developed for a community.

- Disability to be included in all Government agendas
- Conduct more research and provide legal services: Disability related researches and legal services on disaster issues are scarce, but if available can point the way to practical solutions.
- Make it official: Like disability issues are non-existent in Orissa Relief Code which is the main guideline for management of natural disaster etc. needs change. There is no national standard on disability and disaster management.

- Set Standards: Set standards of an international level in an attempt to include the disability sector at all levels.
- Lack of instruction for PWDs in emergency situations in particular for preparedness and training in facing calamities. In general instructions are there but no component for disability.
- Many of the official channels related to disaster management are dominated by non-affected or suppressive and patriarchal groups.
- A liaison group between the government and the community: To keep the local authorities informed about the preparedness of the disabled in the village and put forward the needs of disabled.

Paras 57, 58 of Ch IV, Floods of the Orissa Relief Code *deal with* ***Storage of Food in Interior Vulnerable Strategic and Key Areas & Arrangement of Dry Food Stuff (chuda, mudhi, bread, etc) and other necessaries of life (tarpaulins, kerosene, matchboxes,etc)****, respectively. The Collector is responsible to identify storage places, assess quantity of foodgrains required, and ensure their safety along with the Superintendent of Police. This is done in consultation with district level committee on natural calamities.*

This should be read along with Para ***240 of ORC, i.e., Strengthening of Public Distribution System*** *for which the Collector should notify the Food Supplies & Consumer Welfare Dept. in case of difficulties, and* ***Para 242, i.e., Drawing of Food Stuff for Relief Measures out of the District Allotment. Section (ii) of Para 242 talks of Stocking of food stuff in flood prone areas****, sufficiently before the commencement of floods.*

3.17 ROLE OF TASKFORCE

Register at the Village Level

- Listing of PWDS by the community, first by identification of people with disabilities their abilities limitations such as mobility, visual, speech who are concentrated in residential care facilities, clusters of people with Hansens disease who usually live together, employers known to employ disabled people such as industrial sector, NGOs or schools with large populations of students with disabilities. Secondly all other disabled in the village be registered.

- Local authorities should be informed about the Register. The register needs to be regularly updated for any addition and deletion of disabled people.
- Work delegation related to PWDs needs to be pre-planned and delegated for the purpose
- It could help to carry out a mock drill for evacuation by this group, on a designated rainy night when it is dark (remove electricity). It will give a fair idea of what problems need to be tackled at such times.

Career and Support Services

- Localized task force should be geared up for PWDs
- PWDs should be included in the village task force and disabled specific committees.
- When a Village action plan is envisaged-they should identify the transportation available and disability need.
- Transportation needs to be manned by trained professionals for rescue and evacuation.
- Creation of volunteers, training, disaster risk management programme in all blocks and panchayats should be taken up so that the disabled can be helped to be moved to safety.
- Awareness of the handicapped persons needed so that they know whom to approach when the need for transportation is there
- Attendants should be identified earlier
- Any PWDs without family or community support having no livelihood option should be accommodated in sheltered homes till a solution to their problem is found by the community.

Mapping of PWDs

- Mark on the map the habitations in the village and where they are located, for e.g. Number of houses – thatched, tiled, pucca RCC houses, disabled friendly houses.

- Make a list of the population –Number of families – men - women – children, castes, the disabled category wise, the terminally ill, pregnant disabled women, mothers, so on.

- Make a list of various livelihoods and assets of the community and Exclusive institutions for PWDs and also identify the followings**.**
  - Accessible Cyclone/flood shelters.
  - Accessible areas and buildings

- Temples or any community building that can be used by the disabled
- Schools and education facilities
- Drinking water facilities
- Dispensaries or primary health care units
- Village roads, cart tracks
- Risk prone embankments & safe embankments.
- Power installations
- Telephone
- Post office and other such structures

- This information is put up on a map and displayed. Villagers study it and suggest any errors or oversights there may have been.

The mapping session is important for situational analysis because the following stages to contingency planning depend on the information listed here.

- Listing what causes damage in cyclone/flood and where (Hazard mapping)

The community identifies based on the experiences of the earlier cyclone/flood, what the different weather hazards it faced, for e.g. winds, heavy rains, floods, mudslides and so on. It also identifies where in the village these hazards are most likely to affect life, property, infrastructure and economic activities. These are marked on a separate map.

The list may include:
Roads and paths accessible to disabled and not dangerous especially for the blind.

Flood Hazards

- **Mark on the map** areas near riverbanks, canal banks, village tanks or the sea facing side of the village which is more prone to flooding

Rain Hazards

- Mark on the map lands on an incline that do not have green covers and are most likely to get eroded.
- Mark nearby tanks and ponds, which may flood fields and submerge houses, and so on. ***Note****: People by past experience know the*

general boundary of flood areas. Houses using water-soluble binding are vulnerable in this area.

Earthquake Hazard: Buildings that do not follow earthquake code.

- Make a Description of the Village (Situational Analysis)
- Community, Volunteers, Youth, Women, Ward Member, Sarpanch and other Government and non-governmental officials make a map of the village identifying the following characteristics.
- Mark on the map the geography and topography of the village, for e.g.
  - What is the village surrounded by in the North, South, East, and Western directions. Modifications can be carried out to suit the characteristics of the village. Hint: You may use an updated revenue map of the village as a reference during the exercise.
- Changes in the village for example, new disabled, new families, births, deaths, new installations and so on have to be incorporated in the maps and keep revising the plan accordingly.

Sanitation Group

Before Cyclone/ Flood

- Collect temporary latrine platforms and other sanitation requirements from the concerned departments and put up temporary latrines near the shelters, accessible to the disabled

Para 207of ORC details the responsibilities of the Directors of the Health & Family Welfare Dept in issuing special instructions for hospital treatment of the distressed, in ensuring that medical and public health arrangements for the distressed are made in all the districts, directing the CDMO to inspect sanitary arrangements, quality of food supplied during relief, organise & depute mobile health units to affected areas and report to Government.

IF YOU ARE IN A MAJOR EARTHQUAKE, REMEMBER . . .

Not only do breakable things break the broken pieces and other objects fly off walls and shelves. So, during the shaking move away from windows, mirrors shelves, and bookcases. Watch out for pictures flying off walls, and loose objects from the top of file cabinets. Cabinet doors may open and stored items spill out; bookcases may topple over if not anchored to a wall or the floor.

- Large, heavy furniture gets moved. This means file cabinets, desks, televisions, couches, beds and other items you may not be able to move by yourself will shift position by a foot or more. Out-of-position furniture may actually block the pathway out of the residence or office.
- Many offices have acoustical tile ceilings, and a major quake may shake some out of the ceiling. Fortunately, tiles are not very heavy when they fall. But usually a lot of dust has accumulated above the tiles and this dust will come down as well.
- Telephone service may be interrupted. It is therefore important to have a rescue and evacuation plan ready.
- Electricity may be lost. This means no lights. AT WORK AND AT HOME - KEEP A FLASHLIGHT AND FRESH BATTERIES HANDY.
- A fire is much more possible than under normal conditions. In or near any building or residence, there may be a ruptured gas line, torn electrical wiring, or spilled flammable fluids. AT HOME, HAVE A FIRE EXTINGUISHER HANDY. AT WORK, KNOW WHERE THE NEAREST TWO EXTINGUISHERS ARE LOCATED.
- Don't expect help from fire and police personnel for at least 72 hours: they will be busy with the most crucial situations. Some emergency shelters are up and running within hours of a major disaster; others take two or three days to become operational. BE MENTALLY PREPARED TO RELY ON YOUR OWN RESOURCES AND THE HELP OF NEIGHBORS AND WORK COLLEAGUES DURING THE FIRST 72 HOURS AFTER A MAJOR EARTHQUAKE.
- If you are not within walking distance from home when a major quake occurs, be ready for serious problems with transportation. Roads may be closed; bus service will be suspended.

3.18 FINDINGS OF OTHER STUDIES

During Cyclone/Flood (When warning is received)

1. Move stocks for food, water utensils, and medicines to the shelters and safe houses. See that enough drinking water is stored.
2. Organize space to house evacuee families.
3. Solar lantern to be made available.
4. The blind must be oriented to use of shelters before.
5. Essential disaster aid & appliance such as wheel chair, blind stick, heavy mattress, cots must be kept in shelters.
6. Replenish stocks of food, clothing and fuel wood from the government stores or 'Grain Bank" of the village or any other source. Help disabled groups collect their belongings and evacuate. Ensure that everyone knows which shelter to go to and reach there before the cyclone/flood strikes.
7. Help evacuees especially, children, the disabled (MR, CP, VH, Wheel chair users, SCI etc), pregnant women, sick and old to reach the shelter early.
8. Be able to assist if an evacuation order is issued. Provide physical assistance in leaving the home/office and transferring to a vehicle.
9. Provide transportation to a shelter. This may require a specialized vehicle designed to carry a wheelchair or other mobility equipment.
10. People with impaired mobility are often concerned about being dropped when being lifted or carried. Find out the proper way to transfer or move someone in a wheelchair and what exit routs from buildings are best**.**
11. Register evacuees and hand over identification pictorial or Braille slates as per need to them. To distribute food according to the identification slips to prevent duplication or negligence in giving out food, water and medicines.
12. Ensure strict hygiene practices in the shelter and accessibility.

CHAPTER FOUR

MODULE I

4 ON DISABILITY

This section is comprised of eight modules. This first module focuses on the disability definition and types. This module also teaches on various communities friendly methods for identification of disabled people. Method of coping mechanism of disabled people during and post disaster period can be taught from the second module whereas in the third module efforts have been made to learn the role and responsibilities of various stakeholders working for the benefit of the community. At the same time this module also tells about the role of community and the disabled people. In the fourth module discussion has been made on gender and disability and in the fifth part of this section analysis on the livelihood opportunities whereas there are discussion on the different barrier free environment in the sixth module. In the seventh module we can understand different legal issues to protect the legal rights of the disabled people. In the last module of this section we can work out methods of trauma management.

4.1 DISABILITY, DISCRIMINATION AND STEREOTYPING

Day One: Morning
Disability and Types

I. Activity Description: 🕐 20 – 30 minutes

- **Define Disability and try to examine the types of Disabilities**
- **(Refer Activity Sheet 1, 2 and 3)**

Purpose:

- Get acquainted with the concept of disability
- Ask the participants: how do they understand what the differences are, what disability is.
- Be able to identify factors, which influence the formation of disabled diversities as a whole and individual disability in particular.
- Understand the social model developed in disability
- Understand the specific issues for disabled and – for non-disabled?
- Finishing the introductory talk about disability, it's worth reminding about the three "I", – identity, interactions, institutions. In the system of disability classifications every one of them is equally important and influential.

Notes for Trainers

Understanding Disability

1. The production of disability divisions.
2. The construction of symbols, images and language.
3. The interactions between individuals.
4. The internal mental work of individuals.
5. The ongoing logic of organizations themselves.

From the sociological point of view three levels could be considered:

- Identity
- Interactions
- Institutions

Discrimination

II. Activity Description: 🕐 20 – 30 minutes

Understand Discrimination

- Be able to understand disability equality
- Understand discrimination
- Realize when you realized you were disabled or non-disabled

Purpose:

II. A. Activity Sheet 4: Case Study

- Discuss what is discrimination?
- Give one of the definitions of discrimination.
- Organize the present into small groups. Ask everyone to remember a concrete case and age, when they first realized that they are disabled or non-disabled.
- Understand it through one's own experience, the process of socialization which begins very early.
- In the process of discussion all the cases are written (spoken also if VH persons) on the big sheet of paper in such order

How it happened? What happened?	Where it happened? Who did it?

- Discuss,
- What does this list show?
- What are the feelings after the group work?
- Were the memories comfortable for you?
- Make conclusions together with the group.
- Give explanation that “clear” discrimination (according to one feature) is situated beside a complex one (when several features are discriminated at once, e.g. caste, gender, etc or all threes).

Gender and disability
Scheduled Caste and disability
Gender, Scheduled caste and disability
Then draw a Wall of Discrimination

Fill a brick all with discriminations as observed by each participant. Some may be repeated and project a universal attitude.

- Discuss the oft repeated Discriminations against disabled
- For instance take one example such as employment
- Ask - What characteristics can be regarded as definitely discriminative ones, if they are preferred by employers?
- What requirements do employers most often have for its employees (age, education, appearance, professionalism, work experience, etc)?
- What kind of persons is required at labor market?
- Physically and mentally fit. Even government jobs require a medical examination
- What does it show?
- Discuss the case of Physical Fitness requirement even if job does not require it
- Ask,
- Are there among presented portraits and in real life cases, when labor market sets several discriminative requirements?
- What examples could be given?
- What can be done to overcome existing discrimination on labor market?

Notes for Trainers:
Discrimination is a process of socialization, which begins even when we don’t realize it.

In some groups (aged groups as well), where the term "socialization" is difficult, it can be changed into synonymous ones – "influence of society", "influence of environment", etc.

- By non-structured brainstorm ask the group, how they understand the term "discrimination" (rights violation based on certain feature, for example, mobility)
- Make small groups and ask to remember cases of discrimination from own life or lives of relatives and acquaintances (were violated because they are disabled).
- On returning to the whole group, ask one person from every group to retell the cases remembered in the group. The retelling should be impersonal, which means that only situation is described, without mentioning the person with whom it happened.
- While discussing don't forget to note that, in spite of the fact, that discriminative situations unfortunately very often happen in our life, some people often just can't understand that this is discrimination.

Stereotyping
Understanding Stereotyping of Disabled

III. Activity Description: 🕐 20 – 30 minutes
Disability stereotypes (How Stereotypes are framed, and Danger of Stereotypes)
(Activity Sheet V)

- Where are these social differences formed: own experience, mass media, art, employment, etc, ask how can we entitle this list made by the group?
- Brainstorm stereotypes about disabled

Purpose

- All disabled are seen as being different
- Define stereotypes as a term and be able to fill it with sense.
- Understand the deep roots of stereotypes in our everyday life.
- Be able to describe possible advantages and risks of stereotype existence.
- Ask the group what "stereotype" is?
- Ask to give examples of each type of stereotypes.
- Suggest to choose stereotypes, which refers to attitude to disabled.
- Write one of them on the top of flipchart (in the middle), then on the left side write the list of risks of this stereotype for disabled. (Speak them loudly if VH present)
- Repeat this work, analyzing another stereotype.

- The work on the list of risks can be done either in the whole group by brainstorm or in small groups (then different stereotypes could be given to different groups).
- Who does the stereotype influence on – group it is aimed at or on the other groups as well?
- How does the stereotype influence individuality, diversity, and uniqueness?
- If there will be answers of the group, that such stereotypes exist, ask to say them.
- How can one overcome stereotype?
- Who could it depend on?
- Try to understand the roots of discrimination. and stereotyping
- Understand motivations of people, who discriminate and stereotype and, who are discriminated.

Notes for Trainers

It's worth to remind about the importance of having broken the old stereotypes, construct the new ones instead. By changing and overcoming stereotypes gradually, first of all in own consciousness, we can achieve much more, though certainly, this way is longer and not always so visible from outside.

Looking for the Way Out

Ways to remove discrimination and stereotyping through promotion of rights

Purpose

- Understanding the links between disability and rights
- Help understand possibility and importance of concrete actions on elimination of discrimination.
- Learn how to look for concrete steps of overcoming situations connected with discrimination.
- Think about local specific abuse of disabled rights

III. a. Activity Description: 🕐 30 – 40 minutes

- The activity is conducted with the help of "fishbowl" technique.
- In the center of the circle in turn sit those, who consider the most important (the strongest, the most painful, the first to overcome, etc) certain spokes (e.g. "family", "doctor", "CBO", "observer" etc) and during 5 – 6 minutes

they discuss possible steps of overcoming discrimination in the chosen sphere.

- Suggested steps are written down on flipchart. You can also note by different colors the levels on which it could be done (Issue of birth of disabled child issues of rights, doctors, disabled and societies views etc).
- After finishing ask,
- What are the impressions from work in and out of the circle?
- Maybe some of those who were out of the circle would like to add some actions (steps)?

Who and Why Needs - Justice for Disabled

Purpose:

- See and show the importance of achieving justice, for all human beings including the disabled.

III. b. Activity Description: 🕐 30 – 40 minutes

- Make participants into small groups and ask to depict on flipcharts in four columns, why they need equity (it means, what benefits they will have, what will become better for them, etc).
  - for disabled
  - for non disabled
  - for disabled women
  - for disabled children
  - for society as a whole
- Suggest to present the work of the groups
- Ask,
- What are the impressions from the work in groups?
- Was it similarly easy to depict the necessity in equity for every group?
- For which group was it easier? Why?
- For which group was it more difficult? Why?
- What for is it important to think over the answers to such questions?

Examples of use activities on empowered pedagogy for analysis

Activity title	Schemes (analytical methods)	Sphere of application
Stereotypes	Possible risks of existing stereotypes for different groups.	Analysis of environment with high level of inclination to

		stereotyping with the aim to predict possible risks.
"Photo" of a day at home	What a disabled does if confined to home	Social and economic analysis
"Required for work …"	Defining the list of criteria of interest from the job market and analysis of them on discrimination.	Analysis of factors of discrimination.

Notes for Trainers

Analysis takes into consideration social and economic differences between disabled and others on every stage of policy development with the aim of:

- Revealing potentially different influence of political courses, programs and legislation on women and men;
- Ensuring equivalent results for disabled women and men, boys and girls in the course of conducting and planning activities.

4.2. ACTIVITY SHEET: DISABILITY CONCEPT AND TYPE

(Refer to chapter one for definition and concept of disability)

The followings are the discussion on the various categories of disability those are commonly experienced by the community.

Locomotor Disability

Locomotor disability occurs when movements in our body are affected due to disease, injury, any absence or deformities in the joints, bones and muscles, or an injury of the nerves, spinal cord or brain. This may be due to:

- Polio
- Amputation
- Cerebral Palsy
- Stroke
- Congenital deformities
- Paraplegia

Cerebral Palsy

Cerebral Palsy is the result of damage to the baby's brain either before he/she is born, or during the birth process or soon after birth. Those part of the brain that control the hands and legs are affected. Speech, hearing vision and intelligence may be affected too, depending on the extent of damage happened

to the developing brain. Cerebral Palsy is a condition that does not get worse (non-progressive).

Cerebral Palsy affects each child differently. A mild affected child will learn to walk with slightly unsteady balance. Other children may have difficulty with using their hands. A severely affected child may need help learning to sit and may not be independent in daily tasks. Cerebral Palsy is found in every country and in all types of families. About one in every three hundred babies born will have or will develop, Cerebral Palsy. By therapy, special education and applied technology, child with Cerebral palsy will lead productive lives. He/she is child first; his/her disability comes only after that.

Definition

"Cerebral Palsy" means a group of non-progressive conditions of a person characterized by abnormal motor control posture resulting from brain insult or injuries occurring in the pre-natal, peri-natal or infant period of development (Section-2(e)) of PWD Act, 1995).

Visually Impaired Children

Like anyone with a disability, the blind person wants to be treated like anyone else. Most blind people do not seek pity or even unnecessary help. Although they may need assistance in some situations, mostly they prefer to be reminded of their similarities rather than differences.

Categories

There are two categories:

a. Blindness
b. Low vision

Definition

a) **Blindness**: "Blindness" refers to a condition where a person suffers from any of the following conditions, namely: (i) total absence of sight; or (ii) visual acquit not exceeding 6/60 or 20/200 snellen in the better eye with correcting lenses; or (iii) limitation of the field of vision subtending an angle of 20 degree or worse. (Section-2(b) of PWD Act, 1995).

b) **Low Vision** : **"**Person with Low Vision" means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using

vision for the planning or execution of tasks with appropriate assistive devices. (Section-2(u) of PWD Act, 1995).

Hearing Impaired

Hearing is the main sensory pathway through speech and verbal communication develops. If a child hears imperfectly, he/she is likely to speak incorrectly. Again, hearing also influences learning and other aspects of maturation. Early detection of hearing impairment is very important for the child's overall development. Hearing impairment adversely affects our knowledge of the world around us. Further, it also hampers the child's performance in learning. Hearing-impaired children are more disadvantaged than visually impaired children. Hearing impaired is the greater barrier to the normal development of knowledge.

Definition

"Hearing Impairment" means loss of sixty decibels or more in the better ear in the conversational range of frequencies; (Section-2(l) of PWD Act, 1995)

Types of Hearing Impairment

The age of onset of hearing impairment and the relationship between hearing loss and language delay are important considerations in the classification of hearing impaired children. For this reason, professionals classify hearing-impaired children as follows:

i. **Congenitally deaf** are those children who are born deaf.
ii. **Adventitiously deaf** are those children who acquire deafness at some time after birth.
iii. **Prelingual deafness** is deafness present at birth, or occurring early in life at an early age prior to the development of speech or language.
iv. **Postlingual deafness** is deafness occurring at any age following the development of the speech or language.

The following classification system is also common. This classification is based on hearing sensitivity.

i. **Mild Deaf** are those children who have hearing loss between 26 and 54 decibels.
ii. **Moderate Deaf** are those children who have hearing loss between 55 and 69 decibels.
iii. **Severe Deaf** are those children who have hearing loss between 70 and 89 decibels.

iv. **Profound Deaf** are those children who have hearing losses of about 90 decibels or greater.

Mental Retardation

Mental Retardation is a condition and not a disease. Persons with this condition will have less mental ability or intelligence than others of his/her age. Such persons have difficulty in learning. Understanding and communicating to others and in adjusting their behaviour to the various situations in everyday life. Mental Retardation can result from damage to the brain or from incomplete development of the brain during the developmental period. (0-18 years)

Mental Retardation cannot be cured because it is not an illness. But, early identification and early intervention can greatly improve the effect of mental retardation on the everyday life of the persons affected by it.

Definition

"Mental Retardation" means a condition of arrested or incomplete development of mind of a person, which is specially characterized by sub normality of intelligence. (Section-2(r) of Persons with Disability Act, 1995.

Autism

Autism is not a disease an infant or child can catch, nor is it something one can cause or create. Autism is a disorder of the brain that causes the child to develop in a different way. In particular, people with autism have difficulties in communicating and socializing. Signs of this condition may begin to appear either from birth or after a period of normal development of the young child. But definite signs are visible by the time the child is between 2 ½ years to 3 years old. Autism can occur by itself or along with mental retardation and fits. There is still much that we do not know about this condition, but recent advances have shown that the origins of the condition may be due to genetic factor.

Definition:

Autism means a condition of uneven skill development primarily affecting the communication and social abilities of a person, marked by repetitive and ritualistic behaviour (National Trust Act 1999).

Multiple Disability

A person who has a combination of two or more disabilities is considered have multiple disabilities. The effect of multiple disability can be more than

combination of two individual disabilities. The person who is having multiple disability, the percentage of one of the disability must be 40% and above.

4.3. ACTIVITY SHEET: COMMUNITY FRIENDLY METHODS OF IDENTIFICATION

Locomotor Disability: Identification

Tell the person to do the following:

To lift the arms overhead.
To pick up a small object lying in front of him/her
To pick up a small stone placed on the ground
To walk a few steps
To run a short distance

Conclusion: If a person can do these activities in a normal manner without difficulty, he/she has no Locomotor disability. If a person cannot do one more these, then he/she has a Locomotor disability.

To test Movement of Arms above the Head

Steps	Key Points
Make the child sit or lie on his/her back on the bed.	Back should be straight when sitting Bed should be firm but soft, or cotton mattress on floor should be used
Ask the child to lift first his/her right arm straight up over the head and then his/her left arm.	Do not allow bending at the elbow No arching of back if in a lying position

Conclusion

If the child cannot lift his/her arms are paralysed .
If the child cannot lift his/her arms in full range of motion, it indicates that muscles are weak.

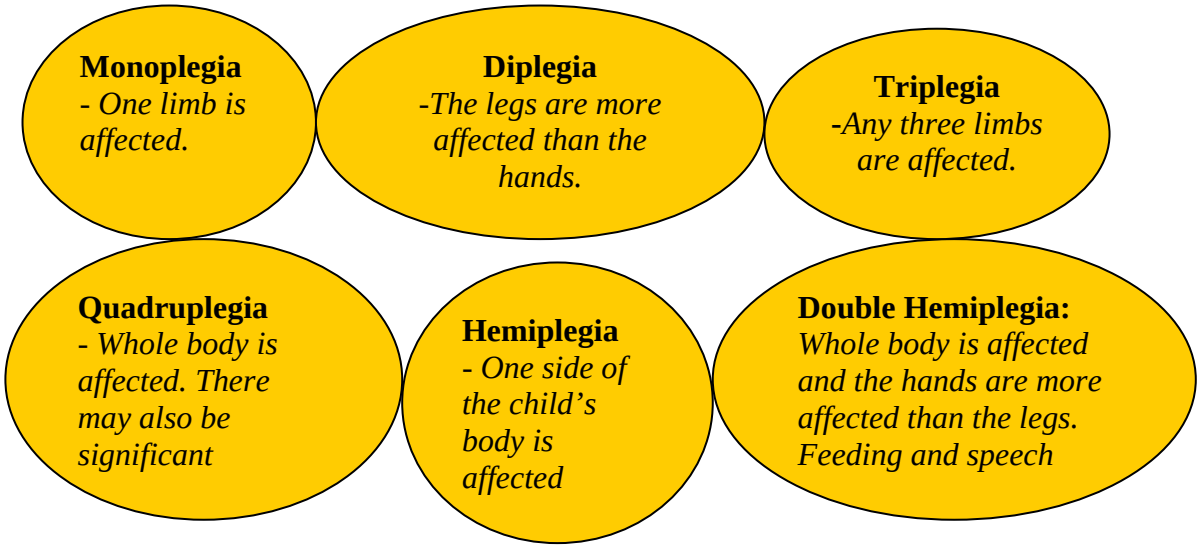
Cerebral Palsy *(Types, causes and prevention)*

There are four types of Cerebral Palsy:

Spastic	**Athetoid**
They have stiff, tight muscles and rigid bodies.	They have uncontrolled movements like fast, jerky tremors or slow continuous movements. This could be of the whole body or part of the

	body.
Mixed *Persons belonging to this category may have effect of two or more* than two difficulties/limitations stated above.	**Ataxic** They have lack of coordination in large movements and in small ones. Persons have difficulty in picking up objects or saving him from falling down. They walk with a broad base.

Cerebral Palsy can also be classified according to the part of the body that is affected.

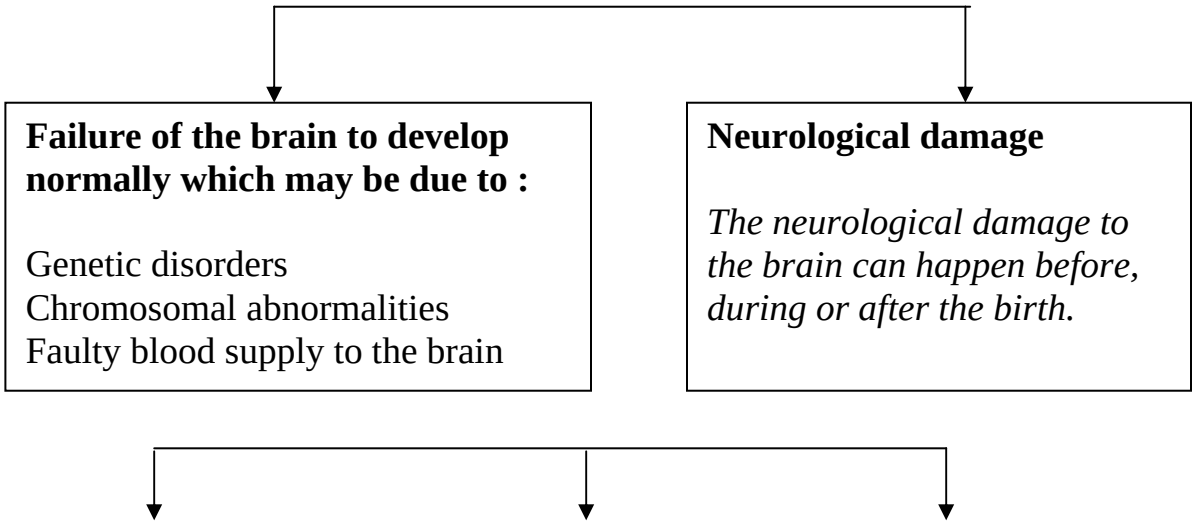


Areas controlling body movements (To be scanned)

Part of the Brain and the movements affected

Type	Affected Area	Muscle Tone	Muscle Type	Movements
Spasticity	Motor Cortex	High	Tight/Stiff	Rigid, scissoring of hands and legs
Athetosis	Basal ganglia	Fluctuating	Jerky movements	Slow, writhing movements
Ataxia	Cerebellum	Low	Shaky at distal ends	Lack of co-ordination and balance

Causes of Cerebral Palsy:



Pregnancy Risk Factors (Before Birth)	***Delivery Risk Factors (During Birth)***	***Neonatal Risk Factors (After Birth)***
1. Maternal diabetes, Hyperthyroidism, asthma, lung diseases. Hypertension.	*1. Premature delivery* *2. Prolonged labour* *3. Severely depressed (Slow) fetal heart rate during labour, indicating fetal stress.*	*1. Infections like meningitis, encephalitis* *2. Seizures caused by abnormal activity in the brain.*
2. Mother being exposed to Rubella, Typhoid, measles, chickenpox etc.	*4.Breach presentation or a transverse lie, which makes the delivery difficult.*	*3. Insufficient oxygen to the brain due to breathing probelm or poor blood flow to the brain (Asphyxia).*
3. Poor Maternal nutrition.	*5.Child born with umbilical cord around the neck, making breathing difficult. (Anoxia).*	*4. Bleeding in the interior surfaces of the brain.*
4. Mother consuming alcohol, smoking cigarettes or taking drugs.		*5. Tumors in the brain.*
5. Mother having seizures.	*6. Delayed birth cry.*	*6. Excessive fluid in the brain (Hydrocephalus)*
6. Mother being exposed to radiation.	*7. Low birth weight/very Glucose levels. (malnutrition).*	*7. Malnutrition*
7. Rh incompatibility Mother facing physical or mental trauma.	*8. Neonatal convulsions.*	*8. Neonatal jaundice.*
	9. An accidental injury to the baby's head during delivery by use of forceps.	*9. Accidents, trauma.*

Preventive Measures

General:

- Marriage between very close blood relations like uncle, niece, first cousin should be avoided for prevention of hereditary disorders.
- Avoid pregnancies before the age of 18 years and after the age of
- 35 years.
- Consult your doctor before planning your pregnancy if there is incidence of birth defects in your family, difficulty in conceiving or have had a series of miscarriages, Rh-negative blood type, and diabetes.
- Provide vaccination against Rubella for all women before reaching child bearing age.

Care During Pregnancy *:*

- Avoid hard physical work such as carrying heavy loads, especially in fields, and other accident-prone activities such as walking on slippery ground or climbing stools and chairs.
- Avoid drugs and medication. Even the normally safe and recommended drugs and medicines may, under certain conditions cause serious defects in an unborn child.
- Avoid smoking, chewing tobacco, consuming alcohol and narcotics.
- Avoid X-rays and exposure to any kind of radiation.
- Avoid exposure to illness like measles, mumps etc. especially during the first three months of pregnancy.
- Avoid sexual contact with persons having veneral diseases.
- Take precautions against lead poisoning.
- Avoid too much use of 'Surma' and 'Kohl'.
- Eat a well balanced and nourishing diet supplemented with leafy vegetables, proteins and vitamins.
- All women of child bearing age need 0.4 mg of folic acid daily.
- Ensure weight gain of at least 10 kgs. Have regular medical check-ups.
- All pregnant women should be given tetanus injection.

Care at the time of Birth:

- Delivery must be conducted by trained persons preferably in a hospital where all facilities are available.
- If the baby does not cry immediately after birth, resuscitation measures should be undertaken at once.
- Babies born prematurely and with low birth weight may need Neonatal Intensive Care.

- If the baby's head appears to be abnormally small or large have it measured and consult a doctor. The approximate head size for a male child at birth is 35 cm and for female child is 34.5 cm.
- To protect the child from infections breast-feeding must be started immediately after birth.

Early Childhood Care:

- Do not allow the child's temperature to remain above 101 degree F at anytime.
- If the child gets fits take him to a doctor immediately.
- The child should be immunized against infectious disease like Polio, Measles, Tetanus, and Tuberculosis etc.
- Do not allow the child to have too much contact with paint, newsprint ink, lead etc.
- Take precautions against head injury and other accidents.
- Ensure that the child gets a well balanced diet and clean drinking water.
- Vitamin A deficiency and its consequences including night blindness can be controlled through the use of Vitamin A.
- Protect the child from Meningitis and Encephalitis by providing a hygienic environment.
- Both cooking salt and table salt must be iodised as a precaution against Goitre.
- Do not allow the child to use hairpins, matchsticks and pencils, to remove wax from the ears.
- Use ear protectors to reduce the exposure to high levels of noise, if children are living or working in noisy areas.
- Do not slap the child on the cheeks and ears as this may lead to hearing loss.

Visual Impairment

Causes of Visual Impairment

- Errors of refraction;
- Glaucoma, Cataracts, and diabetes;
- Pre-natal causes;
- Improper muscle functioning;

Characteristics

There are some psychological and behavioral characteristics pertaining to visually impaired children. These characteristics are :

- Restricted language development.
- Lag behind in conceptual development.

- Tactual perception.
- Obstacle Sense.
- Difficulty in social skill.
- Stereotyped behaviours.

Problem of Visually Impaired Children

The visually impaired children experience many problems like behaviour problems, problem of learning, and problem of their placement in society or problem of social adjustment. Some of these problems are:

- Poor intelligence
- Academic retardation
- Slower speech development
- Personality disorders
- Problems in social adjustment

Identifying Visually Impaired Children

Early identification of visual impairment is indispensable so that correction can be provided at early stage itself before the problem becomes worse or complicated. Totally blind can easily be recognized and identified. But a detailed examination is necessary to identify low vision children. The detection of low vision is a much more difficult proposition. Identification of visually impaired children is also associated with some behavioral symptoms. Teacher should watch for manifestation of these symptoms in the regular classroom.

Symptoms the classroom teacher should watch for behaviour are:

- Rubs eye excessively
- Shuts or covers one eye, tilts head, or thrusts head forward
- Has difficulty in reading or in other work requiring close of the eyes.
- Blinks more than usual or is irritable when doing class work.
- Holds books close to the eyes.
- Is unable to see distant things clearly.
- Squints eyelids together or frowns.

Appearance:

- Crossed eyes
- Red-rimmed, encrusted, or swollen eyelids.
- Inflamed or watery eyes.
- Recurring styles.

Complaints:

- Eyes itch, burn, or feel scratchy.
- Cannot see wall.
- Dizziness, headaches, or nausea following close eye work
- Blurred or double vision.

Method of Identifying Low Vision children

Generally three methods are adopted to identify low vision children. They are:

- Classroom observation
- Ophthalmologic examination, and Visual screening.

Hearing Impaired Children

Characteristics

Hearing-impaired children have certain distinct psychological and behavioral characteristics. The nature and severity of certain limitations pertaining to hearing impaired children cause certain change in behaviour. The following are some important characteristics of hearing impaired individuals:

- **Linguistic Difficulties:** The hearing impaired children are abnormally slow in their linguistic development. These children have a limited vocabulary, they lack comprehension of complex words and words with multiple meaning and concept.
- **Problem in Personal and Social Development:** Hearing impaired individuals have personality and social characteristics that are different from those of people with normal hearing ability. They grow up in relative isolation. They are often perceived as excessively shy.
- **Personality Problems:** Research evidence indicate that hearing impaired children face personality problems. Partially deaf children experience more confrontation and personality problem than the totally deaf children.
- **Psychological Characteristics:** The hearing impaired children develop inferiority complex because of their inability to adapt to circumstances that require verbal communication. They always compare themselves with t heir normal peers and judge the attitudes of the society towards them. They feel that the attitude of the society towards them is not normal. They feel that they are very different than the normal children. They view it as either over protective or rejective. This feeling hampers their growth and development of personality.
- **Abnormal Emotional Behaviour:** Young hearing impaired children evince abnormal emotional behaviour. They may throw tantrums to attract

the attention to themselves or their deeds or needs. They are frequently obstinate and have tendency to tease. They become irritated when they find it very difficult to make them understood.

Causes of Hearing Impairment

Some authorities categorise the causes of hearing impairment under 04 headings:

- Hereditary and non-hereditary
- Congenital and acquired
- Prenatal, perinatal, and postnatal
- Physiological and psychological

Identifying Hearing Impaired Children

The following are some important techniques for identifying hearing impaired children:

Systematic Observation:

- They turn heads on one side to hear better
- These children are unable to follow directions
- In the classroom, they always request the teachers to repeat instructions, questions
- They focus specially on the speaker's lips
- They always hesitate to participate in group discussions,
- They display restlessness, inattention and speech difficulty,
- Frequent ear eggs are observable.

Case Study:

The case study is another technique to identify the hearing impaired children. While collecting data, the statement of the present problem/symptoms, health history (illness, serious disease, surgical operation etc.) and developmental history should be taken into account.

- **Hearing Tests:** There are three different types of hearing tests, i.e. pure-tone audiometry, speech audiometry and specialized tests for very young children.

Advanced Methods

A number of technological advances have made it easier for hearing impaired children to communicate with hearing people. This explosion of technology has taken place primarily in four areas. The four areas are:

- Computer assisted instructions
- Television captioning and teletext
- Telephone adaptations/tele-typewriter
- Hearing aids

Instructional Modifications in Classroom

Kampfe (1984), Palmer (1988) and Ross (1982) recommended the following techniques to promote understanding of hearing impaired children during lectures and discussions.

- The teacher can use an overhead projector to note important points so that he/she can face students while lecturing.
- The teacher must avoid moving around the room while speaking so that the students can see his or her face.
- The teacher should shorten or simplify verbalization.
- The teacher should repeat all the main points.
- The teacher should provide nonverbal cues and use facial expressions, body movements, and gestures.
- He/She should call the speakers' names so that the time spent in locating the source of speech can be reduced.
- The students can be asked to raise their hands so that the noise and confusion that results from several people talking at once can be avoided.

Modification of Oral Communication:

Garwood (1987) suggests a mnemonic device to improve oral instructions with hearing impaired students.

Modification of Written Materials:

Besides modifying oral communication, it is very important to modify written materials by using graphic pictorial forms such as diagrams, pictures, graphs, and graphic outlines. Adapting materials in this way will reduce the language and reading demands and the amount of content the hearing impaired students may find difficult to cover.

Causes

Many authorities are of the opinion that it is possible to pinpoint the cause of Mental Retardation in only about 6-15% of the cases. Although there is some overlap, the casual factors for Mild Retardation differs from those of more

severe level of retardation. The broad causes of Mental Retardation are given below:

Genetic Factors These are generally of two types those that result from some damage to genetic material, such as chromosomal abnormalities, and those that are due to hereditary transmission. Genetic factor includes three conditions such as : DOWN SYNDROME, which results from chromosomal abnormality and PKU (Phenylk-etonuria) and Tay-Sachs disease, both of which are inherited.

Brain Damage: Brain damage causes severe mental retardation. It can result from a host of factors that falls into two general categories.

Infections: Infections that may lead to mental retardation can occur in the mother to be or the infant or young child after birth. Rubella (German Measles), syphilis, and herpes simplex, meningitis encephalitis, and pediatric AIDS are some infections, which may cause retardation.

Environmental Hazard: Environmental hazard that can result in mental retardation are a blow to the head, poisons, radiation, malnutrition, prematurity or postmaturity and birth injuries.

Is Mental Retardation the Same as Mental Illness?

Mental Retardation is not the same as Mental Illness. Mental Retardation is a condition. It cannot be cured. However, the mentally retarded persons can be helped to learn many things. One of the majority feature of Mental Retardation is delayed development. Some mentally retarded persons have external characteristics such as a small head, big or small and slanting eyes, squint, a thick tongue, drooling of saliva, irregular teeth, stiffness or floppiness of limbs.

On the other hand, people suffering from Mental Illness have normal development of physical and mental abilities. Mental Illness is a disease, which can occur at any age due to several causes, if identified early and diagnosed correctly it can be treated completely. Some of the symptoms of Mental Illness are behaving in a strange manner, becoming moody and withdrawn, having suicidal tendencies, seeing and hearing things which others do not see and hear, suspecting others abnormally and becoming unusually cheerful and boastful. The mentally retarded person does not share these features.

What are People with Autism Like?

Persons with autism are different from other people and certain ways, though they may be similar in physical appearance and in many other respects to other non-disabled people.

Characteristic

i) Language:

- Frequently has delay in learning language.
- May respond to a question by repeating it. If you ask him " what is your name" he/she may respond by saying, "what is your name".
- May not use language meaningfully, such as in a conversation or asking questions in a logical sequence.
- May continuously repeat certain songs, words or rhymes.
- May not begin or continue conversations.

ii) Socialisation:

- Act as if deaf and does not react to speech or noises.
- Strong resistance to learning new behaviour or new skill.
- Frequently enjoys playing alone, and does not mix with other children of his/her age, although he/she may enjoy the company of children younger or older to him.
- Stand-offish manner-treats persons as objects rather than a persons.
- May not seem interested in making friends.
- May not look at others straight in the eye (may not make eye contact).
- May not share his/her interest or excitement with others.

iii) Unusual Behaviour

- May like too much order and sameness.
- Resists changes in routine.
- May not enjoy physical contact like hugging or cuddling.
- They have lack of fear about realistic danger; (May play with fire).
- Laughs or giggles for no appropriate reason.
- Prefers to indicate wants by gestures and speech may or may not be present.
- Marked physical over-activity.
- May be attracted to spinning or rotating objects, such as wheels, fans and other moving objects.
- May exhibit unusual facial and bodily movements like grimacing, jumping, hand flapping.
- May become upset for no apparent reason.

- May show unusual response to sensations, including too much or too little sensitivity to sound.
- There may be apparent indifference to pain, heat or cold.

Can Autism be Prevented?

As we do not know the cause, we do not yet know how it can be prevented. Similarly, as there is no cure for autism yet there is no medication, no pills, no injections that can make the problem go away. The only effective treatment for autism is a structured training programme from very early childhood onwards.

Characteristics

- There may be Physical delay in development head control; in sitting, crawling delays in self care skills like toilet-control etc.
- Difficulty in sucking, chewing or eating, or using hands or moving from place to place.
- They respond slowly to what others say and to what happens in their surroundings. Sometimes they do not respond at all.
- They cannot understand easily what they see, hear, touch, smell or taste.
- They may not clearly express their thoughts, needs and feelings.
- They may not learn new and different things as easily as others do. They are slow in learning. They have poor school and academic performance.
- They have difficulty in making even simple decisions.
- Some of them cannot attend to one person or one activity for required time.
- Some of them also have difficulty in changing from one activity to another.
- Some find it difficult to control their feelings, emotions. They may throw things, injure themselves or others.
- Some can remember only for a short time what they have learned and or told.
- They have discrepancy between physical and mental age.
- Appearance of being dull and being slow in understanding, memory, attention-concentration, thinking, problem solving, decision making etc.
- Some of them may incompetence in performing vocational activities or lack of social skills for their age.
- Some of them may have associated features like behaviour problems, fits, sensory handicaps etc.

Characteristic

- Two more disabilities/impairments.
- Additional disabilities because of the combination.

- Missed steps in task performance.
- Need very structured teaching plan.
- Need support in many life areas.
- Difficulty in generalizing
- To learn in small steps with lot of practice and repetition.
- Lack of curiosity and / or emotional attachment.
- Not always independent in activities like toileting, eating etc.
- Communication with others may be difficult and also moving from one place to another.
- Need a lot of support for learning and living task.

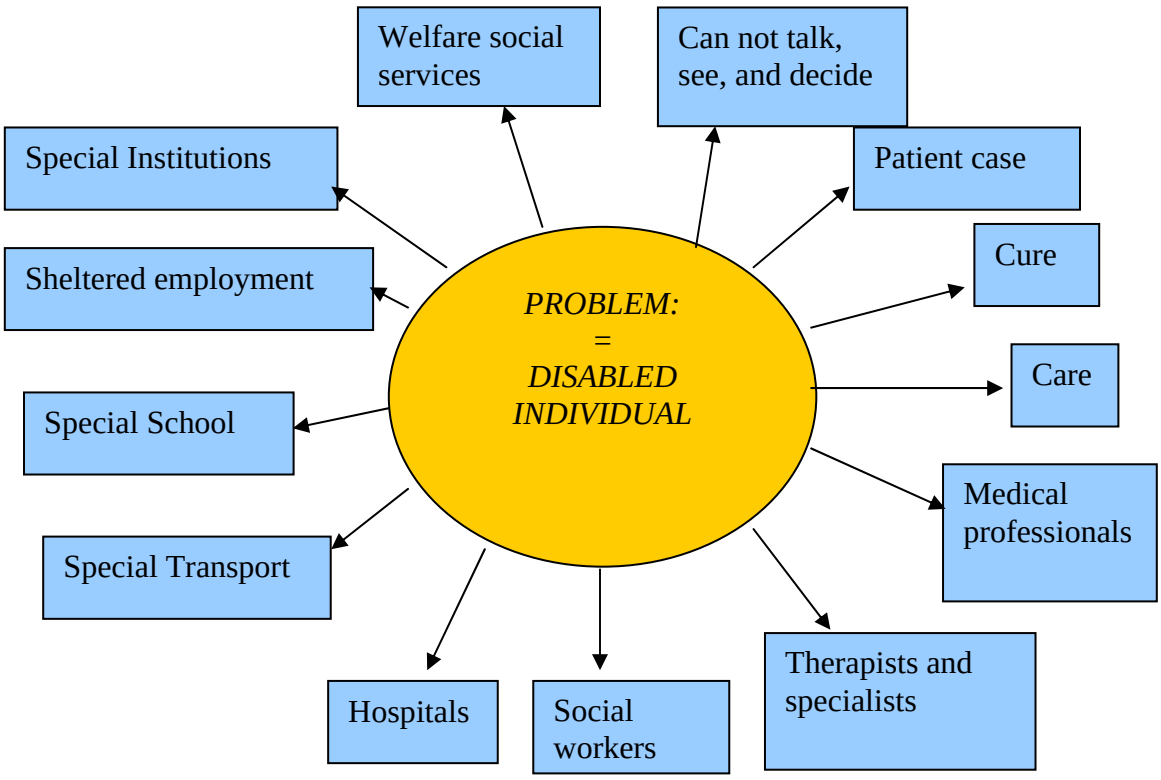
Some Example of Multiple Disabilities

- Deaf blind (Visual Impaired + Hearing Impaired)
- Visual impairment + Hearing Impairment + Mental Retardation
- Visual Impairment + Mental Retardation
- Cerebral Palsy + Mental Retardation/ Hearing /Speech /Visual Problems.

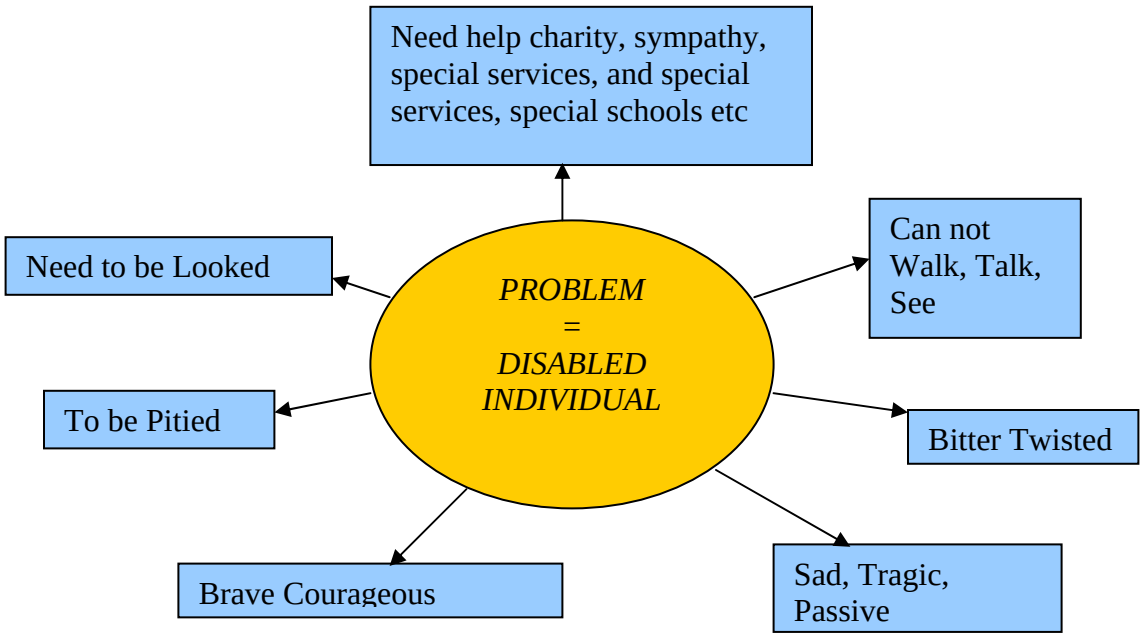
4.4 ACTIVITY SHEET : CASE STUDY

Three Model of Disability

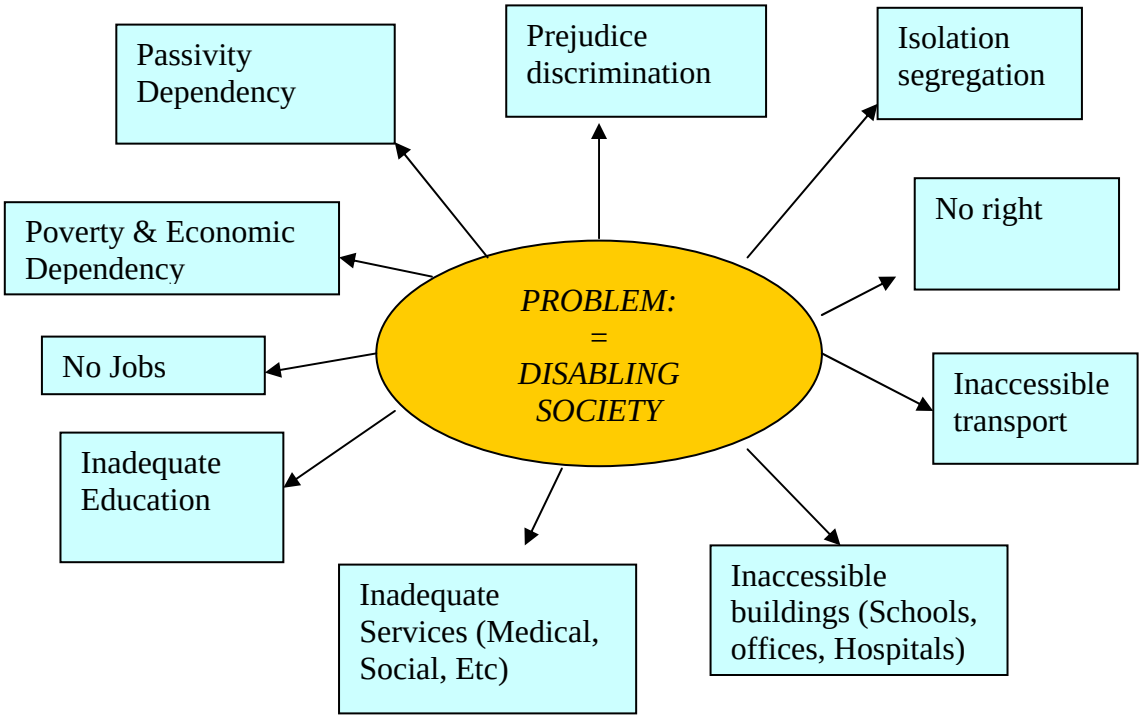
Medical Model of Disability



The Charitable Model of Disability



The Social Model of Disability



Source: Harris Alison and Enfield Sue, "Disability, Equality and Human Rights", Oxfam GB, 2003.

The social model has been developed by the disabled themselves to understand the issues of disability. In this model were therefore recommended the use of this model for detailed training purpose.

Activity Sheet 4: Case Study

Bikram Swain a twelve-year-old boy has Cerebral Palsy, which exits due to birth problems. Looking at Bikram you observe that there is a continuous flow of saliva from his mouth and he looks and laughs at strangers coming into their house.

Seeing his condition and not understanding it they sent Bikram to be taken care of by his maternal grandmothers. *(Inability to Identify)

A widow, his grandmother has financial problems. Her son is a daily wage labourer. with four children of his own. They have a small piece of land on which they cannot depend fully on agricultural income. Their lack of financial resources has meant that they have not been able to consult any physician * (Poverty and Lack of Medical Care)

In the 1999 cyclone the house was damaged and the family had to take shelter in neighbours house. The old woman dragged her grandson somewhat to safety * (Problem of Rescuing disabled during disasters).

As Bikram has motor coordination problems he cannot walk. He moves through the house crawling on the ground. He has not been able to do his own work independently. His mother has to help him in his daily activities. When they sought refuge in the neighbours house their major problem was space, which Bikram was used to. People also looked with disgust at the saliva drooling from his mouth. They said he was mentally ill and kept the family isolated. They received no food the first three days. The grandmother afraid he would die finally approached the community and managed to get food. Her sons rebuild the thatched room. Bikram is not entitled to any assistance, as he has no certificate. The Block promised in 1998 but is yet to issue it * (Assistance has to be sought and in a family with a disabled who cannot access rights and entitlements the only way out for the family is community help). Some problems identified from the case can be discussed.

Activity Sheet 5 Stereotyping
These are some definitions of stereotypes.

Stereotype – a combination of simplified generalizations about the *group* of individuals, which gives opportunity to divide the *members of the group* into categories and perceive them in patterns, according to these expectations. Thus, stereotypes of *race, social and gender groups* lead to perception and attitude to individuals in accordance with unmotivated *prejudiced thoughts*.

Stereotype is a generalization, when features and characteristics of part of the group (not necessary the biggest part) are spread to the group as a whole. There can be race, national, gender stereotypes found. Disability itself becomes s a stereotype.

In Bikram's case has he been stereotyped? Yes, because cerebral palsy does not mean mental retardation also. Without a doctor's diagnosis the community has declared him mentally retarded. His lack of motor coordination has been misidentified. It is normally decided that physically disabled, autistic and hearing and speech impaired are mentally retarded and not fit to be educated.

- They are not admitted to schools. They are not included in games and other children's' activities

Cerebral Palsy: Exclusion
No education
Identity of being a normal human being
Gender Stereotyping among Disabled

Not fit to marry
Does not fit the mold of women as beautiful
Denied motherhood as may bear disabled children
Denied motherhood as may be raped and not able to protect herself.

Deaf: Cannot understand less talented than often will not be able to carry out a job efficiently.

MODULE –II

DISABILITY AND DISASTER

This section tells about the limitations with the PWDs and mechanisms to cope with the difficult situations during disaster. There are variation in the problems depending on the type of disability and needs. So to make it in more clear the problems and coping mechanisms are segregated in to Warning, Evacuation, Rescue, Relief and reconstruction.

4.5 DISASTER

It is needless to say that the problem faced by the PWDs is more acute than that of general people in the affected region. Disaster relief and rehabilitation pay scant attention to the specific needs of the disabled, both those created and affected by disasters. There are an increasing number of people affected by disability during disasters; such people are suddenly deprived of their normal social, economic, and cultural environment. Human relationships and support mechanisms get disrupted beyond recognition. The proportion of the disabled among this group is sizeable, frequently requiring urgent attention.

Disability advocates such as Ashok Hans, working with or on behalf of the disabled maintains that the real problems of people with disabilities are neither properly understood nor adequately responded to by governmental, non-governmental, and international agencies. The mechanisms for disaster management, disaster preparedness, and relevant administrative structures are grossly inadequate. In the case of natural disasters, actions are taken to provide relief initially by local NGOs and the government officials, followed by other national and international agencies. Sometimes as in the Tsunami Irrespective of their legal status after arriving in India, their need for humanitarian support remains pressing. The nature of the disabilities of those affected by disasters is different from the rest of the population and, as such, the help needed by them must come from interventions different from the routine and a sense of urgency must accompany such efforts.

The populations affected by disasters contain a high proportion of the disabled. Unlike the others, a majority of them acquire disability. Their disability does not start in childhood, although the children among them may have been born disabled or may have experienced malnutrition or lack of health service support, like the rest of the population. Their disabilities, by and large, are directly from the conditions created by disasters such as armed

conflict, communal violence, landmines, floods, earthquakes, etc. The disabled from the disaster-affected areas have limited or no access to health services. These affect their desperate conditions even more adversely. Besides, being disabled they face abuse, exploitation, and neglect much more than their non-disabled counterparts. No effort should be spared to protect them from such multiple health, social and security hazards.

People uprooted from their homes without warning are more likely to suffer extreme hardships and a wide range of risks and dangers because of their total lack of preparedness to meet such situations and a sudden, and often total, erosion of the network of support provided by their family and community. Disabled children and children of the disabled face trauma and stress much more than the others. Besides, the formal and informal systems of support break down and do not ever return to a level of normalcy enjoyed by the individuals as they had before the disaster. Without sustained support, PWDs seldom, if ever, regain their confidence, self-respect, and dignity.

Frequently, the disabled among those uprooted from their own environment require extra support but the agencies which come together in a hurry to provide relief, although well-intentioned are frequently unaware of the real needs of those they want to help as they are untrained in the appropriate skills of rehabilitation. The agencies providing relief tend to devise ad hoc solutions loss of papers required by disabled to access specific needs is a problem to which, not attention is paid & may become the time between survival and non survival. The challenge for agencies engaged in relief work include the urgent and pressing tasks of coping with the situations in which the disaster- affected people in general and the disabled among them in particular find themselves trapped.

4.6 PROBLEMS AND COPING MECHANISIM

The table 1 identifies the problems faced by disabled in preparedness & disaster situation & how these challenges can be met.

Table: 1

Pre- Disaster					During Disaster		
No.	Disability & Ability	Limitations	Warnings	Evacuation	Rescue	Relief	Reconstruction - Rehabilitation.
1	2	3	4	5	6	7	8
	T.H.H.P: Majority THHP are healthy, physically strong having normal mobility, vision & intellectual level. They can use normal public transport, rood ways, paths, entrances, toilets etc. of shelter / buildings etc. They are excellent in art and mechanical / technical work. PHHP: Can hear loud voice with or without hearing aid. Can speak articulate. Majority are healthy, physically normal, having normal mobility, vision intellectual, functional level.	THHP can not hear/ speak & unable to understand variable communication Majority Particularly rural THHP are illiterate. Most of them do not understands sign language, list of THHP/individual/family Practical information/ walking along with steps to be initiated by THH/family should be ready with VTEC & VTFC shall ensure that. Warning reaches to THH/individual family quickly as THH need more time to understand pictorial warnings Special Bulletins in sign language along with pictorial material captions in local language should be telecasted. Many may not speak clearly. Many may not hear	Pictorial warnings should be given to literate THH directly. The warning may be given to their family members in normal ways. The THH & their family members should be trained to understand the meaning of pictorial warnings & steps to be initiated for emergency responses. Written warning with details information may be given to educated THH in local language. Warning & Information to PHHP should be communicated directly. You should speak little loudly, clearly in simple, small sentence in local language along with body language. The Doordarshan and private T.V channels should telecast special bulletin in sign language with pictorial signal and written	THHP are capable enough of assuming responsibility for own evacuation and emergency power needs. These people need clear, realistic and accurate information in accessible formats about timing, shelter transport, facilities available, their role & responsibility, whom, how, when to contact for further detail/ clarification, should be given. Like THHP, PHHP are also capable enough of assuming responsibilities for own evacuation and emergency power needs.	These people become confused, looses confidence and patient in disaster situation because they cannot hear, understand, and interact. It is suggested that time should not be wasted in counseling or communication rather they should be rescued immediately preferably with their family members.	After rescues a name plate along with fathers/mothers name and address should be given to THHP which will help them in identification/locating their family member. Immediately hearing aids should be provided to restore their hearing capability which will make them enable to interact /negotiate with relief/emergency manager. Profound and severe deaf people cannot express their needs so services of special educator should be taken.	As per PWD Act 3% reservation (1% each VH, HH,LH) have been earmarked under poverty alleviation programme but it has been observed that HH persons particularly THHP are being neglected in Rehabilitation/Reconstruction packages because of restricted negotiable skills, poor knowledge about Govt. scheme and complex procedures. It is suggested that due share i.e. 1% under poverty alleviation programe should be enforced, awareness should be created and some procedure should be followed with relaxed provisions.

		without hearing aid. Many are illiterate. Hearing aids may amplify background noise or not be adequate under stressful situations. They may looses confidence, become importance, various, disoriented in disaster/ stressful situation more due to lack of information clarification in accessible formalities.	captions in local language. The CRC and SRC should initiate process at central/state level representative.	Beside list of general items (food grains, water, medicine, clothes, candles etc) which have to be carried by them a list if items (pictorial compiled information, should be given to them.		Counseling and guidance through sign languages, body language, pictorial/ written script should be given. The services of special educator (in HH field) may be utilized for counseling & guidance or interpreter, communicator. Special Educators are available in Spl. Schools for HH, SSA, integrated school in your block/dist. List along with address of these Spl. Edu. May be obtained from. Asst. Director TCTD, SIRD Campus, Unit-8, Bhubaneswar	Critical SCI persons should be refereed to RSIC centre, Cuttack, SMRC, Bhubaneswar (Therapy & Post treatment care- Rehab.) or nearest hospital where facilities are available. Scholarship scheme, SSA, schemes should be utilized for education of PWDs Possibilities of livelihood should be explorer under existing scheme in which mandatory 3% reservation has been given in all poverty
	Majority are independent in ADL, indoor/ out door mobility boarding of normal public transport, shelter. Many may assume rescue evacuation responsibilities and emergency responses. Comparatively literacy rate is higher.	(SCI, Wheel Chair User) They have restricted limited mobility wheelchair user. Cannot use normal public transport hilly damaged road, toilets, staircase etc.		Wheel chair user should be	Resources operate team including driver, para-		

	Majority have normal vision, hearing speech intellectual level.	cannot be used with out modification. Majority LH persons cannot undertake hearing, physical hard work. Few wheelchair users cannot walk even short distances, board public transport. C.P (Quadriplegia, Triplegia, double Hemiplegia) are totally dependant on human support having no mobility including feeding speech problem & retardation is also very common.	Auditory (Public announcement, TV, Radio and News etc) Visual (Written, pictorial) warning may be given to them directly/parents. They can access any format of warning given to normal civil society. They do not need any change in format. Since mobility of these PWDs is very restricted and some are wheelchair bound or bedridden so warning complete information about shelter, relief rescue services, accessibility of transport shelter and other services should be given little early.	asked best method for transporting them & their aid & appliances. Some of them can board transport may walk short distances independently or with use of crutches, stick, can, brace, human support. Other persons may need to be lifted. SCI multiplied fractured persons should be transit with due proper care and their equipment's usable items should be carried Many LH persons both hand / one leg/both leg affected having mobility are capable of assuming evacuation responsibilities and emergency response Beside essential items such as food, water, cloths, medicine, candle, aids & appliances, special drugs and other disability specific usable should be carried / transit with PWDs C.P person (Triplegia, Quadriplegia, Double Hemeplegia) totally	medical should have reasonably trained personally to handle the case of physical trauma & SCI persons, because these PWDs need proper positing lifting, shifting and transiting. Transport rates that PWDs utilized and were oriented to using may not be used as roadways, pathways gets damaged due to disaster. The mobility aid (Tricycle, Wheelchair, Crutches, Can & Brace) might have damaged. PWDs totally become dependent on human support for lifting, shifting and transiting. After first aid the SCI/Multiple fractured physical traumatic people should be referred/shifted to nearest hospital, NIRTAR, RSIC, Cuttack, etc.	These people should be kept in those shelters where facilities (toilets, water fountains, resting spaces, shitting space, distribution places etc.) are accessible. These people need privacy and comparatively more time for ADL. Some people can't sit on ground, some cannot sit for long timer, and some cannot sit at all etc. so chairs, resting space should be kept reserve to PWDs. Relief material should be distributed in such a manner so that PWDs faces lesser difficulties. The suggestive ways are	alleviation program (SGSY, JRY, EGS, SJSRY, KVIC, etc) jobs, services of VRCH, BBSR may utilized for assessment of Vocational need (Trg, Self Emp. etc.) for further details Pl. refer Chapter-Resources and accessibility. The Shelter/Houses of LDs must be accessible VTFC/ Parents should help them in documentation to obtain Rehabilitation/Reconstru ction packages. PWDs particularly those who are having restricted mobility are affected adversely (physically, mentally, socially, Psychologically and economically) so the reconstruction and rehabilitation of PWDs must have priority the Govt. both state and central Govt. have framed some programme/schemes for speedy rehabilitation of PWDs and the area of rehab are: Treatment Nearest Hospital Correctional Surgery and therapy at NIRTAR/Medical Colleges, Dist Hospital etc. Aids and Appliances (Wheelchair, Tricycle, Caliper, Crutches, Artificial limbs etc.)

				depends on human support and majority are wheelchair bound having no mobility and can not assume responsibility of own evacuation and emergency response so trained, strong volunteer are needed to transit/lift them.			should be obtain through ALIMCO, NIRTAR, DRC,IRCS through camp approach free of cost for those who are having family income less that Rs. 5000 p.m.
	TVHP Majority TVHP are healthy, Physically strong, having normal speech and hearing intellectual level. Most of them are independent in ADL, acquainted indoor and outdoor mobility. They can access/use public transport, roads, pathways, entrance toilets, shelters etc. They have excellent talent to identify persons, places, targets etc. through smell, sound and touching techniques. They have good concentration, very good memory, skill in craft work, music, song etc.	They cannot see nay thing. Majority are (rural TVHP) illiterate and cannot read-write written script and Braille, so unable to understand written communication. They cannot use un-acquainted roads, pathways, and shelters, without orientation.	Warning/information should be given in a format, which can be understood by illiterate or educated TVHP/PVHP and normal population too (Banqura, TV, Radio	TVHP are capable to assume some responsibilities for own evacuation with human guidance such as walking, carrying their utility item, boarding normal transport, understanding oral warning etc. The TVHP should be given mobility training to make them acquainted to those	TVHP can use normal transport, shelter, Oral instructions etc. After shifting them in sheltered they must be oriented about indoor mobility of shelter and existing utilities / amenities such as toilets, sleeping places, water taps etc. The transport routes, pathways, roadways that were used, may not be used in disaster situations, so TVHP becomes totally dependent on human support. While guiding TVHPs the rescue team should use directional language such as left side, infant etc. instead of saying "Come this side go that side, sit there etc.)		

	<u>PVHP or LV</u> Like TVHP, Majority PVHPs are healthy, Physically strong having normal speech, hearing, and intellectual functional level. These people can visualize big objectives even many are independent in reading & written of big size letters. <u>MR</u> About 90% MRP belongs to mild mental retardation category which is called educable group. They can be taught to be self-supporting with special training and parental assistance. About 6% MRP belongs to Moderate MR category. This group is trainable through some of them may require institutionalization. They can manage to live safely under the protection of	Majority MRP in mild Retardation category cannot perform complex task.	News, Public announcement, person to person communication etc.) Information regarding services, shelter, transport, accessibility provision for PWDs role and responsibility of PWDs/family member, whom to contact etc. should be prepared in advance and audio cassettes/CDs may be given to TVHP. While guiding/assisting TVHPs in mobility, turning, up-down obstacles, sitting and standing places etc. should be communicated properly (left turn, right turn, up stair, down stair, backside, little jump, long jump etc. Though majority adult MRP in mild category can understand	pathways/ roadways transports, which will be used during disaster situations. Complete information about evacuation process shelter, transport and amenities must be given in advance in accessible format (Braille/Audio cassettes) Beside general commodities, disability specific items such as Blind stick (White Cane) special lenses, Dictaphone, Braille etc. should be transit with PWDs. Majority MRP in mild category are capable of assuming own evacuation responsibilities and emergency power needs subject to clear,			

	family members.	The rate of learning of moderate MRP is very slow. Some of them may require institutional services. Severe & profound categories of MRP cannot clearly express their thoughts, needs and feelings. Majority of them may have associated problems like fits, sensory, speech defect, joint stiffness etc. The people in Profound category are unable to look after themselves. They cannot attend to their basic physical need and need life long support. They suffer severely deficient in adoptive behavior and unable to do simple tasks.	warning in normal format such as Bengura, TV-Radio news, public announcement but person-to-person communication is safe mode. The warning to MRP should be communicated on priority basis as they take more time to understand and respond to emergency needs. While communicating disaster warning to MRP of moderate category direct simple, small sentence should be used in local language. The warnings should be given both MRPs as well as their parents/guardians. The severe and Profound category of MRP can not understood any format of warning therefore warning should be given to their parents.	realistic and accurate information about timing transport, shelter, etc. The majority sever & profound category of MRP are in bedridden or carried persons. So strong volunteers are needed to lift/transit them. It is advised that these MRP should be shifted with their parents/Guardians and should be kept in same shelter. Since they cannot sit at all or for a longer time or on floor so same space for their rest should be kept. They need privacy too for their ADL.		Separate containers/lines should be arranged for those who cannot stand for a long time. More than general allotment of food grain, water, fuel, medicine etc. should be given to PWDs and their families.	The sever & profound MRP cannot take any livelihood activity and many may looses their parents, relatives and become single. So institutional care should be provided.

	About 3% MRP belongs to severe MR category. They can perform simple occupational task. About 1% of MRP belongs to profound MR category.					Discrimination which lead to limit their participation and adversely affects his/her opportunities or status, should be avoided Home/shelter delivery of the relief material should be ensure to parents of MRP because MRP of sever/profound categories need partial support at each step or they are fully dependent on parents. Special minimum needs such as medicine; suitable food shelter should be catered on priority basis.	

MODULE III

COMMON ROLE PLAYED BY DIFFERENT STAKEHOLDERS

4.7 DISASTER, DISABILITY, ORGANIZATION AND COMMUNITY: ROLE AND RESPONSIBILITY

In many disasters the role of the services providers has to the clearly understood. Only then could CBOs & the disabled are able to access their rights. This module provides the roles & responsibility of the different government organization. These enclosures counted are produced before the specific officials for purpose of monitoring & providing information to the officers concerned then work as specified by the Government.

4.8 ROLE OF GOVERNMENT IN ORISSA (INDIA)

COLLECTOR&DISTRICT MAGISTRATE

- Being head of district and Chairman of more than 100 monitoring/review committees, please ensure that PWDs are given adequate benefit, full participation and equal opportunities in all existing schemes/programs as Indian citizen and due share i.e. not less than 3% in education, training, paid job, self-employment & poverty alleviation programs etc. as Govt. has given 3% reservation which is mandatory (Section-73, 40 of PWD Act, 1995) to PWDs.
- Giving direction to different departments/offices which are under his/her administrative control to have separate column for PWDs (male/female) in their target allotment format, Monthly Progress Report, Quarterly Progress Report etc.
- Sending verbal/written direction to implementing agencies periodically.
- Interacting with specialized Govt. institutes like Vocational Rehabilitation Center for Handicapped (VRCH), National Institutes or their Regional Centers, (TCTD, TCTVH, TCTMR), DRCs, DDRCs, RRCs for Spinal Injuries, CRCs, ALIMCO, Special Employment Exchange for PH etc. to chalk out meaningful program for your district. The well qualified professionals/technicians may provide specialized/expert support services to those PWDs who are needy even at block level through camp approach
- A district cell, on the pattern of ALOK – Koraput, which does not require any additional financial implication or staff, may be opened which will work as data bank and information center to minimize the problems of both, yours as well as PWDs. Secondly some information boards, in local language may be displayed at prominent public places, Railway station, Bus stand, District hospital, office of the Municipality/Zilla Parishad/ DSWO/ BDO/ Tahsildar etc. to create awareness.

CHIEF DISTRICT MEDICAL OFFICER/DOCTORS

- Ensure that each PWD gets proper disability certificate on stipulated dates and through block level camps. Ensure that reasonable awareness has been created about date, time, venue, and process & documents needed for issue of Disability Certificate of Medical Board.
- The CDMO may send periodical instructions & guidelines to Govt. Doctor to issue fare concession certificate.
- Ensuring early identification, intervention and referral for appropriate treatment/surgery/therapy/aids & appliances.
- Referring the PWDs to appropriate institute for other rehabilitation services too such as education, training, self-employment, disability pension etc.
- Doctors can create awareness on causes, prevention and management of disability. You may create new hope among and between parents & PWDs by displaying positive stories, helping them to understand limitations/restrictions of disability & residual abilities. Information Board may be displayed in prominent places.
- The Govt. institutes, NGOs, service clubs can be used to organize different kind of camps (health camps, disability certificate/rehabilitation camps). Please extend your service, depute your doctors if required and requested.
- Ensure that working place, toilets, water fountains etc. are accessible for PWDs, ramps & slopes are constructed.

PROJECT DIRECTOR, DRDA

- According to Section-40 of PWD Act not less than 3% funds under poverty alleviation program has to be reserved for PWDs. Rural development work, including poverty alleviation program are being monitored by the project director, DRDA.
- Allotment of specific target for PWDs (In numbers with amount, if possible) under various schemes such as SGSY, IAY, EGS etc. and place a special strong note that, the targets fixed for PWDs are mandatory, and can not be diverted for others. These targets have to be achieved by any means.
- Review/inspect the progress of PWDs', under various schemes, especially in poverty alleviation programs. Besides inclusive reviews/inspections, exclusive reviews/inspections may be conducted to have focused efforts, which will caution the field functionaries.
- Apply for Central grant under ADIP scheme of Ministry of Social Justice & Empowerment, Govt. of India for distribution of aids & appliances, such as tricycle, wheelchair, hearing aid etc. to PWDs.

DISTRICT SOCIAL WELFARE OFFICER

- Being the nodal person of welfare schemes, including welfare of PWDs having vast ICDS infrastructure and network. DSWO have very meaningful role in prevention, early identification, referral, pre-schooling and rehabilitation of PWDs.
- Co-ordinate & collaborate with different GOs/NGOs to ensure maximum benefit for PWDs through their schemes and programs. Maintain up-to-date data bank of PWDs, share data with GOs/NGOs for common goal.
- Nodal officer of NHFDC loan scheme. Ensure that target is fulfilled, deserving PWDs get loan, balance between sex, distance, disadvantage & disability is maintained and PWDs who have capability to run business get loan under NHFDC.
- Besides exclusive scheme for PWDs (NHFDC, Orissa Disability Pension, Scholarship etc.), ensure that PWDs gets adequate benefit under inclusive scheme too, implemented and monitored by you, such as Social Security Schemes, Annapurna, Balika Samrudhi Yojana, Adolescent Girls Scheme, Mission Shakti etc.
- The office must be accessible to PWDs. Display information boards in local language to create awareness. Different kind of forms (Rail/Bus fare concession form, disability certificate, ADIP, Scholarship etc.), Govt. Memoranda / Notifications may be kept, in well arranged manner for reference and for distribution to needy, on request.
- Sensitise/utilize ICDS network in such a manner that all disabled children are brought to Balwadi to integrate them with other children at early stage, to increase their will power and confidence to tackle their problem independently and to search & exhibit their talent.
- The Govt. has formed more than 1,07,800 SHGs' constituted by 130 Millions women members (as on year—2004) under Mission Shakti Program. Following activities may be undertaken to lead the activity through ICDS network :
- List out Women with Disabilities (WWDs) in existing SHGs & process for NHFDC credit.
- Include at least one WWD in remaining active & viable SHGs.
- Form exclusive SHGs if possible and feasible, having at least 5 WWDs and get these groups financed, under NHFDC SGSY scheme or NABARD etc.

EXECUTIVE OFFICER MUNICIPALITY/NAC

- Municipal and NAC is the implementing agency of Swarna Jayanti Sahari Rojgar Yojana in which 3% reservation has been provided for PWDs. Executive officer have to ensure that adequate no. of applications are collected/selected/recommended and disbursed. (Section-40 of PWD Act, 1995).
- Allotting space to PWDs for installation of small shops such as OMFED booths, ISD/STD/PCO Booth, Juice/fruit stall, barber shops etc.
- Permitting cycle/vehicle stands to a group of PWDs, which will make them the earning member of the society.
- Shops constructed by municipality or NAC may be allotted to PWDs on priority basis and on concessional rate. (PWD Act, 1995, Section-43).
- Ensure that recreational places such as cinema halls, parks, theatres, museums, town halls, sea beaches, commercial establishments, offices, public buildings, municipality schools, hospitals, toilets, drinking water spots, bus stands etc. are accessible to PWDs with facilities like ramp, hand railings etc. being provided.
- Issue bus concession pass and sanction and distribution of disability pension to urban PWDs. Please ensure that disability pension goes to most deserving & disadvantageous PWDs, bus concession passes are issued to all eligible PWDs in accessible mode.

DISTRICT MANAGER --OSFDCO / PROJECT ADMINISTRATOR - ITDA/WELFARE OFFICER

- Extending adequate benefit to PWDs on priority basis with regard to the schemes meant for SC/ST.
- Encouraging the PWDs for Vocational training, loan for self-employment, assistance for construction of homes will help in mainstreaming SC/ST—PWDs. So extend prioritized help for training, self-employment, employment etc.
- Admission in schools & hostel (Residential/Ashram & non-residential school), providing scholarship and other educational facilities will contribute promotion of education of ST/SC PWDs to great extent. Mobilizing resources for better education of SC/ST PWDs.
- Maintain database of PWDs (Disability/Caste/Gender-wise) as it is now being reviewed at local/ district/state and national level.

DISTRICT LEAD BANK MANAGER/BANKERS/FINANCIAL INSTITUTES

- Motivate, sensitize the bankers about abilities and rights of PWDs as Indian citizen as well as reserved categories as Govt. has provided concessions, relaxation and mandatory reservations in loan/credit schemes.
- It has been observed that bankers have denied, opening of account, issue of cheques for NHFDC loan and rejection of loan application under existing schemes (SGSY, SJSRY, PMRY, KVIC, DRI etc.) on account of disability, which shows discrimination and leads to violation of provisions of PWD Act, 1995. Bank managers are to ensure best possible help from the bankers.
- Initiate innovative work to facilitate PWDs to utilize bank facilities as it has been done by **Central Bank of India at No.10 Bus stop Branch, Bhopal (MP).** This Branch is completely accessible to PWDs with ramps, railings and counters at lower heights for wheel-chair users and brochures are printed in Braille for the visually impaired.
- Raising the voice in **State Level Bankers Committee Meetings (SLBC)** about problems and progress of PWDs under various schemes. You should insist that there should be independent agenda for PWDs on the pattern of SC/ST/OBC/Women/Minorities at SLBC level.
- Branch Manager/Field Officer may help PWDs up to a great extent in form of disbursing loan under subsidy linked schemes & DRI scheme on priority basis.

BLOCK DEVELOPMENT OFFICER

- Evolve such a mechanism that mandatory due share goes to rural PWDs. Few of the following specific task that can be carried.
- Ensure that not less than 3% reservation under all poverty alleviation programs (SGSY, IAY etc.) as it is mandatory under Section-40 of PWD Act, 1995 has been practically given to parts. It needs periodical sensitization of official, close monitoring and co-ordination. If allotment of house, under IAY is given to PWDs, it will minimize his/her problem & will create confidence and sense of better living.

C.D.P.Os/I.C.D.S. SUPERVISOR/ANGANWADI WORKER

- Being a block/village level functionary for taking care of welfare/development, including prevention, early identification, intervention and pre-schooling of children and women through vast I.C.D.S. network.
- Ensure that each SHG has at least one woman with disability. List out the WWDs in existing groups, include WWDs in remaining groups and form exclusive SHGs of WWDs if possible.
- Ensure that ICDS network is effectively engaged in prevention and early identification of disability and subsequently proper referral, to minimise the effect of impairment
- Ensure that all PWDs are brought to Balwadis, which will ensure early integration of PWDs in mainstream of society.

DISTRICT EMPLOYMENT OFFICER

- Maintain a data-base of PWDs of your district, channelise them in appropriate gainful vocations or earning activities. Build good networking, close co-ordination and cordial relations with GOs/ NGOs in the district. Inform the PWDs about exclusive and inclusive schemes of employment, self-employment, vocational training etc.
- Ensure that the Govt. offices/public sector undertaking, local bodies, notify reserved vacancies as it is mandatory. The employer must submit returns in DPER-I/ER-I & DPER-II/ER-II.
- Organize periodical Entrepreneurship Development Programs, Pre-Recruitment Training Programs (EDPs/PRTs), and Career Counseling & Avenue Guidance Program for Adult PWDs.
- Prepare and display information board in local language, about schemes and programs available for PWDs.
- Being in the district level committee of PMRY. Ensure that at least 3% of PWDs are being selected & recommended for PMRY loan and disbursement takes place.
- Brief about the current employment scenario and motivate them for self-employment too, guide them in selection of self-employment ventures and tell the loan scheme in detail, help them in documentation & filling up loan form/applications.

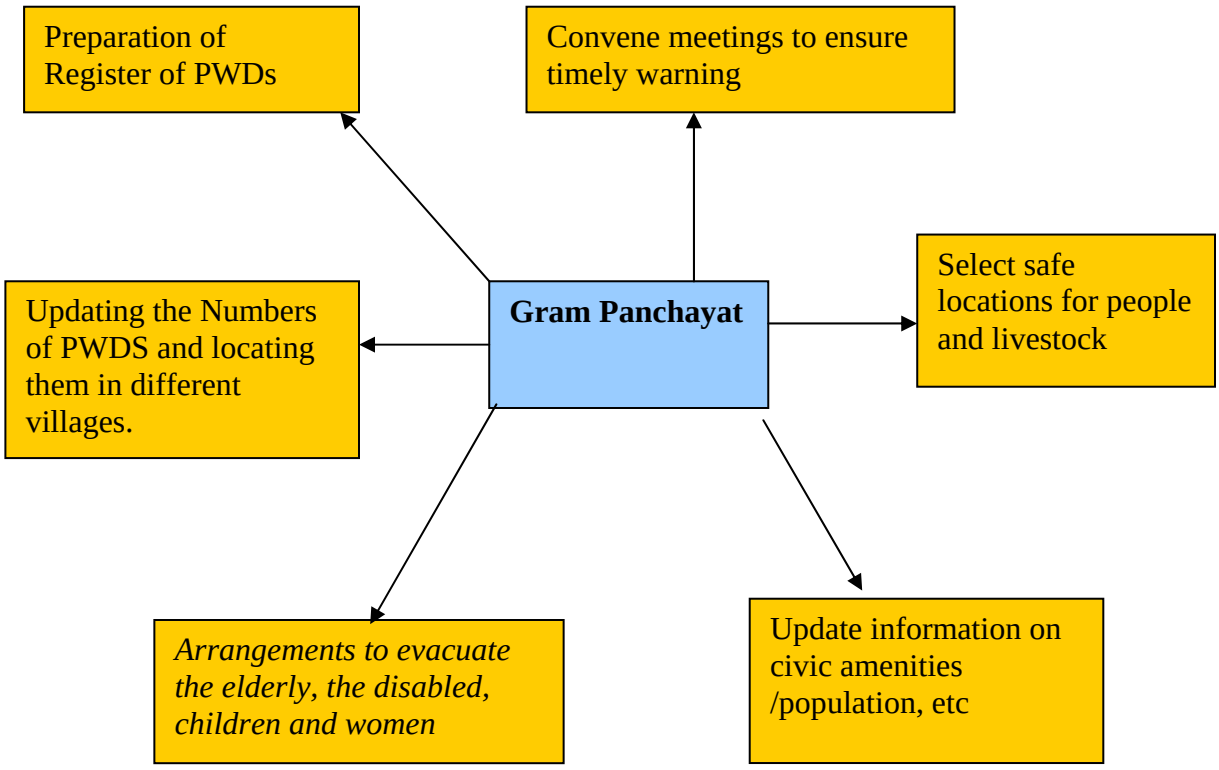
4.9 ROLE OF NGO/CBOS/COMMUNITY

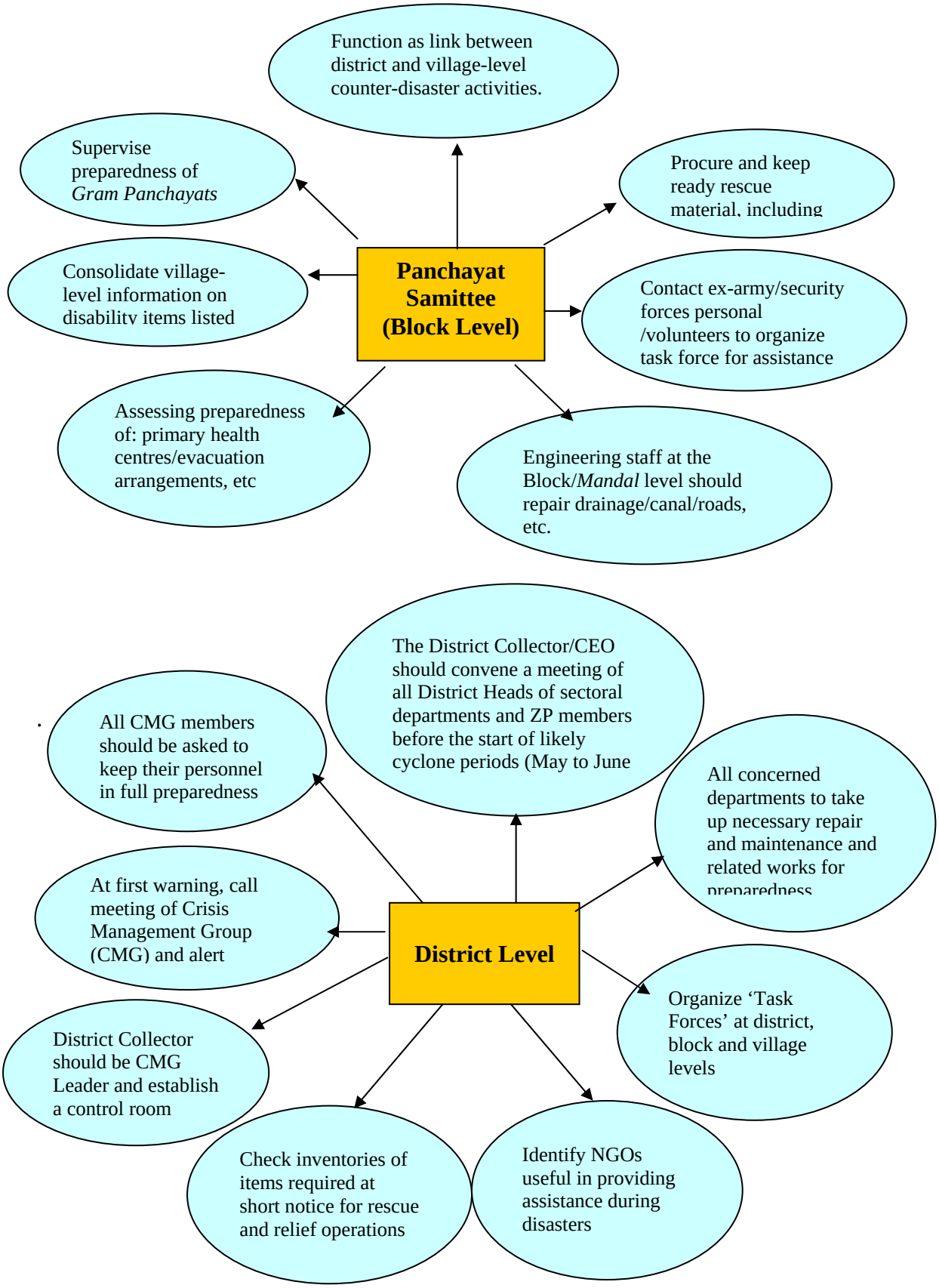
- Ensure equal opportunities, protection of rights and full participation to PWDs as Indian citizen, in all the schemes/programs implemented or monitored.
- Ensure that the office building of the District/block administration and other essential amenities such as toilets, waiting rooms, shelters, drinking water tap places etc are accessible. Ramps, hand railing, auditory signals, written instructions are provided. Parking near to the entrance has been earmarked.
- Efforts are to be made to maintain separate data (disability/sex/caste/caste-wise) and project this data as and when required, as it is being reviewed/monitored periodically at local/block /district/state and national level.
- Organise inclusive or exclusive review meetings at regular intervals to review the progress/ hardships related to PWDs under various schemes.
- Listen to PWDs carefully and patiently, showing minimum human courtesy, within your limits. Guide and refer them to appropriate person/office/agency.
- Prepare information board in local language about your schemes/programs, and display it at prominent places of your office.
- When implementing the scheme and programme it is advisable to see that adequate benefit goes to deserving PWDs.
- Provide employment in your establishment (permanent, temporary, casual, seasonal, NMR, job work, home-based etc.) wherever and whenever possible.
- Maintain a guard file of Govt. O.Ms/Notifications, instructions, schemes etc. related to PWDs and nominate an official who will look after this work in addition to his/her routine duty.
- Sensitize your subordinates, make them aware about new Govt. Programs/policies related to PWDs, and orient them to deal with PWDs in best possible ways.
- In order to promote for the cause, you may purchase items/goods, manufactured/sold by PWD entrepreneurs.

4.10 ROLE OF PRI MEMBERS AND FAMILY

While the government has the duty to help people in distress, the PRI members have greater responsibility to help the government to cope with disasters. Panchayat Raj bodies (Local Government) are the most appropriate local institutions for involving people in natural disaster preparedness. In our three tier Panchayat Raj system different roles are to be expected from different level of Panchayat members at the time of disaster.

Panchayat role during first phase of Natural Disaster




Function as link between district and village-level counter-disaster activities.
Supervise preparedness of *Gram Panchayats*
Procure and keep ready rescue material, including
Consolidate village-level information on disability items listed
Panchayat Samittee (Block Level)
Contact ex-army/security forces personal /volunteers to organize task force for assistance
Assessing preparedness of: primary health centres/evacuation arrangements, etc
Engineering staff at the Block/*Mandal* level should repair drainage/canal/roads, etc.
The District Collector/CEO should convene a meeting of all District Heads of sectoral departments and ZP members before the start of likely cyclone periods (May to June
All CMG members should be asked to keep their personnel in full preparedness
All concerned departments to take up necessary repair and maintenance and related works for
At first warning, call meeting of Crisis Management Group (CMG) and alert
District Level
Organize 'Task Forces' at district, block and village levels
District Collector should be CMG Leader and establish a control room
Check inventories of items required at short notice for rescue and relief operations
Identify NGOs useful in providing assistance during disasters

Panchayat role in Rescue and Relief before and during Natural Disaster Impact

***Gram Panchayat* or Village Level:**

- Set up temporary shelters/relief camps after initial warning/store food and water for people/livestock
- Evacuation of people and livestock should start immediately after final warning
- Keep rescue volunteers and task forces ready
- District/block medical/relief teams may be asked take position at strategic points and coordinate with village volunteers/task forces
- Organize veterinary aid teams for taking care of livestock and removal of carcasses
- Disposal of dead bodies and measures to prevent likely epidemics
- Assessing loss of life, livestock and damage to farming, property, etc.

Block/Mandal Panchayat*:*

- Identify vulnerable areas and send task forces/volunteers to supervise safety measures
- Evacuate people from these areas and help GPs in organizing relief camps
- Arrange for emergency communication through police wireless/ham radio, etc.
- Arrange supply of food and other items to relief camps in adequate quantities
- Supervise rescue and relief activities with district-level officers
- Inform CMG in case help needed from police and defence forces
- Assist armed forces in rescue and relief operations
- Supervise rescue and relief and coordinate with various agencies including NGOs.

Zilla Panchayat or District Level

- Monitor situation, identify blocks and villages most likely to be affected and issue warnings
- Activate control room and keep a full watch on the situation
- Arrange emergency communication with the help of police wireless/ham radio, etc.
- Put CMG on the job of assisting block and village *Panchayats* with counter-disaster steps
- Arrange transport for evacuation of people and livestock
- Arrange for temporary shelters/relief camps
- Seek assistance of the armed forces if necessary
- Monitor rescue and relief operations at village and block levels
- Assist lower *panchayats* in mobilizing task forces/volunteers/NGOs for rescue and relief.

Panchayat role in Reconstruction and long-term Mitigation Planning

Gram Panchayat or Village Level

- Assist in identifying victims for compensation, and then in its distribution
- Formulate reconstruction plans for houses, community buildings, roads, etc. within GP jurisdiction with the assistance of technical departments at block and district levels
- Enforce minimum specifications for safe construction
- Help district and block level organizations in arranging awareness camps for management and mitigation of disasters and ensure participation of the villagers
- Organize village-level task force/volunteers and train them in counter-disaster measures
- Assist in supervising and monitoring reconstruction and development projects
- Encourage local people to insure assets/livestock, which should be mandatory for those who can afford. Seek government help for those who are too poor to afford insurance.

Block/Mandal Panchayat

- Assist in rehabilitation, repair and reconstruction
- Assist *gram Panchayats* in identifying victims for payment of compensation and in its distribution
- Prepare village and block-level mitigation plans; consolidate/integrate these with the block plan
- Enforce minimum safety specifications for construction
- Assist in long-term mitigation planning and its integration with block/district development plans
- Supervise and monitor reconstruction and long-term mitigation projects implemented by GPs and Block *Panchayats*.

Zilla Panchayat or District Level

- Planning and implementation of rehabilitation, repair and reconstruction
- Compensation for loss of life, property, etc.
- Hazard and vulnerability mapping
- Anti-disaster measures to be integrated in all development projects
- Special funding to use disaster-resistant construction technologies in vulnerable areas
- Supervision of all construction and developmental activities.

4.11 DISABLED / THEIR FAMILIES AND THEIR ROLE

- Disaster can happen anytime, anywhere and without warning. Your local Govt., disaster manager, disaster task force will respond when a disaster threatens or strikes. However they cannot be everywhere at once. Although you may not know when a disaster will strike, if you are prepared ahead of time, you will be better able to escape with the disaster and recover from it more quickly.
- Relief organisations and Government agencies right away may not attained your personal needs such as replacing specific medicine, adoptive devices and restoring your regular ways of ADL. You/your family member should arrange specific medicine, batteries for adoptive devices, at least for 7 days.

- You should know what can happen and what your environment may be like after disaster.
- Road transports and sidewalks which were used by you may no longer be used after disaster. Obtain proper and reliable information about alternatives.
- Familiars landmark which use to help you, may move or damaged both indoor and outdoor. You should orient yourself with changed landmarks, pathways and shelter.
- You may not get information from relief officials in accessible format (Braille, audio cassettes, large print, pictorial etc.). Identify the other mode of information, which is in accessible format.
- You may not access the help from policeman, fireman, and ambulance service.

Transport

Roads and sidewalks, which were used/oriented by you, may no longer be used after disaster. Obtain proper and reliable information about alternatives.

Families landmark you use to help you may move or damaged both indoors and outdoors. You should orient yourself with changed landmarks.

You may not get information from relief officials in accessible format (Braille, audiocassettes, large print, pictorial etc.) Identify the other mode of information and that should easy for the PWDs to understand the warning properly and response to emergency needs.

You may not access the help from policeman, fireman, and ambulance services.

Disaster Related Stress may affected your Disability

Medical authorities independently in disaster situation. You should establish a workable self-help network with support of family, CBOs and emergency manager. Your network should know your abilities, limitations and special needs.

Everyone affected by a disaster may experience are or several of the following systems.

Psychological and Emotional

Anxiety, Foritability, Restlessness, Over Excitability, Depression, Crying, Anger, Blaming, Feeling of Apathy, Feeling if Isolation, Detachment, Estrangement, Feeling of guilt about Surviving, Denial or Constriction of Feelings, Flashback or under care Memories of Disaster, An Exaggerated

reaction to being started inability to full or Safe Sleep, Recruitment of Traumatic Events, Sleeping Excessively.

You should constitute Psychologist special educator, Rehabilitation professional.

Thought

Poor concentration, mental confusion, slow thought processing, inability to make judgments and decisions, inability to express, loss of ability to think of alternatives or prioritize tasks forgetfulness. Parents should access to in rebuilding confidence, willpower, positive thinking and though processing.

Physical

Onset of disabilities or washing of disabilities, Weakness, Numbness or Tingling in body parts Chaste pain, Breathing trouble, Fatigue, Heart palpitations, Hot or Cold spells, Sweating or Chills, Upset stomach, Allergies. Seek medical attention from doctor/therapist.

Family members should arrange first aid and transfer to hospital

MODULE IV

4.12 GENDER, DISABILITY AND DISASTERS

Introduction

Women and girls with disabilities are estimated to represent up to 20 percent of the world's female population. They are usually excluded from disaster management and mitigation. We begin with the assumption that among the problems faced by disabled women is that they have not yet been fully integrated into either the disability movement or the women's movement.

Disabled women are commonly devalued for two basic reasons:

i. The emphasis on physical appearance found in every society, and
ii. The importance placed on strength to carry out household duties as well as work outside the home.

Aim of the Module:

This module is designed to create an understanding of the Gender dimension of Disaster and the Gendered perspective of Disaster

i. Identify the discriminations and restrictions on women with disabilities (WWD)
ii. Enable women to share their experiences
iii. Apply their experiences to disaster situations

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Overall Objectives of the Module are:

i. Explain the difference between sex and gender;
ii. List key gender roles assigned to men and women by their community
iii. Discuss differences in the life experiences of disabled men and women, and explain the reasons behind them;
iv. Think about some specific issues of women with disabilities, which includes both gender and disability.
v. Be prepared to meet disaster situations from a holistic perspective

Specific objectives of the module are:

i. It is for People who are not familiar with issues underlying gender and the situation of disabled people.

ii. It is also for people who have well developed understanding the basic concept of gender equity, but have not applied them disability issues during disasters

Process

Section one is about understanding gender
Section two is about gendered issues and disability
Section three related to women with disabilities and disasters

Sex and disability are two separate factors which, when combined in the same person, usually reinforce each other and compound prejudices

The participants both disabled men and women and non disabled men and women share experiences and try to understand the differences in an attempt to eliminate them, to understand their social roles and its impact on their lives and the developmental process, to prepare the community for including women with disabilities during disaster situations in their planning and implementation processes.

4.12.1 WHAT IS GENDER TRAINING IN THE CONTEXT OF DISABILITY?

Gender training which includes disability issues is a development intervention which aims to change awareness, knowledge, skills, and behaviour in relation to WWDs. It differs from training in other subjects in that it touches on personal and political issues.

Gender training works best if there is a strong element of awareness –raising as well as skill building. Otherwise, there is a danger that techniques will be learnt, but prejudicial attitudes will still remain; or that awareness will be raised but work practices will not change. The exact balance of the two elements will depend on the particular training needs and characteristic of the group, such as job requirements, sex and educational level of the participants.

Methods that can be used- Group / Discussion/ Visualization/ Role play/Women's voices

4.12.2 WHY GENDER TRAINING WITH THE INCLUSION OF DISABILITY?

Gender training in general is becoming increasingly popular with many institutions, as a way to improve the quality of relief and development work. This training does not usually deal with the aspects of disability. While the negative effects of ignoring gender issues are now widely acknowledged, those that include WWDs are still excluded from gender training.

This module therefore focuses on women with disabilities during disasters.

To introduce the concept of 'gender' and understand the difference between the concepts of 'gender' and 'sex'.

Concept of Gender

Definitions – Gender refers to the expectation s that people have from some one because they are male or female. It is the socially constructed relationship between men and women. Thus Gender refers to the socio – cultural definitions of man and woman and the way society assigns social roles. Gender refers to the differences between women and men within the same household and between cultures that are socially and culturally constructed and change over time.

Sex is the physical and biological differences between men and women. It is universal and static. Thus sex is the genetically determined biological characteristic.

Difference between Sex and Gender

Sex	***Gender***
Natural	*Socio cultural (man made)*
Biological differences in physical qualities	*Masculine and Feminine qualities in roles, behaviour*
Sex is constant everywhere	*Gender is variable. It changes from time to time, culture to culture*
Sex cannot be changed (barring sex change operations)	*Gender attributes can be changed.*

4.12.3 WHY TALK AND KNOW ABOUT GENDER?

Studying gender would enable us to understand the gender inequalities that exist in our society. Women are nearly half of the human population but are placed unequally with men in every respect starting from right to freedom, to education, to health, reproduction, nutrition etc. Ironically the gender roles vary so much between cultures that they cannot be explained by sex differences alone. The two relevant questions that could arise here are – Should there be differences between men and women ? If yes should these differences be the basis for inequalities between men and women, especially when these inequalities have led to oppression, subjugation and subordination of women.

Manifestations of Gendered Discriminations

- Son preference - Birth of a son is celebrated whereas the birth of a daughter is not.
- Discrimination against girls in food distribution- Sons are showered with love, respect and given better and more food, while the girls eat the last with lesser share. This limitation on post-neo natality food intake creates malnutrition in the girl child, which in most cases results in disability. Married women are taught to eat the last especially after the husband and all the other male members have eaten.
- Better health care for boys and less for girls again increasing disability among girl children.
- Lack of educational facilities – The girls have to struggle and fight for availing educational facilities while boys are given the choice of accessing better education.
- Mobility – Girls have restricted freedom of mobility and the boys have no bars to movement. While security of the girls is given as the reason for preventing the girls to go out, the restriction is on the girls and not on the culprits (men).
- Sexuality – Women are to submit their bodies to their husbands and have no say on reproductive rights and sexuality.
- Property – Girls do not demand their share of property on the father's family. They are to be satisfied with the 'dowry' given by the natal family to the in-laws. Very rarely are WWD entrusted with property.
- Most girls with disability are not married while men face the problem in a lesser way.

There are differences within the women of different social groups such as the urban middle class girl and the tribal girl. Within these groups the status of disabled women is usually worse.

4.12.4 WHAT THE SOCIALIZATION PROCESS MEAN?

As parents, peers, teachers, elders we are not aware of what we are doing to our children. Societal institutions such as schools, communities expect differential behaviour. If one does not conform to prescribed/ expected male / female behaviour there is social ridicule. The socialisation process happens at multiple levels and is also influenced by the various actors of the society. Characteristics are nurtured in accordance with the norms of the society and the natural ways of children are quashed.

Most people consider that the gender division of labour natural i.e. because women give birth to children and breast feed them, they are better equipped for caring and nurturing activities. The gender division of labour are "natural" based on women's biology and thus people find it difficult to think beyond bodies.

In fact within a household too, conscious care is taken that the male members have rest, space and time while it is expected that women can and will manage with no allocation of space and time.

Jobs are Gendered.

Statements

- Women give birth to babies ; men don't. *(Sex difference)*
- Girls are gentle; boys are tough. *(Gender difference)*
- Men's voices break at puberty; women's don't. *(Sex difference)*
- Women are better at caring for children than men. *(Gender difference)*
- Body hair is fine on men ; women have to shave. *(Gender difference)*
- Women breast feed babies; men bottle feed babies. *(Sex difference)*
- Boys play outdoors; girls tend to enjoy playing inside the house. *(Gender difference)*

Gender roles are therefore restrictive (see Activity Sheet I)

4.12.5 SEX STEREOTYPES

One of the most significant manifestations of stereotypes is in the area of sex bias. The socio cultural importance of sex makes the stereotype a standard basis of categorization. Sex based categorization leads to sex stereotyping. Sex stereotypes are unconscious thoughts and habits that link personal attributes to sex. It tells us what the sexes are supposed to be. They function as standards against which an observer evaluates women and men's

behaviour. Thus sex stereotypes bias the perceptions, interpretations, retention and recalled information about men and women.

4.12.6. GENDER DIFFERENTIATION AND PATRIARCHY

Patriarchy is :

- Male dominated family
- Male domination
- Male head of the family
- Male control over economic, social and political resources

Patriarchy is both a social structure as well as an ideology/ belief. Social institutions, media all reinforce patriarchy.

The Institutions Controlled by Patriarchy:

- *Social institutions such as family is male headed – female headed households are mostly due to distress (male migration)*
- *Cultural institutions*
- *Political institutions – In politics there are no women in decision making positions and those who have been in high positions it is basically because due to the proximity of a powerful male person.*
- Law- not sensitive to women
- Religion- controlled by men, debars women in decision making seats
- Media – controlled by men, gender insensitive
- Educational systems – Male hegemony over knowledge has marginalized women's knowledge and experiences.

In all these some women might be allowed to break barriers, disabled women rarely do so.

Women's lives are controlled by patriarchy. It is a system of control. Patriarchy influences women's productive and labour powers.

It provides:

Allocation of different roles, responsibilities and tasks to men and women which are based on societal ideas of what men and women should do.

Also men are in better positions then women – men are more skilled and hence paid better and are in better productive positions.

Women are in low paid jobs with the least job security. Their inputs are less important and have less value. Women are paid less than the men.

Patriarchy affects women's roles in the development process by excluding them. This is much more visible in the case of women with disabilities.

4.12.7. WOMEN WITH DISABILITIES AND DEVELOPMENT

International development and women's organizations must combat -- not contribute to – marginalization, oppression and segregation of women with disabilities.

Women and girls with disabilities are estimated to represent up to 20 percent of the world's female population, the majority living in less economically developed countries, yet are under-represented and under-served in every aspect of the international development field.

Women with disabilities offer an untapped resource for international development, as partners, staff and beneficiaries. They are under-represented and under-served in every aspect of the international development field and are denied significant participation in community projects, human rights organizations and international development programs.

Problems and issues that exclusion creates

Among the important problems articulated by women with disabilities:

i. Women and girls with disabilities are denied access to education, vocational training, employment, transportation and housing, making it difficult or impossible to achieve economic self-sufficiency and contribute to their communities.
ii. Women and girls with disabilities receive inadequate -- if any -- rehabilitation services, because the very limited available resources are directed toward adult men with disabilities.
iii. Women with disabilities are less likely than non-disabled women to marry, but more likely to be abandoned with children, facing social stigma, loneliness, and poverty.

iv. Protection against violence, even the inadequate protection afforded to non-disabled women, is not available to women and girls with disabilities.

Women with disabilities tend to be more vulnerable to exploitation of various kinds, such as sexual harassment, domestic violence and exploitation in the workplace. They are twice as prone to divorce, separation, and violence as able-bodied women Disabled women also tend to be relatively easy targets of sexual exploitation, particularly if they are mentally retarded. Involuntary sterilization, contraceptives, and abortion continue to be forced upon women with disabilities.

In general, disabled women tend to be in a state of physical, social and economic dependency. This can lead to increased vulnerability to exploitation and violence. Because of the relative isolation and anonymity in which women with disabilities live, the potential for physical and emotional abuse is high. It is also estimated that having a disability doubles an individual's likelihood of being assaulted . Because of their isolation however, women with disabilities are likely to have less resources to turn to for help. Most battered women's shelters and rape crisis centers are not accessible to them.

v. Women with disabilities are denied access to reproductive health services by cultural attitudes, physical barriers, financial constraints, and unenlightened medical personnel and health care providers.
vi. In most countries, women and girls with disabilities have a higher mortality rate than do disabled males.
vii. Women and girls with disabilities are more likely to be malnourished than disabled males.

In accordance with the traditional social and cultural norms in village societies, many women do not go out of their houses to seek help for health care, especially if the care-provider is a male.

Most rehabilitation personnel, including community based rehabilitation workers in developing countries are men. Thus even home based services provided by male CBR workers, are out of reach for women with disabilities.

Strangers, even if they are part of a service provider team, are usually not allowed inside the house in traditional societies. If these strangers are male, it is next to impossible for them to even talk to the women in the house. Even if a traditional community accepts males as service providers in health care and rehabilitation to some extent, it still would be impossible for them to provide services to, or teach the women in the community. Such a situation can only be improved if local women were to be trained as rehabilitation workers. While women rehabilitation workers are becoming common in the sub-continent, cultural barriers continue to persist, preventing women from taking up rehabilitation work in the community setting, because it involves visits to houses of strangers.

viii. Restricted to their homes by inaccessible environments, lack of mobility aids or transportation, family overprotection and shame caused by cultural biases, women with disabilities are often isolated and unaware of either rights or options.

4.12.8 TOOLS FOR EMPOWERMENT

i. Inclusion of women and girls with disabilities must be comprehensive and take place at all levels of the development process.
ii. Full inclusion of women with disabilities in the development process must go beyond limited approaches which traditionally offer separate programs for people with disabilities, often charity-based, focused on prevention, medical intervention, physical rehabilitation, and custodial care (and which, in fact, have been traditionally underutilized by women with disabilities.) While women with disabilities may benefit from appropriate targeted interventions, which enable them to maximize their skills and abilities, development assistance programs must support women

with disabilities to access the full range of options available to all members of the communities.

iii. Leadership training and community development projects must conduct specific outreach efforts to include women with disabilities.

iv. Women with disabilities must be involved in all policy and decision making processes, and at every level of the projects: as staff, consultants, participants, and evaluators.

v. Advice and expertise of women with disabilities must be utilized in designing programs and policies, research, conferences, and documentation of major social issues that affect women.

vi. Education, vocational training and rehabilitation programs must include women with disabilities, to prepare women and girls for careers and gainful employment.

vii. Rehabilitation and adaptive technology must be available for women with disabilities, and women with disabilities must be involved in the development and production of adaptive devices.

viii. Health service personnel must be trained to offer informed and sensitive service and education addressing the health needs of girls and women with disabilities.

ix. Governments and non-governmental organizations must be pressured to effectively implement the many important recommendations which have been made over the years by various UN bodies and non-governmental organizations, particularly at the Fourth World Conference on Women in Beijing.

x. Governments and non-governmental organizations in host countries must be educated to prioritize issues of women with disabilities in development efforts.

xi. "Consultation with local women's organizations and involving women participants in program planning is perhaps the best way to ensure a gender perspective in program design."

xii. All development organizations, micro-credit programs and lenders must consult with women leaders who have disabilities for strategies to make all information, programs and services accessible for women with disabilities." (Mobility International USA: Resolution and Recommendations: Loud Proud and Prosperous: an International Coalition on Micro-credit and Economic Development for Women with Disabilities, 1998) Promoting self-help groups of women with disabilities will play a

major role in reducing their isolation, providing mutual support, and improving their participation in community life. It can promote economic self-reliance if they have access to income generation activities though savings and credit and other schemes. Being economically self-reliant will give a woman with disability an added advantage in marriage and allow her to contribute to the household economy. Promotion of self-help groups can educate women with disabilities about their rights and opportunities, and greatly reduce the chances of exploitation and violence against them.

xiii. Collect data on involvement of women and girls with disabilities. Data collection is essential in order to accurately assess the extent of inclusion of women and girls with disabilities in the development assistance process, and design and evaluate effective strategies to remedy inequalities. Strategists for gender integration recognize the importance of data collection to serve as baseline and evaluation of interventions.

xiv. Participation in Community Life: Women with disabilities tend to have fewer opportunities to participate in community life than disabled men, mainly due to cultural reasons.

a. Restricted mobility and absence of access provisions in the surrounding environment can be a hampering factor in the participation of women with disabilities in community life, but this aspect is common to disabled men as well.
b. The families of disabled women tend to be over-protective about them, and prevent them from going out of the house; for fear that they may be exploited in some way because of their disability. Although well intentioned, these anxieties can be stifling to women with disabilities. There are superstitions in village communities about the presence of disabled women being inauspicious in community gatherings. It is also believed that their presence in a family can block the chances of marriages of their female siblings. As a result, many women with disabilities remain confined to their parental homes, without being able to play the roles traditionally expected of women in society. This can lead to feelings of isolation, loneliness and low self-esteem in women with disabilities.

Families in traditional societies are generally supportive in terms of physical assistance to their disabled women, but often fail in providing emotional support, which is a more complex issue.

c. Many families prefer to ignore the existence of feelings, emotions and the need for emotional support in women, especially if they are also disabled.

Adapted from: LOUD, PROUD, AND PASSIONATE: INCLUDING WOMEN WITH DISABILITIES IN INTERNATIONAL DEVELOPMENT PROGRAMS by Cindy Lewis & Shobha Raj

4.12.9 PRACTICAL GENDER NEEDS (PGN)

Practical Gender Needs are related to the condition of women. They are easily identifiable (food, water, medicines, housing) and they are related to the existing gender division of labour. For example women's issues are water, house, fuel, fodder as they are in charge of child bearing, rearing and house managing and livestock care. Fulfilling the PGNs does not change the existing power relations and no one feels threatened by the activities and programmes aimed at meeting the PGNs.

Strategic Gender Interests (SGI) are related to women's subordinate position in society and their desire to change the existing hierarchical gender relations and make them more equal. Activities that promote SGIs are education, mobilization, organizing women, capacity building, consciousness raising. Such activities are often resisted because they challenge the male domination and demand long term changes in gender relations.

4.12.10 AFFIRMATIVE ACTIONS: GLOBAL INITIATIVES

To influence member governments the UN organized a major global conference on Women and Development" was organized in 1975 in Mexico.

1975 – 85 was declared by the UN as the Decade of Women

The International Women's Decade (1975-85) as well as the International women's year (1975) were positive events which gave the push to the women's agenda in mainstream politics and planing.

During the third World Conference on Women, held in Nairobi in 1985, women activists with disabilities made a special effort to be present. Even though the location of the parallel NGO Forum was not very accessible and many governmental delegates were more concerned with political issues, activists like Ruth Begun from DPI in the United States were able to convince Governments to include two paragraphs on women with disabilities in the section of the "Nairobi Forward-looking Strategies for the Advancement of Women" on "groups requiring special concern". Women with "physical and mental disabilities" were among the 13 special groups of women listed in the "Strategies", and taken together they were considered to be "vulnerable".3

Chapter II of the "Rules", Target Areas for Equal Participation is the only place in which the "Rules" are especially gender-sensitive

15. The purpose of the Rules is to ensure that girls, boys, women and men with disabilities, as members of their societies, may exercise the same rights and obligations as others. In all societies of the world there are still obstacles preventing persons with disabilities from exercising their rights and freedoms and making it difficult for them to participate fully in the activities of their societies. It is the responsibility of States to take appropriate action to remove such obstacles. Persons with disabilities and their organizations should play an active role as partners in this process. The equalization of opportunities for persons with disabilities is an essential contribution in the general and worldwide effort to mobilize human resources. Special attention may need to be directed towards groups such as women, children, the elderly, the poor, migrant workers, persons with dual or multiple disabilities, indigenous people and ethnic minorities. In addition, there are a large number of refugees with disabilities who have special needs requiring attention. "

The Beijing Conference (Adapted from Ann Darnborough)

Unlike its predecessors, the Beijing Conference was attended a record number of disabled women delegates - no less than two hundred. Whilst in practical respects the conference managers were ill prepared to receive disabled women or to communicate with them effectively, disabled women themselves were well organised, and included a number of disabled people's organisations, including Disabled People International (DPI), the Federation for the Deaf, the women's committee of the World Blind Union.

At the conference, disabled women successfully lobbied official delegations to take on board

i. The Standard Rules of the Equalisation for Persons with Disabilities
ii. to abolish "negative stereotyping of women with disabilities by the media",
iii. to adopt measures to ensure "commitment to promote employment of women with disabilities."

Beijing Platform for Action

46. The Platform for Action recognizes that women face barriers to full equality and advancement because of such factors as their race, age, language, ethnicity, culture, religion or disability, because they are indigenous women or because of other status. Many women encounter specific obstacles related to their family status, particularly as single parents; and to their socio-economic status, including their living conditions in rural, isolated or impoverished areas. Additional barriers also exist for refugee women, other displaced women, including internally displaced women as well as for immigrant women and migrant women, including women migrant workers. Many women are also particularly affected by environmental disasters, serious and infectious diseases and various forms of violence against women.

The women's and disability movement intersected officially with disability when the Commission on the Status of Women forty-sixth session in 2002: addressed the issue of women and gender perspectives on natural disasters. In its agreed conclusions on environmental management and the mitigation of natural disasters, the Commission recognized that women played a vital role in disaster reduction, response and recovery and in natural resources management, and that some women faced particular vulnerabilities during disaster situations

The Biwako Millennium Framework for Action towards an Inclusive, Barrier-Free and Rights-Based Society for PWD on Asia and the Pacific recognizes that the girls and women with disabilities are one of the most marginalized sections of the society and even after the completion of the first Asian & Pacific Decade of Disabled Persons, 1993-2002 the situation has not changed much and therefore, the governments and other stakeholders

in the region need to undertake special measures to resolve the imbalance, providing the necessary support service to promote the full participation of girls and women with disabilities in mainstream development.

4.12.11 INDIAN CONSTITUTION AND WOMEN

- It is grounded on the principles of liberty, fraternity, equality and justice.
- Equality, social justice, commitment to freedom lies at the core of India's nationhood.
- The Constitution pledges "to secure to all people … justice, social, economic and political; equality of status, opportunity and before the law; freedom of thought, expression, belief, faith, worship, vocation, association and action, subject to law and public morality".
- Women's right to equality and non-discrimination are defined as justifiable fundamental rights.
- Indian Constitution guarantees to all women of India the following –
    - Equality before the law (Article 14)
    - No discrimination by the State on the grounds only of religion, race, caste, sex, place of birth or any of these. (Article 15 (1))
    - Special provisions to be made by the State in favour of women and children. (Article 15 (3))
    - Equal opportunity for all citizens in matters relating to employment or appointment to any office under the State. (Article 16)
    - State policy to be directed to securing for men and women equally, the right to an adequate means of livelihood. (Article 39a)
    - Equal pay for equal work for both men and women. (Article 39d)
    - Provisions to be made by the State for securing just and humane conditions of work and for maternity relief. (Article 42)
    - To promote harmony and to renounce practices derogatory to the dignity of women. (Article 51A e)

CONSTITUTIONAL FREEDOMS AND RIGHTS

- *Freedom from want and the right to enjoy a decent standard of living*
- *Freedom to work and the right to work without exploitation*
- *Freedom from discrimination on the grounds of sex, ethnicity or religion*
- *Freedom from injustice and violations of the rule of law*
- *Freedom from fear*
- *Freedom of thought and speech*
- *Right to participate in decision making*

In the post independent India the visibility of educated upper and middle class women in educational institutions and elite organizations gave the impression that all the women have achieved a higher status and are in an advanced stage of development.

The Towards Equality Report prepared in 1974 by the Committee on Status of Women in India (CSWI) gave some meaningful insights into the status of the women in India. Some of the aspects are – low female literacy especially of the rural and tribal women, high mortality and declining sex ratio, marginalisation of women in the economy. These findings shocked the planners and the policy makers who were complacent that the Five Year Planning was reaching the grass root and impacting men and women equally. The efficacy of the policies and programmes were questioned for the first time and this was the foundation of the women's movement during that period.

4.12.12 GOVT. PROGRAMMES/ SCHEMES FOR WOMEN (INCLUDING WWDS)

1	**Vocational Training** - Vocational training courses are conducted for women in type writing, stenography, tailoring, TV and radio repairing etc on a yearly basis.	Dept of Women and Child Development
2	**Short Stay Homes**- There a total of 26 Short Stay homes in the state	- do -
3	**Working Women's Hostel** - These hostels provide accommodation to women with monthly income below Rs. 5000.00. There are 12 hostels in the state with 16 more being completed. 10 are more under construction	- do -

4	**Rehabilitation of Women in Distress**: The objective of the scheme is to identify the distressed women and provide them training and support for their economic rehabilitation. NGOs working in the scheme bear 10% of the expenditure and the State Govt bears 90%.	- do -
5	**Swadhar:** For women in difficult circumstances like destitutes, widows, women prisoners, women survivors of natural disasters, trafficked women etc.	- do -
6	**Mahila Vikas Samabaya Nigam (MVSN)**: The Orissa MVSN is the state nodal agency for empowerment of women. It takes up 3 kinds of activities – **a. Economic programmes** – (i) NORAD assistance for setting up employment generation projects for poor and needy women both in urban and rural areas. (ii) under STEP different trades like goat rearing etc for about 500 beneficiaries, (iii) MVSN is the nodal agency for Rashtriya Mahila Kosh, (iv) Indira Mahila Yojana (IMY), (v) National Handicapped finance & Devl Corp channelising agency, (vi) District Rural Industrialization prog (DRIP) sponsored by NABARD, (vii) MVSN provides margin money and working capital assistance to its members, (viii) undertakes EDP, MTP in collaboration with SIDBI. **b. Social sensitisation programme** - MVSN undertakes the task of sensitising and educating the women elected into Panchayat Raj institutions**. c. Allied infrastructural activities** – (i) setting up a ready to eat plant to process and supply food recipes to children under Special nutrition programme (ii) setting up a State resource Center for women (SRCW) with support from DANIDA.	
7	**DWCRA** : Introduced in ’83 – ’84 as a part of IRDP with an objective to provide **gainful** self employment to women from rural families below the poverty line. Now it is merged with SGSY from 1999.	
8	**Mission Shakti** since 2001: It aims at empowering women through formation and promotion of ten Million women’s Self Help Groups over a period of four years (2001 – 2005) and strengthening the already existing ones.	
9	**Indira Mahila Yojana:** Central scheme implemented in the 6 KBK districts.	

10	**Swayamsidha –** scheme starting from 2001 – 02 replacing the Indira Mahila Yojana and will continue till 2005 – 06. Operational in 36 blocks of KBK districts and also in Boudh. The main components are WSHG formation, awareness among the members on health, nutrition etc.	
11	**State Commission for Women**: Set up in 1992, it acts as a Civil Court and recommends criminal proceedings against persons accused of offences against women. Conducts in depth studies on economic, educational and health status of the women, compile information on atrocities on women etc.	
12	**State Social Welfare Advisory Board:** Started since 1954, it has worked for women and children through its Balwadi creche, vocational course etc. The State Govt bears 50 % of its establishment cost.	
13	**National Maternity Benefit Scheme**: Central programme started since 1995 in which a pregnant woman of 19 years or above living below the poverty line is provided with financial assistance of Rs 500.00 upto two live births.	
14	**Balika Samridhi Yojana**: Central scheme operational from 1997 in which a girl child in families below the poverty line will be given a grant of Rs 500.00. This benefit is restricted to two girl children in each house born on or after 1997 irrespective of the total number of children in the household.	
15	**NORAD, STEP**	
16	**State Old Age Pension and National Old Age Pension**:	
17	**National Family Benefit Scheme:** Effective since 1995 to provide financial assistance to the family below poverty line on the death of the primary bread winner of the bereaved family within the age group of 18 – 64 years.	
	ICDS - All blocks of the State (314) are under the coverage of ICDS project. Thee target group consists of children in the age group of 0 – 6 years and expectant and nursing mothers in the age group of 15 – 45 years belonging to families below the poverty line.	
	Feeding Programmes: Programmes such as Mid day Meal (for school children of Class I to V), Supplementary Nutrition Programme (for children below 6 years, nursing and expectant mothers), Emergency feeding Programme for	

	the 6 KBK districts	
	State Council for Child Welfare: Established since 1959, it works for the welfare of children, adolescents in the State. It operates 6 Balashrams There are a total of 1375 children in the 44 Creches run by the SCCW. The Council also giving vocational training to 25 women trainees since 1995.	
	TEWA (Training and Extension for Women in Agriculture) - This programme running in 3 districts with the assistance of DANIDA is meant to address women's issues in the extension activities of agriculture.	Dept of Agriculture
	Polytechnics - 4 out of 13 Government Polytechnics in the State are meant for women with an intake capacity of about 600.	Dept of Industry
	Primary educational facilities for the girl child and especially for the SC and ST girls called Kanyashrams and hostel facilities for girls in the KBK districts.	Dept of SC & ST Development
	Pre matric scholarship @ Rs 325 per month for 10 months to SC & ST girls who are hostellers	
	Post matric scholarship to SC & ST girls	
	SGSY – Swarnajayanti Gram Swarozgar Yojana, which is the combination of IRDP, DWCRA, TRYSEM, SITRA, GKY, MWS effective from 1.4.1999 and pattern of funding, is 75 % from Center and 25 % from State.	
	JGSY - Jawahar Gram Samridhi Yojana is a centrally sponsored scheme	
	EAS – Employment Assurance Scheme is a centrally sponsored plan with a sharing of 80 : 20 started from 1993 for wage generating opportunities in all the 314 blocks of the 30 districts.	
	Subsidy to women's cooperative	
	Sericulture	
	Choolah	
	Social forestry	

4.12.13 GENDER IN THE DISASTER POLICIES OF THE STATE OF ORISSA

The **Orissa Relief Code** (effective from March 1980), published by Revenue Department, Board of Revenue (Special Relief) supersedes the Bihar and Orissa famine Code 1930.

Chapter X on Care of orphans and destitutes gives the general rules on the *disposal of orphans*. It mentions that firstly every effort should be made to locate the surviving parents or relatives of the children – if not then such persons should be identified who are willing to adopt them or support them. Lastly, if no such persons are found then an orphan child be sent to an orphanage. In fact the policy prescribes that if the abandoned children or orphans are found suitable then they should be sent to the relief work for earning their livelihood. The policy on destitute is limited to the men only who should be provided with house building or repairing grant. Employment should also be provided to them.

- Mother and Childcare finds mention under the Chapter XI on Heath measures (Medical and Public health). It recommends the following in the event of disaster and relief distribution.
- Mother and child care centers to be started in each village or a group of villages affected by scarcity and distress conditions
- To provide minimum health and nutritional needs of pre school children, pregnant women and nursing mothers
- Provide clean drinking water and hygienic environment.
- Identify the pre school children for supplementary nutrition and nutritional therapy
- Convey to the community especially the parents, simple educational messages relating to health, nutrition and personal and environment hygiene.
- Detect and treat common diseases such as cold, cough, Diarrhea in children

4.12.14 GENDER GAPS IN DISASTER POLICIES

Gender differentials exist even before disasters. This is reflected in disaster policies which do not have any gender sensitivity and even go to the extreme case of gender blindness in some instances. Women issues are not at all addressed in the policy and if addressed gets relegated to the stereotyped maternal health and children section where health and nutritional aspects are only touched upon. Even this aspect is looked with a patriarchal approach

with a welfaristic notion of the State just being a provider. Concerns of women are totally overlooked in issues such as livelihood, safety, security, rehabilitation etc.

If gender and disaster issues are not taken into account gaps will exist as disasters affect women and men differently. Gendered differences exist due to men and women's different roles and vulnerabilities. If not taken into account more than fifty percent of the populations needs go unheeded. In the context of women with disabilities as they are usually invisible they are a minority whose needs are overlooked.

4.12.15 GENDER ISSUES AT TIMES OF DISASTERS

The gender discrimination and the unequal treatment of women have a great influence on women's personal development, self-image and behaviour in emergency situations.

Women-always the Hardest hit , Disabled Women more so

At times of disasters the hardships that women have to bear increase even further. Women and children suffer the most during and after a calamity. The reasons for this are many, some of which are due to the religious and socio- cultural environment. In families where food is scarce, women are usually the last to eat. The main income- generating person, usually the man, gets most of the food. Women who do housework and raise children do not contribute to the family's income in the patriarchal sense and therefore receive less food. They also do without food in order to provide more for their children. Malnutrition and the lack of food reduce women's physical and resistance, and therefore they are the most vulnerable when a disaster strikes. Due to their physical condition, they are less able to cope with the dreadful situation and in some cases die of exhaustion.

One of the reasons for the high females death rate during disasters is due to their subordinate position within the family .Not many women are encouraged to make their own decisions or take responsibility for their lives, and depend on their husbands or fathers to make even the simplest of decision for them. This thinking affects their reaction in emergency situations. In a dangerous situation they do not make their own choice on when and whether to leave the home, but instead and wait for a man in the family to decide This can lead to a delay in evacuation and therefore increase the possibility of being injured or even killed.

One example of such lack of attention is evident in emergency shelters. These have been built to help save people in times of disasters and to provide shelter for those who can not return to their own homes. Although going to a shelter is sometimes the only possible way to survive, some women refuse to do so. Why ? Certain cultural rules. Especially for Muslims women keep away them from entering these shelters. In Islamic culture it is regarded inappropriate for women to show themselves to unknown men. In a crowded shelter it is impossible not to do so. Also the shelters do not provide enough privacy for women and seen as being unpleasant and unsafe.

Another sad fact is that traditional clothing like saris reduce the ability of women to escape in an emergency situation. Wearing a sari makes it difficult to run fast or to climb over objects blocking the escape way. During a cyclone long hair gets entangled in bushes and makes it difficult to run quickly.

Women with disabilities do not only have to cope with the above but also with the problems of mobility, psychological impairment as well as inability to see, hear or speak.

4.12.16 WOMEN'S ACTIVITIES AFFECTED BY DISASTERS

Activity
Collection of drinking water
Cooking and serving food
Collection of water for other uses such as bathing, cleaning utensils
House cleaning
Collection of earth for house construction
House repair – rat hole filling
Collection of fuel wood
Child care
Livestock care
Agriculture/cultivation operations
Collection of forest products and NTFPs
Market functions – selling
Market functions – purchase
Supplementary wage work
Reproductive functions and health aspects

Source - Gender and disasters: coping with drought and floods in Orissa by Prafulla K Mishra, Shaheen Nilofer and Sumananjali Mohanty in Sumi Krishna ed Livelihood and Gender, Sage Publ, 2004

4.12.17 ACTION REQUIRED

Awareness of Women's Needs

All these different factors regarding the special needs of women have to be considered in good disaster mitigation, management and relief plans. Both short term and long term plans have to be taken into consideration - local needs and identify the different categories of vulnerable persons, like women, children, the disadvantaged and elderly. The gender issues have to be fully considered in planning. Gender awareness has to be created. And both men and women have to be educated and trained in the special needs of the marginalized. The government and the voluntary sector have also to educate themselves and receive training so as to be able to provide the necessary administrative and technological support during disaster preparedness and rehabilitation.

It is extremely important that a gender and culture sensitive environment exists in all relief and rehabilitation activities During a disaster all affected people need urgent treatment and help, but all well –meant support does not necessarily help if it is not applied appropriately.

Making initial disaster responses gender sensitive

Relief distribution (adapted from ITDG)

Disaster relief that is gender sensitive requires:

1. Data
   a. Gendered disability disaggregated data as.
   b. Close interaction with the group during the relief planning process.
   c. Gender-disability disaggregated assessments for relief distribution.
2. Female Workers
   a. Relief must be distributed by women especially appointed to deal with gender and disabilities issues and be sensitive to the needs.
3. Recognition of disabled women's skills and capacities
   b. Including them in the planning
   c. Relief work including planning and distribution

4. Relief for people who find it difficult to access: disabled, old women, female-headed households, and widows, single women, etc.

Relief for women with disabilities must be provided at home by the community. When pre-disaster training takes place it is easy to devise a suitable method.

Provision of drinking water within a reasonable distance

5. Ensure privacy
    a. In shelters
    b. Provision of bathing facilities and toilets for women in general and specific facilities for women with disabilities.
    c. Provision of sanitary ware and rags for menstruation etc.

6. Prevent Violence : Provide Security and safety

During disasters, especially in temporary shelter and in camps, women and children are targets of sexual harassment, abuse and violence.

    a. provide *secure sleeping places, some lighting even if electricity is cut of.*
    b. *safe location of toilets.*
    c. *Decide with the community before disasters as to who will be in charge of this work.* They must also see that domestic violence does not take place.
    d. See that women are accompanied by another person when trying to access relief or when searching for lost family members
    e. *medical assistance should be available to women and children victims of physical or sexual abuse.*

Health Concerns

Women's health needs should be taken care of, as they are not only individual persons requiring health care but also carers of families. In the case of disabled their rights cannot be overlooked, and even among them there may be many carers.

a. Among the health concerns are reproductive health care. Antenatal and postnatal care should be provided;
b. Pregnant and lactating women would also need additional nutrition.

c. Women with disabilities may need catheters, special medication etc.

Trauma Counseling
Trauma manifests sometimes openly and sometimes it is not clearly visible.

Trauma could be physical or mental.
Physical trauma due to injury would mean the onset of disability itself. The community would have to decide future action (See Module VII)

In the context of psychological impacts of disasters women are as at risk as men. Sometimes they are more so as being carers of families.

It is also high I the case of single women, widows, battered women, and women with new and old trauma. These women should be provided trauma counseling

Reconstruction
Women's local knowledge should be used by bodies responsible for reconstruction.

Women's local and traditional knowledge would provide sensitive planning and implementation of programmes.

Women's needs in house building have to be taken care of. In most disasters women are never consulted about the designing of their houses.

Women's knowledge of conservation and effective use of natural resources would provide the dividing line between a successful and effective disaster management plan.

There are many Self Help Groups, Mahila Mandals and women elected local government representatives to serve as a resource.

Their involvement would mean timings according to their choice as they are already overburdened with work.

These groups could carry out activities and monitor them. Financial assistance should in these cases go o them directly. Most such groups have bank accounts.

The land must have a joint patta i.e. be owned by husband and wife jointly as must houses also. Special care must be taken of women who cannot access land and houses as they are single women, widows and women with disabilities etc. with no property in their names. Legal services must be provided to women when such decisions are taken, as many women lose their property to family members.

Livelihood

Disasters can provide opportunities for women to be independent. The process of reconstruction can be utilized

a. Include women in the workforce.
b. To access credit
c. To access livelihood opportunities
d. Access to economic resources must include skill building including training on business and office practices, market linkages, new vocations
e. Support income-generation projects that build non-traditional skills among women, by providing women with access to non-traditional projects such as construction-related employment
f. Provide women with professional qualifications for training on all aspects of reconstruction work such as housing construction.
g. Provide assistance to family care givers to support them economically and ensure continued care to the injured, children, and disabled.
h. Monitor the percentage of women and men in construction, trade, other employment; the numbers of disabled women trained; the proportion of economic recovery grants and loans funds received by women including the disabled ; monitor and assess long term impacts on women and girls of disrupted markets, forced sale of assets, involuntary migration, increasing proportion of female headed households etc

4.12.18 TRAINING OF WOMEN

Women and child are the most vulnerable to disasters due to their physical condition.

Traditionally women depend on their husbands or other family members to make decision, but in a disaster situation quick decisions are required. Women have to learn how to act on their own in an emergency situation. It is not enough if in the family the father is trained and the rest of the family is

not. Women have to be integrated in to the planning process to ensure that their special needs are taken in to consideration.

ACTIVITY SHEET

The Game of Life
Time – one hour

Preparation
Adapt the story used in this activity to make it appropriate to local circumstances.

Process
Ask the group for four volunteers to line up across the middle of the room. The rest of the group should sit around the edges, where they can see the volunteers. (you need a large room for this, or an outside space)

Tell one volunteer to think of him / herself, for this exercise, as a non-disabled man, the second to play the part of a disabled man, the third that of a non – disabled woman, the fourth that of a disabled woman. It is a good idea to have people assume different identities from their real identities.

Explain that this exercise is to help us to examine how experiences of life may differ, depending on who we are and how our community sees us. You will go through the main stages of a typical life story, one by one, and each of the volunteers must respond to each stage. According to how they think it would affect their assigned character or their family

- Two steps forward for a very positive or very successful experience.
- One step forward for a positive or successful experience.
- One step back for a not so positive or not so successful experience
- Two steps back for negative or unsuccessful experience.

Emphasize that they are each representing a group of people, so they should respond accordingly rather than basing their response on their own experience, or the experience of on individual, which may not apply to the majority

Emphasize that heir response should be based on what they think is currently accurate for their culture and situation, not what they think it ought to be.

After each life stage, and the response by the volunteers, you will allow time for the rest of the group to react and comment on the moves made by the volunteers. If there is disagreement, the rest of the group should decide by consensus and instruct the volunteer if appropriate how to change the move that she and he made.

It is important for the facilitator to judge when to intervene and comment, to clarify reasons for decisions, and bring out and discuss any prejudicial points.

Start with the first life event, as if you are telling a story

- One fine day, after a long wait of nine months, your character is born.
- How does your family feel when they see who you are? Make your moves comments / suggestions by the rest of the group?
- Example to facilitator of what might happen.
- If the family is very happy (non disabled son born) two steps forward quite happy (disabled son / non disabled daughter) one step forward not happy (disabled son) one step back
- Very happy (disabled daughter) two steps back
- Now you are a bit older, and its time to start thinking about school
- How likely is it that you will be able to attend school? Make your moves Comments / suggestions by the rest of the group?
- How you are a bit older, and its time to start thinking about school.
- How likely is it that you will be able to attend school? Make your moves Comments / suggestions by the rest of the group ?
- Now you are 20 years old, spring is in the air, and you would like to get married, or form a relationship, how much do you think this will possible for you? Make your moves.
- You like to keep busy and want to make some money for your family. You try to get a job. How easy will it be for you to find one? Comments / suggestions by the rest of the group ?
- A few years go by, and everyone in your age group is having babies. How much will this be a possibility for you ?comments / suggestions by the rest of the group ?Check if the disabled woman takes two steps back, or is instructed to do so by the group. Why did this happen ? They may say that it’s because most disabled women are physically unable to have children – a common myth. Two steps back may well be an accurate response for a different reason; disabled women often don’t have children because society thinks that they cannot or shouldn't?

- Now you are in your 40s, and you have a lot of experience of life. You want to help your community by becoming involved in local politics. How would you achieve this goal? Comments / suggestions by the rest of the group?

Question

- When all the moves have been make, ask the group:
- Who is in the best position? Who is in the worst position?
- Ask the volunteers (especially those in the best and worst positions) how they feel about being where they are.
- Are there any surprises?
- At what point(s) were the experiences of disabled men and disabled women the same/ different?
- Do they think that it is accurately reflects the general situation for men and women, disabled and non – disabled, in their community ?can they explain why things are like that ? How do they feel about it ?
- What have they learned from this exercise about different people's experiences ?

Facilitator's Note

This exercise needs particularly careful introduction and facilitations.

To many participants it dramatically reveals things about which they have never consciously thought before. It can be fun, the humor taking the edge off the hard facts exposed by the game; but some participants have found it distressing, because it makes plain some very painful and personal truths. We include it here because we think that, at the right time and in an appropriate way, taboos and difficult issues need to be identified and spoken about that we can all recognize where the core of discrimination lies, and from there work out strategies for change.

In a way, this exercise shows how arbitrary the game of life really is, depending on the chance facts of one's birth. It can be an effective way of revealing to non – disabled people how much disabled people are discriminated against (directly and indirectly) in their community; and of helping non disabled and disabled people alike to recognize hat disabled women usually face worse discrimination than disabled men. This is a fact that is often hotly denied by disabled men and DPOs, and used as a justification for not including women, or not working on disabled women's issues)

In groups with a mixture of disabled and non disabled participants, it is essential that participants have worked together enough, and know each other well enough, to feel comfortable with each other.

Options
With groups of disabled people, it is sometimes more effective to address these issues in another way, for example through small group discussions, each group considering one of the major life-events and the personal issues involved, with feedback to the whole group. The reason for this is that the game's outcome is all too obvious from the outset for most disabled people, and the time may be better spent on deeper discussions of the issues. It is good nonetheless for disabled trainee facilitators to learn the Game of Life, in order to be able to facilitate it with other groups, whatever their composition.

Especially with groups consisting entirely of disabled people, or groups of any composition who already have a good understanding of the discrimination faced by disabled people, you may decide to omit the contrast between disabled and non disabled lives and shift the focus of the game to emphasize male / male issues, changing the characters of the four volunteers to (for example) urban disabled man, rural disabled man, urban disabled women, rural disabled woman.

Another alternative, for use with any type of group in a different context, is to use this exercise to raise differences in the likely life experiences of people with various types of impairment, for example, learning disabled people and people with physical or sensory impairments. Or to explore the question of whether disabled people (or disabled and non disabled people) from different racial or religious groups receive different treatment within the broader community.

ACTIVITY SHEET

Disabled Women's Voices
Time –one hour

Objective
To raise awareness of the following facts

Disabled women have issues in common with disabled men and non-disabled people. They may thin the same or different things, but their voices are usually not heard.
Disabled women also have their own issues, but again their voices are not heard.

Preparation

Prepare one set of nine statement cards for each small group. Each statement should be numbered (for easy reference) on a separate card. Draw or print the numbers very large so that they fan be seen from a distance for the whole group feedback.
We used the following statements, taken from gender and Disability
Women's experiences in the middle east, by Lina Abu-Habib, published by Oxfam, and
Disabled Women in Europe, published by Disabled people's international Europe and reproduced here with permission.

- We are all fighting for the same cause, so let us join together and not be divided. We are weak as it is. Now you want to divide the disabled people's movement into men and women.
- To confront barriers, the most important thing is to have a fierce determination to be like other women and get rid of any feelings of inferiority or uselessness.
- Health care services were the biggest problem for me as disabled women. The nurses had a very negative attitude.
- I have to fight against the belief that a disabled person is an object of pity who always needs assistance. The problem is made worse by the fact that I am a women. Being disabled woman is a double disadvantage.
- My oldest brother makes all the decisions for us disabled girls in the family. The role of our mother is just to take care of us.
- As a disabled woman I am allowed to go out, but my non –disabled sisters cannot. I guess my parents are not concerned for my honor and safety. They probably think, "she disabled; who in the world would want anything to do with her"
- It is necessary to lift the veil on certain aspects considered taboo or unacceptable for disabled women; child bearing has long been considered impossible for disabled women.
- My father is disabled too. He is totally against the idea of marriage for disable women like me. He says a disable women can never satisfy her

husband's needs; the physical ones or the housekeeping, or raising children.

- Education is the most important thing. A proper education will be a disabled girl on an equal level with other children.

Process

Ask participants how often they hear disabled women speaking about their own lives, their wishes, their problems, the state of the country, the economy, etc. on TV, Radio, in the community, at home.

Then explain that they will how spend sometime hearing from women about some issues that are important to them.

Ask them to form small groups of four or five. Give each group a set of statements, a piece of flipchart paper, a marker pen, and some sticky tape.

Ask them to read and discuss each of the statements. Then they should agree, as a group, how to rank the statements, depending on how much or how little they agree with them. The ranking should be in a diamond pattern. Draw an example on a flipchart sheet.

X Completely agree
XX Agree
XXX Partly agree
XX disagree
X Completely disagree

They should stick their cards on to their flipchart sheet to illustrate their ranking. As an alternative, the small groups can simply arrange their cards on the floor, and the feedback can be done with a walk around the room. One person from each small group should be prepared to present to the whole group, explaining briefly the ranking that their small group chose.

Facilitate the feedback. This could lead into a whole group discussion, and / or you could close the session with Handout 35 to take home, explaining that it contains some more disabled women's opinions. You could also recommend participants to read a complete chapter of Gender and Disability: Women's experiences in the Middle East, not reprinted here for reasons of space. This could be done as homework, and then discussed in a future session.

Facilitators

For this type of introductory workshop, the use of the statement cards, as opposed to asking women in the group to identify issues, is a safe way of addressing topics that women might think too personally revealing if they

raised them themselves. This is especially true in mixed male/ female groups.

Restrictive Gender Roles

Objectives

To identify restrictions imposed on men and women.

To share personal experiences of gender roles.

To consider whether, in the group's experience, women encounter more restrictions than men.

To apply these insights to the life experiences of disabled people.

Process

Introduce the exercise and give some examples of occasions (may be one from childhood and one more recent) when you were prevented from doing something because social rules did not allow someone of your sex to do it.

Participants work in pairs, having chosen partners with whom they feel comfortable. Allow them ten minutes to think of a time when they w ere prevented from doing something because of being male or female. What happened, and why ? how did they feel ? The partners share their experiences with each other for ten minutes.

The whole group discuss in general terms what they feel ? The partners share their experiences with each other for ten minutes.

The whole group discuss in general terms what they have learned from the exercise. Bring out the point (if true for local circumstances, and if the group does not raise it) that women's lives are generally more restricted by social rules and gender roles than men's lives are – and that many women experience this as oppression.

Introduce the question of how gender roles might affect disabled men and women. They often experience discrimination if their impairment is perceived preventing them from fulfilling their gender roles. For example, most societies assume wrongly) that disabled women cannot or should not

be mothers. Disabled women may even be prevented from marrying, and may be forcibly sterilized. It is more common for disabled men to be married than disabled women, because society expects men (disabled or not) to be looked after at home by women. Another example; it is considered possible for a physically disabled man to fulfill his gender role of bread – winner or community elder, by using his rational or intellectual faculties, or by skilled manual work even if, for example his legs are paralyzed) on the other hand, one of a woman's prime gender roles is to be physically attractive, according to her cultures definition of beauty. In many societies this definition does not include difference from the accepted norm, so many physically disabled women are not considered to fulfil their role.

Can the group think of similar examples from their own experience ? sum up the discussion.

MODULE V

LIVELIHOOD OPTIONS FOR THE PEOPLE WITH DISABILITIES

Disability is both a cause and consequence of poverty. Eliminating world poverty is unlikely to be achieved unless the rights and needs of people with disabilities are taken into account. According to the United Nations, one person in 20 has a disability. More than three out of four of these live in a developing country. More often than not they are among the poorest of the poor. Recent World Bank estimates suggest they may account for as many as one in five of the world's poorest. Disability limits access to education and employment, and leads to economic and social exclusion. Poor people with disabilities are caught in a vicious cycle of poverty and disability, each being both a cause and a consequence of the other.

4.13 LIVELIHOOD AND DISABLED

After each disaster people cope with livelihood issues. As Orissa has 85% population the focus has to be on agricultural issues livestock & small enterprise which the disabled can manage. Despite this keeping in view manual will be use by many organisation all types of livelihood are included.

The Government both union and state government has provided restoration, relaxation and priorities in vocational training, wage employment, self employment for economic empowerment of PWDs. Inclusive scheme NHFDS has been launched. Exclusive scheme such as SGSY, SGRY, IAY, PMRY, KVIC,DRI have reservation/priority for PWDs.

An attempt should be made to utilize all Provisions / Scheme / (Inclusive/Exclusive) to rehabilitate the PWDs of disaster areas. The government should announce enhance package for economic rehabilitation of PWDs of disaster affected areas.

The few self-employment ventures have been listed here indicating disability and area. This list is illustrative not exhaustive.

CATEGORIES OF PWDs

LV – Low Vision

VH – Visually Handicapped

HH – Hearing Handicapped,

PHH—Partially Hearing Handicapped

MR – Mentally Retarded (Mild-Moderate)

LH – Locomotor Handicapped

BL – Both legs affected not arms

OL – One leg affected not arms

AREA: U – Urban, SU – Semi-Urban, R – Rural.

SERVICE SECTOR VENTURES

Sl.No.	Name of Venture/Activity	Category of PWDs Suitable	Area (Urban/Suitable Semi-Urban /Rural)
1	Beauty Parlour	HH, LH (OL)	U, SU
2	Health Club	HH, LH	U
3	Carpentry	HH, LH, LV, MR	U, SU, R
4	Laundry & Ironing	HH, LH, OL, BL, MR	U, SU
5	Blacksmith	HH, LH, OL, BL, LV	U, SU, R
6	Barber's shop	HH, LH, OL	U, R
7	Plumbing	HH, LH, OL	U, SU, R
8	Cycle Repairing shop	HH, LH, LV	U, SU, R
9	Electronic Equipments Cleaning	HH, LH	U, SU
10	Repairing of diesel engine pumps	HH, LH (OL)	R, U, SU
11	Masonry	HH, LH	U, R, SU
12	Two-wheeler repairing	LH, HH	U, R, SU
13	Hiring of sound system	LH, HH, VH, MR	U, SU
14	Hiring of generator & lighting	LH, HH, VH, MR	U, SU
15	Domestic Appliances Repairing	HH, LH, LV	U, R
16	Tyre servicing & vulcanising shop	LH, HH, LV	U/R/SU
17	Repairing & servicing of agriculture tools	HH, LH, LV	R, U, SU
18	STD/PCO, Fax with conference facilities	VH, HH, LH	U, SU
19	Clock & Watch repairing	LH, HH	U, SU
20	Musical Instrument Repairing	PHH,LV,LH—OL/BL	U, SU
21	Mobile, EPBX, Fax, Phone repairing	LH, OL/BL	U

22	Radio & TV, CD player, tape-recorder repairing	LH—OL/BL	U, SU
23	Sewing-knitting machine repairing	LH, HH	U, SU
24	Physiotherapy Centre	HH, LH, OL	U, SU
25	Footwear & leather goods repairing	HH, LH—OL/BL	U, SU
26	AC, Refrigerator, cooker repairing	HH, LH – OL	U
27	Xeroxing, lamination, spiral binding	HH, LV, LH,—OL/BL	U, SU
28	House wiring & electrification	HH, LH—OL/BL	U, SU
29	Computer Hardware & Repairing	HH, LH—OL/BL	U, SU
30	Coil Binding	HH, LH	U,SU
31	Gardening (Mali)/Nursing	HH, LH, LV, MR	U
32	Screen Printing & Commercial Art	HH, LH	U, SU
33	Photo framing	HH, LH—OL/BL	U, SU
34	Tailoring shop	HH, LH	U, SU, R
35	Musical Band	VH, LV, LH, MR, PHH	U, SU, R

PRODUCTION/MANUFACTURING VENTURES

Sl. No.	Name of Venture/Activity	Category of PWDs Suitable	Area (Urban / Semi-Urban / Rural
1	Cement jail-pipe, flower pot Mnfg.	LH, HH, VH	U, SU
2	Cane Products Unit	HH, VH, LH—OL/BL	U, SU, R
3	Chalk Making	LH, HH, VH, MR	U, SU, R
4	Candle Making	HH, VH, MR, LH—OL/BL	U, SU, R
5	Agarbatti Making	VH, HH, MR, LH—OL/BL	U, SU, R
6	Jute Products	HH, VH, MR, LH	U, SU, R
7	Leather goods (purses, bags etc.)	HH, LV, LH	U, SU
8	Agriculture implements Mnfg.	HH, LH	U, SU, R
9	Plastic Goods Manufacturing	LH, HH, VH, MR	U, SU
10	Rope Making	HH, VH, LH, MR	U, SU
11	Readymade garments	HH, LH	U, SU
12	Book Binding	HH, VH, MR, LH	U, SU
13	Rubber stamp, sign-board, Badges, Number Plates, Name Plates	HH, LH	U, SU

14	Sauce-pickles, Papad-Badi Mnfg.	HH, LV, LH	U, SU, R
15	Broom making	HH, VH, LH, MR	R
16	C.B. Bricks Manufacturing	HH, VH, LH—OL/BL	R
17	Processing of maize & Ragi	HH, VH, LV	U, SU, R
18	Processing, Packing, Marketing of cereals	HH, VH, LH, MR	U, SU, R
19	Leaf-cup plate making	VH, HH, LH, MR	U, SU, R
20	Bamboo item production unit	VH, HH, LH, MR	U, SU, R
21	Bee keeping	HH, LH	R, SU
22	Processing-Packing & Marketing of spices	HH, VH, LH, MR	U, SU, R
23	Furniture Manufacturing	HH, LV, LH	U, SU
24	Orthotics-Prosthetic Manufacturing	HH, LH—OL/BL	U, SU
25	Note Book-copy-file manufacturing	HH, LH	U, SU
26	Stone-wood carving	HH, LH—OL/BL	U, SU, R
27	Handloom Products	HH, VH	U, SU, R
28	Appliqué Work	HH, LH, VH	U, SU, R
29	Rice Processing Huller	LH, HH	SU, R
30	Dairy Unit	HH, LH, VH, MR	U, SU, R
31	Goatery—Piggery	HH, LH	R, SU
32	Poultry farming	HH, LH	R, SU
33	Fisheries	HH, LH, LV	R, SU
34	Pottery	HH, LH, LV	R, SU
35	Paper Bags Manufacturing	HH, LH, VH, MR	U, SU
36	Renting Power Tillers	HH, LH, VH, MR	U, SU
37	Mat Making	HH, LH, VH, MR	U, SU

BUSINESS/TRADING VENTURES

Sl. No.	Name of Business/Trade	Category of PWDs Suitable	Area (Urban/Semi-Urban/Rural
1	Ladies Corner	LH, HH, LV, MR	U, SU
2	Blouse Petticoat Matching Center	LH, HH, LV	U, SU
3	Cloth Store	LH, HH, LV	U, SU, R
4	General Store	LH, HH, LV, MR	U, SU, R
5	Utensil shop	LH, HH, LV	U, SU
6	Medicine shop	LH, HH	U, SU
7	Sweets-snacks shop	LH, HH, LV	U, SU, R

8	Betel shop	LH, HH, VH	U, SU, R
9	Hardware & Paints shop	LH, VH, LV	U, SU
10	Book & Stationery shop	LH, HH, LV	U, SU
11	Video-VCD Cassette hiring shop	LH, HH, LV	U, SU
12	Audio-Video Cassette sales shop	LH, HH, LV	U, SU
13	Variety store	LH, HH, VH	U, SU, R
14	Electrical item sales shop	LH, HH, LV	U, SU
15	Electronic goods sale shop	LH, VH, HH	U, SU
16	Luggage sales & service shop	LH, VH, HH	U, SU
17	Watch-clock sales shop	LH, HH, LV	U, SU
18	Cycle repairing & sales shop	LH, HH, LV	U, SU
19	Gift item center	LH, HH	U, SU
20	Vegetable vendor	LH, HH, LV, MR	U, SU, R
21	Fruit juice & fruits vendor	LH, HL, LV	U, SU
22	Milk product parlours	LH, HH, LV	U, SU
23	Dhaba & Restaurant	LH, HH, LV	U, SU, SH/NH Roads
24	Photo Studio/Videography	LH, HH	U, SU
25	Seeds, fertilizer & Pesticides shop	LH, HH, LV	U, SU, R
26	Tent House	LH, HH, LV	U, SU
27	Cyber Café & DPT job work	LH, HH	U, SU
28	Clinical Lab	LH	U, SU
29	Ice-cream-juice parlour	LH, HH, VH, MR	U, SU
30	Sea foods selling	LH, HH, LV, MR	SU, R
31	Travel Agent	LH, LV, HH	R
32	Building material	LH, LV, HH	U, SU
33	Sports Emporium	LH, HH, HH	U, SU
34	Photography & Videography	HH, LH (No major defect)	U, SU
35	Flour Mill	HH, LH	U, SU, R

GOVT. SCHEMES FOR ECONOMIC EMPOWERMENT

WHOM TO CONTACT	PURPOSE & Reservation for PWDs	ELIGIBILITY
Mahila Vikas Samabaya Nigam, Qr.No.A/5, Unit-V, Bhubaneswar-751 001. Ph: 0674-2401852/1050,2401321. Fax: 2401852	▪ *For setting up small business in service/trading sector* ▪ *For agriculture activities* ▪ *For purchase of vehicles* ▪ *For self-employment amongst persons with mental retardation, cerebral palsy and autism* ▪ *For setting up small industrial units* ▪ *Loan for education/training* ▪ *Micro financing scheme* ▪ *Mahila samridhi yojana* ▪ Parents association of mentally retarded persons	▪ *Any Indian citizen with 40% or more disability* ▪ *(Locomotor disabled, Visually Handicapped, Hearing Handicapped, Mentally Retarded, Autism and parents' association of Mentally Retarded persons .)* ▪ *Age between 18 to 55 years.* ▪ *Annual income below Rs.80,000/- for rural areas and Rs.1,00,000/- for urban areas.* ▪ *Relevant educational/technical/vocational qualification / experiences and background.* ▪ *Should not be debtor.*
		▪
The Executive Officer,	• Swarn Jayanti Sahari Rojgar	▪ *Urban people living under poverty line*

Municipality/NAC.	Yojana (SJSRY) • 3% Reservation for PWDs	▪ *Age preferably between 18-45 years* ▪ *The applicant should not be defaulter* ▪ No minimum education required but person above 9th standard of school education are not considered for this scheme.
General Manager/Project Manager, District Industries Center (DIC) of your district or I.P.O. of concerned block.	• *Prime-Minister Rozgar Yojana (PMRY)* • *10 years upper age relaxation* • *top priority to PWDs*	▪ *Age – General Candidate: Between 18-35 years* ▪ *PWDs/SC&ST/Ex-Servicemen/Women: Between 18-45 years* ▪ *Qualification: 8th class pass or above* ▪ *Income: Family income should be less than Rs.40, 000/- per annum.* ▪ Should not be defaulter
DIC office of your district KVIC (State office), 69, Buddha Nagar, Kalpana Sq., Bhubaneswar-751 004. KVIB, Unit-3, Kharvel Nagar, Bhubaneswar-751 001	• Khadi & Village Industries Commission (KVIC) • 3% Reservation for PWDs and 30% subsidy	▪ Indian citizen ▪ Should start village industry. ▪ Should not be defaulter ▪ Any other document asked by implementing agencies.

The Branch Manager/Field Officer of nearest nationalized bank or District Lead Bank Manager.	• Differential Rate Of Interest (DRI) Scheme • Priority to PWDs	▪ Preferably between 18-55 years ▪ Should belong to BPL category. Applicant's land holding should not exceed beyond one acre irrigated and 2.5 acres non-irrigated. (The institutes are exempted from land hold criteria). ▪ Should not be defaulter
Chairperson-cum-Managing Director, Orissa Sch. Caste Sch. Tribes Dev. Finance Coop. Corpn. Ltd., Lewis Road, Bhubaneswar-751 014. Ph: 0674-2432949/2431623. Fax: 2431798	• National Scheduled Tribes Finance & Development Corpn. (NSTFDC) • 3% Reservation under poverty alleviation programme.	▪ The beneficiary should belong to Scheduled Tribe (ST) community. ▪ Annual family income of the beneficiary should not exceed double of the poverty income limit. ▪ Partnership firms/cooperative societies/any other form of legal association are also eligible subject to the following: ▪ All the members should belong to ST community. ▪ Annual family income of each member/applicant should not exceed double the poverty line
Managing Director, Orissa Sch. Caste & Sch. Tribes Dev. & Fin. Coop. Corpn. Ltd., Lewis Road, Bhubaneswar-751 014. Ph: 06742431623,	• National Safai Karmcharis Finance & Development Corpn. (NSKFDC) • 3% Reservation under poverty alleviation programme.	▪ Safai Karmcharis or scavengers or their dependants duly identified under the National Scheme for Liberation & Rehabilitation of scavengers (NSLRS) or in a survey. ▪ The beneficiary should be a member of a registered cooperative society of Safai

2432107, 2432949. Fax: 2431786	•	Karmcharis or legally constituted association/firm promoted by the target group. ▪ If a person from target group is not covered in the survey , he/she should produce a certificate from local Revenue Officer/ Municipal Officer or Cantonment or Railway Officer, not below the rank of a Gazetted Officer.
The public sector oil companies (IOC, HP, BP etc.) as per advertisement	• Dealership Of Petroleum Products • 7.5% Reservation for PWDs	▪ PWDs (Visually Handicapped, Hearing Handicapped, Locomotor Handicapped) having more than 40% disability. ▪ He/she should be Indian, resident of that district for which dealership to be allotted/earmarked. ▪ **Education** : Minimum Class-X pass. ▪ **Age** : Between 21 to 40 years. ▪ **Income** : Family income should not exceed Rs.50,000/- (Rs. Fifty thousand) per annum ▪ Such dealership should have not been allotted to any close relative (parents/ husband/ wife/ son/daughter). ▪
The District Telecom	• ALLOTMENT OF	▪ Unemployed persons with disabilities.

Manager, BSNL of concerned district	STD/PCOs • Top Priority to PWDs	▪ A**ge** : Adult in working age. ▪ **Qualification** : **Urban** — Minimum Matric Pass ▪ **Rural** — Minimum 8th pass
The Block Development Officer/Sarapanch	• For getting wage employment under Swarn Jayanti Sahari Rojgar Yojana (SJSRY), Swarna Jayanti Gram Swarozgar Yojana (SGSY) and Indira Awas Yojana (IAY). • 3% Reservation for PWDs	▪ *Individual / SHGs* ▪ *Individuals from rural area / SHGs* ▪ *He/she should not be defaulter* ▪ He/she should be B.P.L. card holder.

Rural Development and Self-Employment Training (Rudset) Institute

The Rural Development & Self-Employment Training (RUDSET) institute was established in 1982 at Ujire, in Karnataka with sponsoring support of two public sector banks and Sri Dharmasthala Manjunatheswara Educational (SDME) Trust. The institute have been receiving grant from NABARD, SIDBI and Govt. of Karnatak. The main objective of RUDSET is to transform rural youth to acquire a productive identity through short duration interventions, which include motivation and training.

There are 20 such institutes operating in 11 states of the country including Orissa. Each institute offers needbased and location specific training in 50 different types of programs with duration of 1-8 weeks. The institute caters to youth in the age group of 18-35 years. The basic education is desirable, preferably upto Xth class. The facilities are provided free of cost to the trainees.

The trainees are expected to reside at the institute, which increases their self-confidence and develops their ability in interactions with batch-mates. The unique innovative initiative taken by the RUDSET is introduction of RUDSETI Bizar to support trainees by providing them with marketing outlets at various fairs for their products. The PWDs may contact to these institutes at the following places :

ORISSA

356P, Opp. Jagannath Temple, Po: Aiginia, Khandagiri, Bhubaneswar-751109	0674-2470644(O)/2471315(R) 2563262 (R)	Khurda, Cuttack, Puri, Nayagarh Jagatsinghpur

MODULE VI

ACCESS

This module provides information about legal provision to make barrier free environment for the disabled. Some of the common measurement guidance for reconstruction activities has been specified in this module.

Under the law, India's disabled are entitled to a host of rights. The Persons With Disabilities Act of 1995 says public transport, including trains, buses and aircraft, should allow easy access to the disabled; sound signals should be installed at traffic lights; and pavements should be made wheelchair accessible. But more than six years after the Act was passed, few public places and institutions are disabled-friendly. Virtually no buses are wheel-chair accessible, the blind still cannot cross roads on their own and the deaf face a host of problems.

The government, which provides artificial limbs, wheelchairs, Braille kits and other devices, says it is working towards a barrier-free environment but is hamstrung by a lack of funds. The problems were highlighted last year when British physicist Stephen Hawking, who suffers from motor neuron disease, visited India. The government had to build special ramps for him to see two of the capital's biggest tourist attractions -- the historic Red Fort and Qutab Minar.

Access to resources and service providers is an important component for the disabled people. They need to access the basic services like health, education during their daily living. Due care should be taken and special steps should be followed during construction of building and floor. This section focuses on some of the suggestive measures for the creation of barrier free environment.

4.14 BARRIER FREE ENVIRONMENT

(Disasters, Reconstruction and Barrier free access)

Disabled people encounter **environmental barriers** in the following areas.

Public transport	housing
Public buildings	roads
(*Esp*. hospitals, Govt. offices and Markets)	
Pedestrian streets	leisure and recreation facilities
Offices and factories	places of worship
Communications systems	access to information.

In the post disaster major reconstruction work follows emergency relief work. Before this period though there is a need for barrier free access to the buildings and construction works it is not feasible on the part of the development agencies to reconstruct the structures. This is due to lack of

financial strength with the Govt. and Non-govt. agencies. As the disability act says on the accessibility of the disabled to the building and other structures opportunity should be taken to create disabled friendly environment because in this period financial provisions are made to meet such reconstruction needs. It is advisable that community with Govt., NGOs and corporations who are asked to rebuild should be pressurized by the community to carry out all activities as per the act.

Pic: 1 Ramps in cyclone shelter

Pic: 2 Disabled friendly cyclone shelter

Pic: 3 Inaccessible shelters

Pic: 4 District hospital without ramps

Evidences in Jagatsinghpur district shows except one cyclone shelter constricted by Red Cross is disabled friendly. Others are found to be inaccessible by the disabled.

Along with this in the reconstruction phase the schools are to be reconstructed to make it disabled friendly. This will check limiting the disabled children to lead a better life and employment and thus can contribute directly to the national or local economy. The advantage of restructuring the buildings is that it is often more cost effective to modify the plans for a new building retrospectively to make it accessible. Depending on the type of building, providing full access facilities from, the outset costs an average additional 1.12 percent (ranging from 0.1 percent for the public building to 3 percent for individual family homes). It is reasonable to expect that, as architects and builders become more

experienced in incorporating elements to improve accessibility, costs will fall further.

It may be argued that accessibility is not cost effective over looks the fact that everyone, not just disabled, will benefit from an accessible built environment. Older people, young parents with small children, those who are temporarily injured need the same sorts of access modification in the built environment. An accessible environment, designed to meet the needs of people with disabilities, is safer for everyone, it reduces the number of accidents, leading to long term (but unrecognized) saving in health care and welfare costs, lost income, and so on.

Measurements

There are specific measurement guide recommended by CPWD, Govt. of India. This section discusses the following suggested measurements**:**

Item/Purpose	**Measurements/Ideal specification**
Size of the wheel chair	1050mm X 750 mm
Accessibility by the wheel chair users	350mm deep and 750mm high under the counter , stand etc
Construction standard for Wheel chair, crutches and walker users	Adequate space should be allocated as suggested in picture
Locking and opening controls for window and doors	Less or equal to 1400mm from the finished floor
Height of switches for electric light and power, door handles and other fixture fittings	900mm – 1200mm
Power point for general purpose	400-500mm
Toilet size	1500 X 1750mm
Vertical /horizontal hand rails Height of the W.C seat	50mm 50mm
Water fountains	700mm height and 350mm deep
Telephones	700mm height and 350mm deep under the telephone stand
Mail box height	1200mm
Bus stops	Two rows of guiding blocks 300mm away from bus stop pole
Kitchen	Width 1500mm
Heights of the Worktops ,sinks and cooking area	780mm to 800mm
Non ambulatory disabilities	
Width of entrances and exists	900mm
Width of the passage/corridor	Minimum 900mm

Minimum ramp slope	1:12
Toilet size	
Semi ambulatory disabilities	
Width of passage for crutch users	Min. 900mm

Figure –I Size and Different Parts of the Wheel Chair

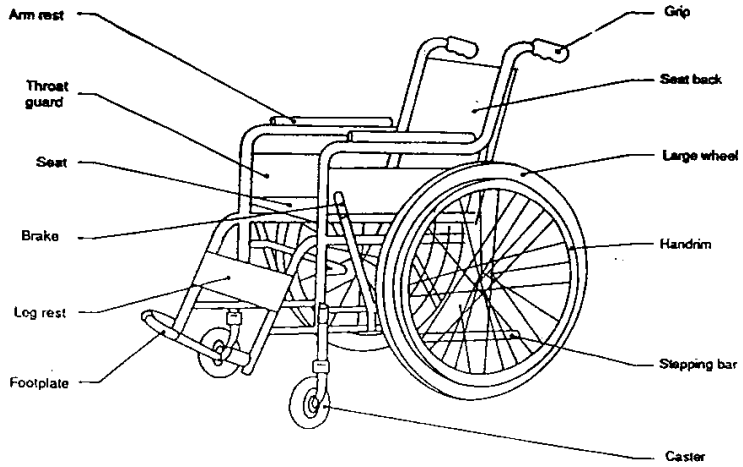


Figure – II Space Allowance for Wheel Chair Users

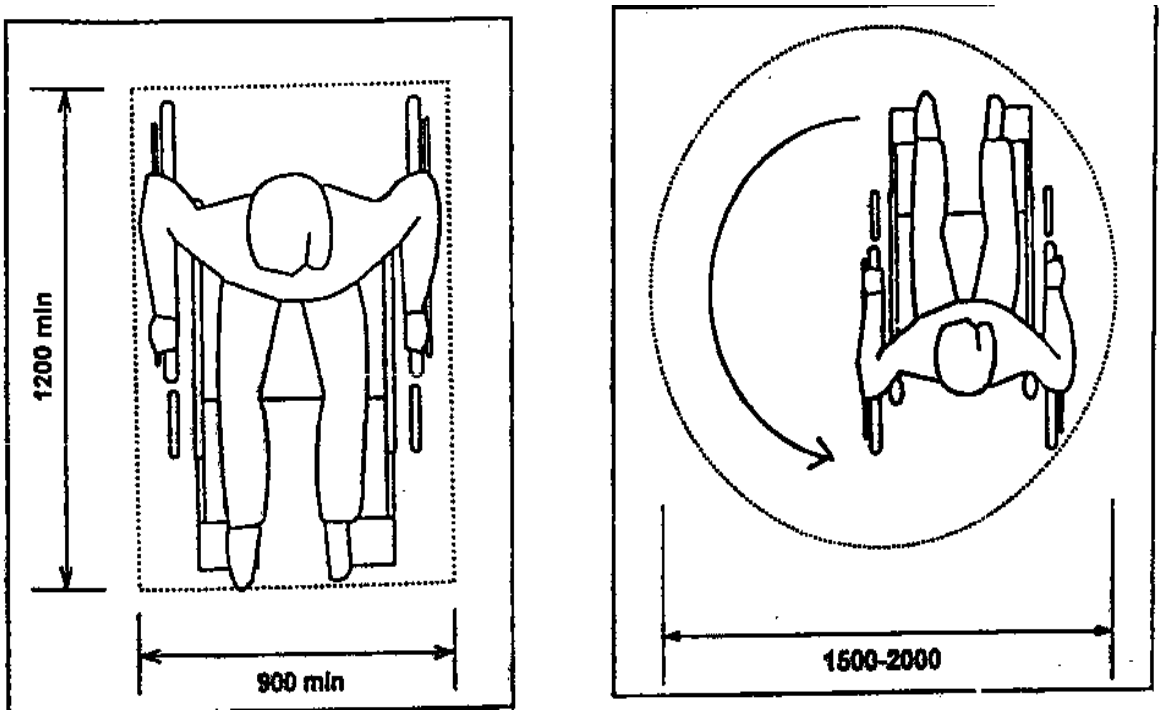


Fig-III Space Allowance for Crutches Users

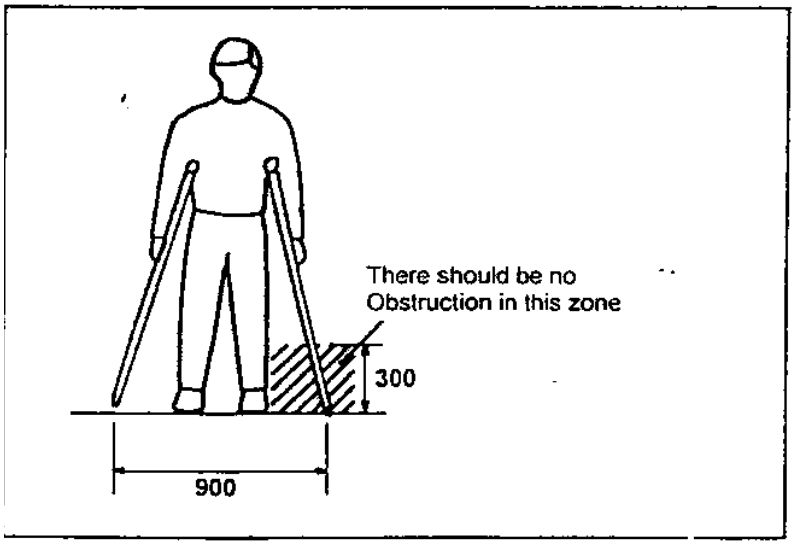


Fig-IV: Locking and opening controls for windows and doors

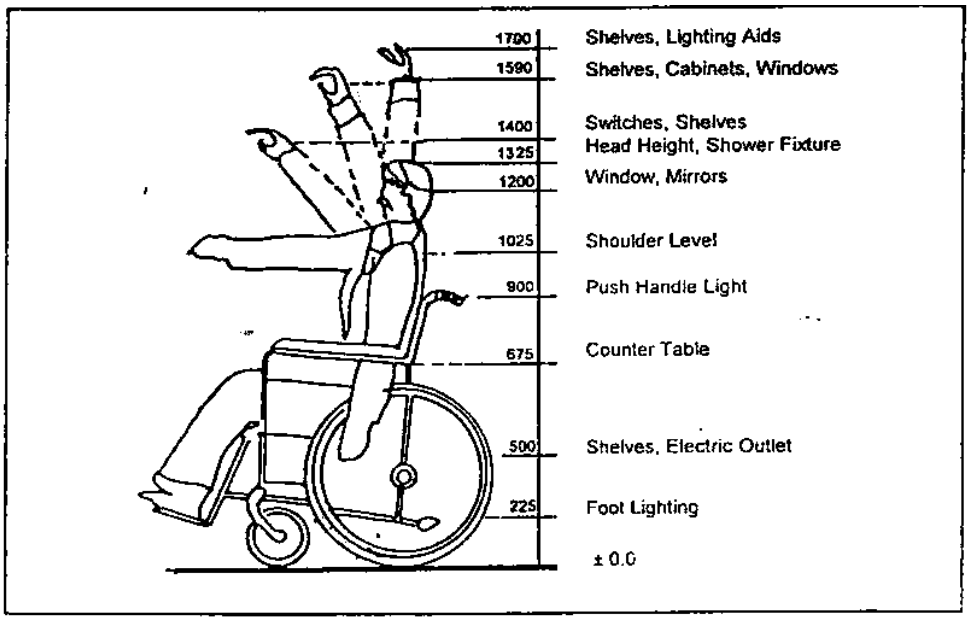


Figure V: Entrance and Exit Door

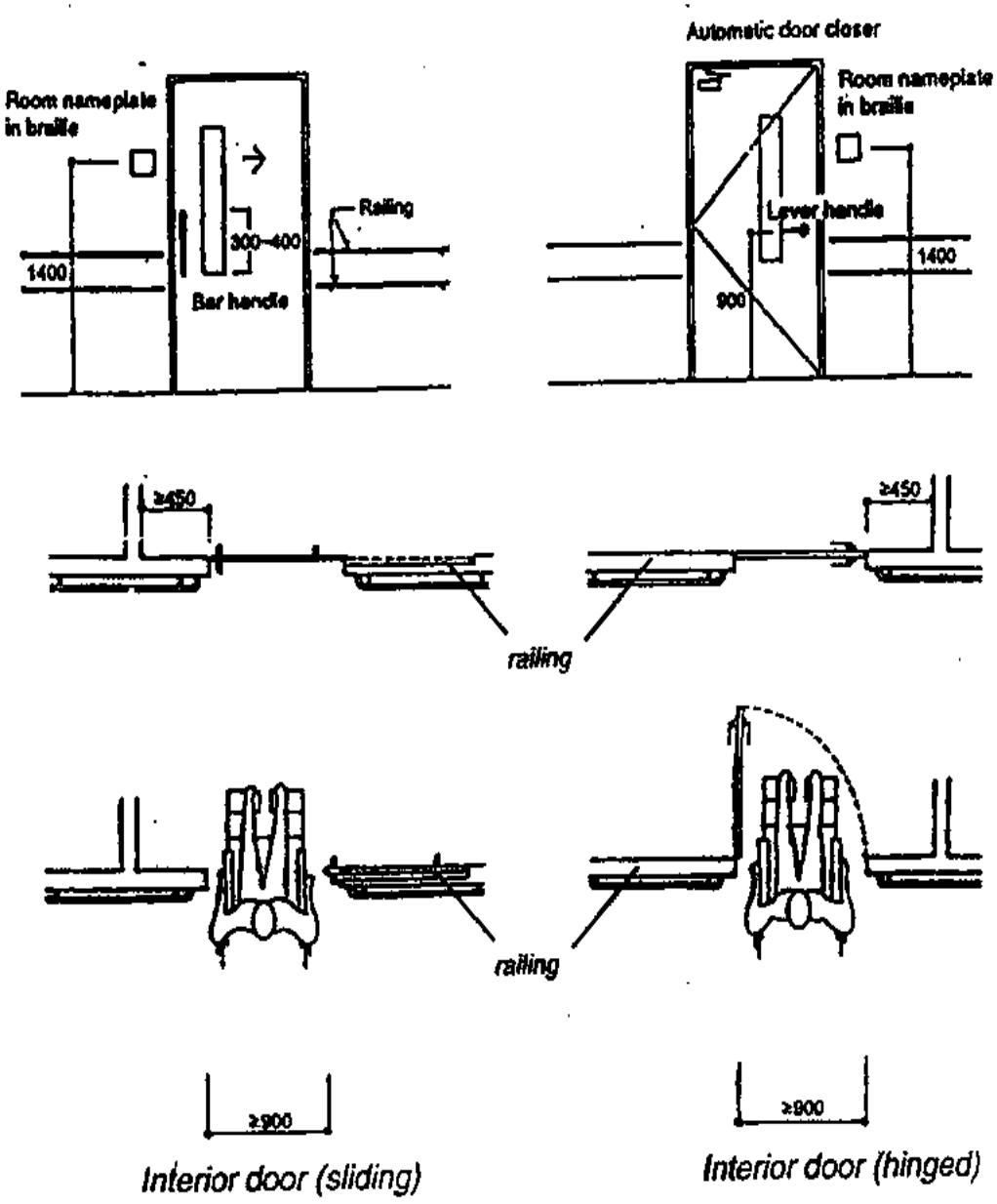


Figure – VI Passages and corridors

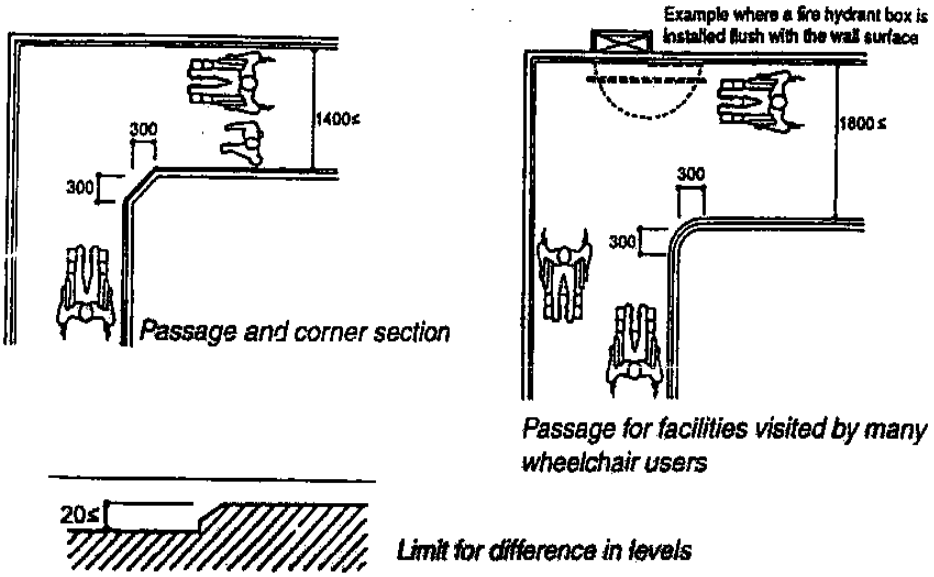
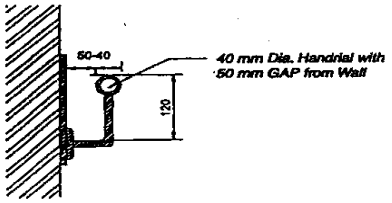
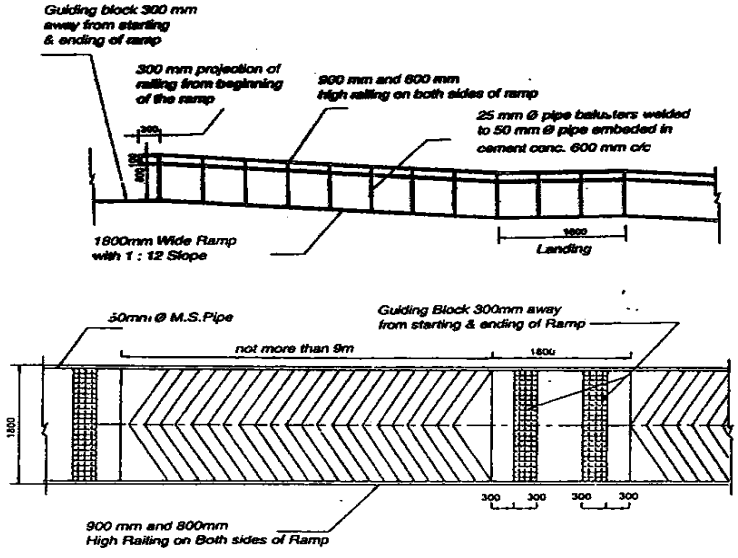


Figure – VII Ramp details



Fixing Detail of Handrail to the Wall



PLAN

Fig VIII - Toilet size

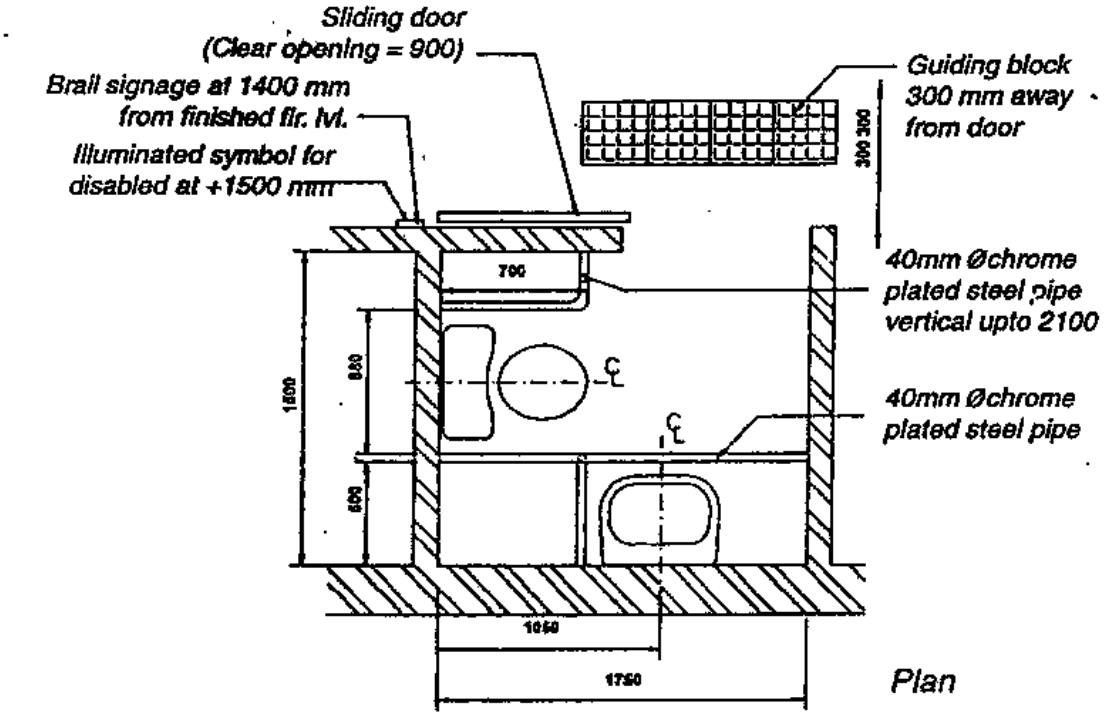
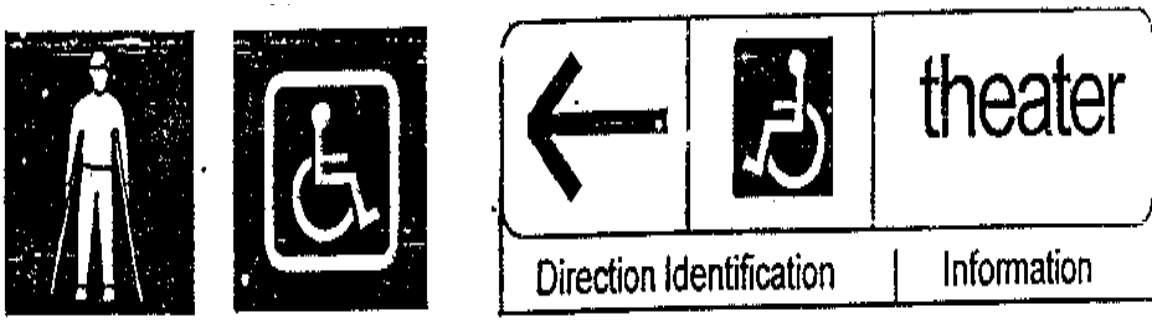


Fig IX Signage



4.15 BARRIERS AND RECONSTRUCTION

Design Requirements

Persons with by Sight Disabilities*:*

- Installation of information board in Braille.
- Installation of audible signages (announcements)
- Removal of any protruding objects and sufficient walking space for safe drinking water.
- For persons with limited vision use of contrasting color arrangements.

Persons with Hearing Disabilities:

- Provision of information board in an easily understandable manner.
- Provision of illuminated signages, layout diagrams to help the persons easily reach the desired place.

The Department of Tourism has been taking several steps for providing facilities to physically challenged persons. This issue was discussed in the Tourism Coordination Committee meeting and the hotels were advised to have some guidelines formulated so that accessibility to them by physically challenged becomes easier. Accordingly the Hotel Association of India have formulated guidelines for providing facilities to the physically challenged persons. Some of these guidelines can be borrowed for District Magistrate are as follows:

Parking and Approach Area

1. Exclusively earmarked and sign-posted and accessible parking spaces nearest to entrance.
2. Ramps at the main entry with handrails for the disabled sufficiently wide for movement of wheel chair. Anti-slip material to be used on the floor of the ramp.
3. If there is a revolving door at the entrance, adjacent singing door should provide 32" of clear width for entry.

Public Spaces

1. Provide at least one pay telephone not higher than 48" of the floor.
2. Accessible routes in public area to be free of protruding objects that could be dangerous to guests with visual impairments.
3. Fire and emergency alarms to have both visible and audible signals.
4. If a hotel has several dinning facilities it is necessary that, one multi-cuisine restaurant will have access for wheelchair (without change of floor level to negotiate). Tables should allow easy movements and approach by the customers in wheelchair.
5. Provision of one toilet in the lobby/public area similar to those in disabled-friendly guestrooms.

Lifts (W*herever Possible)*

1. A lift to provide 46" x 48" car platform for easy boarding of a wheelchair with doors of the elevator to provide 32" of clear opening.
2. Elevator call buttons to be located at 42" of floor level.
3. "UP" button on the top and "DOWN" on the bottom.
4. Elevator may be equipped with audio-announcement indicating number of the floor arrival for guests with vision impairment.
5. Provide hand bar on the two sides in the interior of lift.

Room

1. Door to guestroom to provide 32" width chair opening and 18" clearance on the pull side.
2. Room number on the door may be raised a Braille equivalents to the raised letter to be provided.
3. Key to the guestroom to be easily operable by one hand without tight gripping or twisting.
4. Door of the bathroom should be same as of entrance door.
5. Room should have adequate clearance for wheel chair to negotiate round the beds. Mirror and other facilities such as writing desk. Lights etc. easily accessible from sitting in wheel chair.

Bathroom

1. A person confined in wheelchair must have an external shower facility to enable him to maneuver backwards under the shower and taps accessible. Ideally a certain should be provided on a rail that can be pushed around the bath chair.
2. W.C. Pan seat should be lower than the normal for easy sliding from wheelchair. Toilet seat should be 17""to 19""above floor. The floor level of the bedroom and the bathroom to be same. A disabled friendly hotel room shall have no split-level floor. Towels and toiletries etc. to be located at arms-length/appropriate height.
3. Faucet to be operable with closed fist i.e. by pressure of hand
4. Provision of grab bars alongside and behind toilet.

4.16 IMPLEMENTATION CHECKLIST

Questions	Possible solutions
Obstructions:	
Can all protruding objects within the path of travel be detected by a sightless person with a cane?	*Remove or block out protruding parts. *Place tactile markings in an area extending at least 0.60 m beyond the projection area of the obstruction.
Are all overhanging obstructions mounted at a minimum height of 2.00 m (1.95 m)?	*Construct a raised platform 0.10m high around the obstacle. *Place an object, easily detectable with a cane, on the ground or floor beneath low-mounted overhanging obstructions
Can all obstacles within the path of travel be easily identified by a person with partial sight?	Mark obstructions at eye level with contrasting colour marking strips at least 0.30 m long in a contrasting colour.
Signage	

*Are accessible spaces identified by the international symbol of accessibility?	Mark accessible spaces with the international symbol of accessibility.
Are there directional signs indicating the location of accessible facilities?	Provide directional signs.
Are maps, information panels and wall-mounted signs placed at a height between 0.90 m and 1.80 m.?	Adjust the height of signs mounted too high or too low.
Are signs clear, simple and easy to read?	Colour engraved texts Replace sign.
*Is the colour of signs clearly distinguishable?	Use contrasting colours.
Is the surface of the sign processed so as to prevent glare?	Provide a non-gloss surface.
Is the sign supplement by a text in embossed letters or in Braille available next to information signs?	Add a text in embossed letters or in Braille.
Is the lettering size proportional to the reading distance?	Change the lettering size.
Street Furniture	
*Does the location of street furniture obstruct the free passage of pedestrians?	Change the location of street furniture. Mark the location of street furniture with tactile marking.
Resting Facilities	
Are resting facilities provided at regular intervals?	Provide seating facilities at regular intervals between 100.00 m and 200.00m.
Is there an adjoining space for a wheelchair next to benches and public seats?	Rearrange the layout of seats to allow an adjoining space of at least 1.20 m.
Are public seats between 0.45 m and 0.50 m high?	Modify or replace seats and tables that are too low or too high

Are knee spaces at accessible tables at least 0.70 m high, 0.85 m wide and 0.60 m deep?	
Public Telephones Is there at least one telephone accessible to a wheelchair user? Is there at least one telephone equipped with hearing aids? Are the numerals on the telephone raised to allow identification by touch? Is the coin slot mounted at a maximum height of 1.20 m (1.40 m)? Are accessible facilities identified?	Enlarge or adjust one telephone booth. Install volume controls and induction loops. Install push buttons with raised numerals. Reduce the mounting height. Add signage.
Mailboxes Are mailbox slots mounted at a maximum height of 1.20 m (1.40 m)?	Modify the height of the letter slot
Water Fountains Are water fountain spouts mounted at an approximate height of 0.90 m? Are controls easy to operate with one closed fist?	Modify the height of high drinking fountains. Install a double-tiered fountain. Replace controls.
Pathways Is the pathway clear of obstructions? Is the path of travel free of steps or stairs? Is the path of travel easy to detect?	Mark obstructions with tactile marking. Provide an alternative accessible pathway Construct a ramp. Continue natural guidelines. Construct guide strips. Provide a tactile marking area of at least 0.90 m x 0.90 m at changes in the pathway direction Construct tactile marking to indicate the location of curb ramps, stairs, ramps and

	obstructions.
Is the pathway at least 0.90 m wide? *.	Widen the pathway Remove obstructions and landscape features that limit the pathway width.
*Is the surface, level, smooth and non-slip? *Does the pathway have a different colour and texture than the adjacent surfaces?	-Replace gravel paths with a surface of uniform texture. *Repair holes and uneven paving. *Apply textured rubber stick - on tiles to slippery paving.
*Are manholes placed outside the pedestrian path of travel?	*Relocate grating outside the path of travel.
*Is grating flush with the surface of the pathway?	*Make grating flush with the pathway surface.
*Are the grating openings narrow, not more than 13 mm?	*Replace gratings with wide opening patterns.
*Are the edges of raised pathways protected? *Are there barriers separating the pathway from planting areas, pools and other landscape features?	*Construct guards with a minimum height of 0.15 m.
*Are the plant varieties used obstructive to the pathway ? *Are the plant varieties used harmful? *Are the plant varieties used harmful to the surface of the pathway?	*Replace plant varieties. *Relocate plant varieties. *Clean pathway surface constantly. *Erect warning signs.
Curb Ramps *Are curb ramps provided to overcome differences in level between the road surface and pathway level at: * Pedestrian crossings? * Drop-off zones? * Accessible parking spaces? * Building entrances?	*Install curb ramps. *Slope narrow pavements to street level

. *Are curb ramps located at each corner of each street intersection? *Is every curb ramp faced by another curb ramp on the opposite side of the street? . *Are curb ramps easy to identify? *Are curb ramps placed outside the usual line of pedestrian flow? *Is the maximum slope of a curb ramp 1:12 (1:10)?	*Install curb ramps *Apply a coloured texture to the surface of the curb ramp. *Construct guide lines to direct pedestrians to the location of curb ramps.
Pedestrian Crossings *Is the road surface even and slip-resistant at pedestrian crossings? *Is the road surface at pedestrian crossings easy to identify? *Are pedestrian traffic lights installed? *Do traffic lights have both audible and visual signals? *Is the minimum time interval for crossing adapted to the slowest person? *Are push-buttons located at a maximum height of 1.20 m? *Do traffic islands have street-level pathways cut through them? *Is the minimum width of the cut 1.50 m?	*Widen pathway. *Add a small built-up curb ramp. *Redesign or replace steep, unsafe curb ramps. *Add a slip-resistant surface. *Mark the pedestrian crossing area on the road surface with coloured stripes. *Install traffic lights. *Provide both audible and visual traffic light signals. *Delay the crossing time interval. *Install push-buttons at a maximum height of 1.20 m. *Cut a level area, at least 1.50 m wide through traffic islands

Parking	
*Are there accessible parking facilities?	*Re-strip to obtain the required number of spaces.
*Is the number of accessible parking spaces sufficient?	*Combine two parking spaces to obtain one accessible space.
*Are the designated spaces wide enough?	*Combine three parking spaces to obtain two accessible spaces.
*Are accessible indoor parking spaces located closest to accessible elevators or lifts?	*Locate accessible parking spaces close to accessible elevators.
*Are accessible parking spaces within 50.00 m of building entrances?	*Construct accessible parking spaces close to the accessible entrance. *Provide a drop-off zone near the accessible entrance.
*Is the minimum height clearance in indoor parking 2.40 m?	*Modify the parking slab height. *Provide alternate outdoor provisions for disabled peoples' vans.
*Do curb ramps connect accessible parking spaces with side curbs?	*Construct curb ramps.
*If there is no curbs, can the parking space be differentiated from the pedestrian path?	*Provide a tactile marking at least 0.60 m wide to separate the pathway from the vehicular area. *Use pre-cast wheel stops. *Use bollards.
*Are accessible parking spaces marked by the international symbol of accessibility?	*Add signage
*Are there enforcement procedures to ensure that accessible parking spaces are not misused or used by non-disabled people?	
.	*Provide a drop-off area.
*Is there a 3.60 m wide drop-off area within 30.00 m of the accessible entrance?	*Provide a curb-ramp.

*If the drop-off area has a curb, is there a curb ramp leading to the pathway? *If the drop-off area has no curb, is there a warning to sightless people? *Is the drop-off area marked by signage? *Is there an accessible path of travel from the drop-off area to the main entrance?	*Provide a tactile marking at least 0.60 m wide to separate the pathway from the vehicular area. *Use pre-cast wheel stops. *Use bollards. *Add signage. *Provide an accessible route. *Use another entrance, accessible from the drop-off area.
Ramps *Is there a complementary ramped route next to stairs or steps? *Is the ramp slope no greater than 1:20? *Do steeper ramps comply with requirements? *Is there a landing of at least 1.20 m length, at 10.00 m intervals, at every change in direction and at the top and bottom of every ramp? *Are ramps with a rise of 0.45 m or more protected on both sides? *Are wide ramps(more than 3.00 m) provided with an intermediate handrail? *Add an intermediate handrail where necessary. *Is the width of the ramp at least 0.90 m? . *Is the surface of ramps non-slip? *Is the ramp surface clear of obstructions?	*Construct a ramp. *Redesign or relocate ramp. *Lengthen ramp to reduce slope. *Remodel or relocate the ramp. *Add railings. *Widen the ramp *Add non-slip surface material. *Remove obstructions. *Construct coloured tactile marking strips at least 0.60 m wide at the top and bottom of the landing and at every

*Is the location of the ramp clearly identifiable	change of direction.
Elevators *Is there an accessible path leading to the elevator? *Are all levels generally used by the public accessible? *Are the minimum internal dimensions of a residential elevator cab no less than 1.00 m x 1.30 m.(0.95 m x 1.25 m)? *Is the clear door opening no less than 0.80 m (0.75 m)? *Is the elevator cab provided with handrails on three sides? . *Are the handrails mounted at a height between 0.80 m and 0.85 m? *Is the maximum tolerance for stop precision 20-mm? *Is the control panel mounted at a height between 0.90 m and 1.20 m (not exceeding 1.40 m)? *Are control buttons large and provided with embossed numerals? *Are lobby call buttons placed at a height between 0.90 m and 1.20 m (not exceeding 1.40 m)? *Is the elevator provided with audible and visual warning signals indicating arrival at a floor?	*Add a ramp or a platform lift if stairs exist. *Enlarge the elevator dimensions. *Install a new cab. *Enlarge the door opening. *Install new doors. *Install handrails *Modify height of handrails. *Adjust the stop precision. *Modify the height of control panels. *Change control panel. *Install tactile or Braille numerals next to buttons. *Adjust the position of call buttons. *Add bells and flashing light signals. *Change finish.

*Is the finish of the elevator cab non skid-resistant?	*Change the colour of the elevator door frame.
*Is the elevator door easy to identify?	*Replace the communication system.
*Is the emergency intercom usable without voice communication?	*Add simple tactile instructions.
*Are there tactile or Braille instructions for the communication system?	*Install devices to delay the motion of the door.
*Is the door opening/closing interval long enough?	*Install tactile signs at an approximate height of 1.40 m from the floor to identify the floor number.
*Is there a sign on the jamb of the elevator door identifying the floor number in raised or Braille letters?	
Platform Lifts	
*Can the lift be used without assistance?	*Post clear instructions for use of the lift at each stopping level. *Provide a call button.
*When vertical movement platform lifts are installed, is the maximum level change 2.50 m?	*Replace the special platform lift with an elevator.
*Is the lift placed within a closed structure for level changes of 1.20 m or more?	*Place the lift within an enclosed structure
*Where inclined movement platform lifts are installed, is the minimum width of the stairs 0.90 m?	*Widen the stairs.
*Is the minimum lift size 0.90 m x 1.20 m?	*Replace the lift.
*Are controls placed at a height not exceeding 1.20 m (1.40 m)?	*Lower the controls.
Stairs	
*Is the minimum width of the stairs 0.90 m? .	*Widen the stairs
*Is an intermediate handrail installed	*Install an intermediate handrail, where

for stairs 3.00 m wide or more?	necessary.
*Is there an intermediate landing with a length no less than 1.20 m, when the stairs cover a difference in level of more than 2.50 m?	*Remodel the stairs.
*Is the landing length at the top and at bottom of the stairs no less than 1.20 m?	*Enlarge the landing space.
*Do stairs have flush or rounded nosing?	*Remodel nosing. *Add slip-resistant strips to nosing.
*Do treads have a non-slip surface?	*Change finish material.
*Is the location of the stairs clearly identifiable?	*Construct coloured tactile marking strips at least 0.60 m wide, at the top and bottom of the stairs and intermediate landings of each stairs. *Identify emergency stairs with signage.
Railings and Handrails	
*Are safety guards or railings installed around all hazardous areas and raised platforms more than 0.40 m high?	*Install safety guards or railings *Change railing
*Is the spacing between the vertical and horizontal elements of railing around dangerous areas narrow?	*Change handrails.
*Are handrails mounted at a height between 0.85 m and 0.90 m?	*Reinforce the fixtures.
*Are handrails easy to grip?	*Add or replace railings.
*Are railings securely attached?	
*Do handrails extend horizontally between 0.30 m and 0.45 m at the top and bottom of every staircase or ramp?	*Continue or replace handrails.
*Are handrails continuous throughout the full length of ramps and stairs?	*Install railings.
*Are handrails continuous	

throughout the landing of ramps and stairs except when interrupted by doorways? *Are low positioned windows at landings protected by railings? *Is the space between the handrail and the wall no less than 40 mm for smooth walls, and 60 mm for rough textured walls? *For fully recessed handrails, is the distance between the top of the rail and the top of the recess no less than 0.15 m? *Are handrails easy to identify?	*Adjust the location of the handrail. *Paint the handrail in a contrasting colour. *Provide a tactile strip indication for emergency stairs.

MODULE VII

ACTS AND POLICIES

Disasters are part of a national system. In the context it is important to know the rights of each group of people. In this section, discussion has been made on the rights of disabled as provided by the UN and Indian context.

4.17 INTERNATIONAL CONVENTIONS

The Plan of Action for the International Year of Disabled Persons, adopted at the UNGA 34th session (1980) declares that 'Disabled persons should not be considered as a special group with needs different from the community, but as ordinary citizens with special difficulties in getting their ordinary human needs fulfilled.

The "Declaration of the Rights of Disabled Persons" adopted in 1975 states the rights of disabled persons to lead a self-reliant life just as their fellow citizens regardless of the kind of disabilities they have, the right to engage in gainful employment, the participation of disabled persons in social life, and the prohibition of discrimination (including discrimination in living conditions and treatment in facilitates) and violence against them. These concepts were radically different from the Japanese government policies at that time.
In 1982, the :"World Programme of Action Concerning Disabled Persons," designated as a guideline for achieving concrete results from the International Year was adopted.

In 1983, the UN Decade of Disabled Persons was proclaimed. These initiatives urged the governments to enhance their polices on promoting equalization of opportunities for the disabled.

The UN standard rules on the equalization of opportunities for PWDs

1. **Preconditions for equal participation**
   Rule 1- Awareness – raising
   States should take action to raise awareness in society about persons with disabilities their rights, their needs, their potential and their contribution.
   Rules 2- Medical Care
   States should ensure the provision of effective medical care to persons with disabilities.
   Rule 3: Rehabilitation

States should ensure the provision of rehabilitation services to persons with disabilities in order for them to reach and sustain their optimum level of independence and functioning.

Rule 4- Support services

States should ensure the development and supply of support services, including assistive devices for persons with disabilities, to assist them to increase their level of independence in their daily living and to exercise their rights.

2. Target Areas for Equal Participation

This part of the standard rules sets out goals in various areas of life. Meeting these goals will help to ensure equal participation and equal rights for disabled people.

Rules 5- Accessibility

States should recognize the overall importance of accessibility in the process of equalization of opportunities in all spheres of society. For persons with disabilities of any kind, states should (A) introduce programmes of action to make the physical environment accessible. And (b) undertake measures to provide access to information and communication.

Rule -6- Education

States should recognize the principle of equal primary, secondary and tertiary educational opportunities for children, youth and adults with disabilities, in integrated settings. They should ensure that the education of persons with disabilities in an integral part of the education system.

Rule 7- Employment

States should recognize the principle that persons with disabilities must be empowered to exercise their human rights, particularly in the field of employment. In both rural and urban areas they must have equal opportunities for productive and gainful employment in the labour market.

Rule 8- Income maintenance and social security

States are responsible for the provision of social security and income maintenance for persons with disabilities.

Rule 9- Family life and person integrity

State should promote the full participation of persons with disabilities in family lie. They should promote their right to personal integrity and ensure that laws do not discriminate against persons with disabilities with respect to sexual relationships, marriage and parenthood.

Rule 10- Culture

States will ensure that person with disabilities are integrated into and can participate in cultural activities on an equal basis.

Rule-11 Recreation and sports

States will take measures to ensure that person s with disabilities have equal opportunities for recreation and sports.

Rules 12- Religion

States will encourage measures for equal participation by persons with disabilities in the religious life of their communities.

3. Implementation Measures

This section outlines ways in which the standard Rules can be carried out efficiently

Rule 13 Information and research

States assume the ultimate responsibility for the collection and dissemination of information on the living conditions of persons with disabilities and promote comprehensive research on all aspects, including obstacles that affect the lives of persons with disabilities.

Rule -14- Policy making and planning

States will ensure that disability aspects are included in all relevant policy making and national planning.

Rule -15- Legislation

States have the financial responsibility for national programmes and measures to create equal opportunities for persons with disabilities.

Rule 16- Economic Policies

State have the financial responsibility for national programmes and measures to create equal opportunities for persons with disabilities.

Rule 17- Coordination of the work

States are responsible for the establishment and strengthening of national cooperating committees, or similar bodies, to serve as a national focal point on disability matters.

Rule 18- Organisations of disabled people

States should recognize the right of organizations of persons with disabilities to represent persons with disabilities at national, regional and local levels.

Rule 19- Personnel training.

States are responsible for ensuring the adequate training of personnel, at all levels, involved in the planning and provision of programmes and services concerning disabled people.

Rule 20- National monitoring and evaluation of disability programmes in the implementation of the standard Rules.

States are responsible for the continuous monitoring and evaluation FO the implementation of national programmes and services concerning the equalization of opportunities for persons with disabilities.

Rules 21- technical and economic co-operation

States, both industrialized and developing, have the responsibility to cooperate in and take measures for the improvement of the living conditions of persons with disabilities in developing countries.

Rule 22- International cooperation.
States will participate actively in international cooperation concerning policies for the equalization of opportunities for persons with disabilities.

Sphere project on Humanitarian Charter and Minimum Standards in Disaster Response, launched in 1997 by a group of humanitarian NGOs and the Red Cross and Red Crescent movement, who framed a Humanitarian Charter and identified Minimum Standards to be attained in disaster assistance, in each of five key sectors (water supply and sanitation, nutrition, food aid, shelter and health services). Taken together, the Humanitarian Charter and the Minimum Standards contribute to an operational framework for accountability in disaster assistance efforts. The Humanitarian Charter, which is based on the principles and provisions of international humanitarian law, international human rights law, refugee law and the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief. The Charter describes the core principles that govern humanitarian action and reasserts the right of populations affected by disaster, whether natural or man-made (including armed conflict), to protection and assistance. It also reasserts the right of disaster-affected populations to life with dignity.

Common standard 1: participation
The disaster-affected population actively participates in the assessment, design, implementation, monitoring and evaluation of the assistance programme.

Common standard 2: initial assessment
Assessments provide an understanding of the disaster situation and a clear analysis of threats to life, dignity, health and livelihoods to determine, in consultation with the relevant authorities, whether an external response is required and, if so, the nature of the response.

Common standard 3: response
A humanitarian response is required in situations where the relevant authorities are unable and/or unwilling to respond to the protection and assistance needs of the population on the territory over which they have control, and when assessment and analysis indicate that these needs are unmet.

Common standard 4: targeting
Humanitarian assistance or services are provided equitably and impartially, based on the vulnerability and needs of individuals or groups affected by disaster.

Common standard 5: monitoring
The effectiveness of the programme in responding to problems is identified and changes in the broader context are continually monitored, with a view to improving the programme, or to phasing it out as required.

Common standard 6: evaluation
There is a systematic and impartial examination of humanitarian action, intended to draw lessons to improve practice and policy and to enhance accountability.

Common standard 7: aid worker competencies and responsibilities
Aid workers possess appropriate qualifications, attitudes and experience to plan and effectively implement appropriate programmes.

Common standard 8: supervision, management and support of personnel
Aid workers receive supervision and support to ensure effective implementation of the humanitarian assistance programme.

4.18 INDIAN LAWS

4.19 PERSONS WITH DISABILITY (EQUAL OPPORTUNITIES, PROTECTIONS OF RIGHTS & FULL PARTICIPATION) ACT, 1995

The persons with Disabilities (equal Opportunities, Equal Opportunities, Protections of Rights & Full Participation) Act, 1995 has come into enforcement on February 7, 1996. This law is an important landmark and is a significant step in the direction to ensure equal opportunities for people with disabilities and their full participation in the nation building. The Act provides for both preventive and promotional aspects of rehabilitation like education, employment and vocational training, reservation, research and manpower development, creation of barrier free environment, rehabilitation of persons with disability, unemployment allowance for the disabled, special insurance scheme for the disabled employees and establishment of homes for persons with sever disability etc.

- Main Provisions of the Act
- Prevention and Early Detection of Disabilities
- Education
- Employment
- Non-Discrimination
- Research & Manpower
- Affirmative Action
- Social Security
- Grievance Redressal

Prevention and Early Detection of Disabilities

- Survey, Investigations and Research shall be conducted to ascertain the cause of occurrence of disabilities.
- Various measures shall be taken to prevent disabilities. Staff at the Primary Health Centre shall be trained to assist in this work.
- All the children shall be screened once in a year of identifying "at risk" cases.
- Awareness campaigns shall be launched and sponsored to disseminate information.
- Measures shall be taken for pre-natal care of the mother and child.

Right to Free Education

- Every child with disability shall have the rights to free education till the age of 18 years in integrated schools or special schools.
- Appropriate transportation, removal of architectural barriers and restructuring of curriculum and modifications in the examination system shall be ensured for the benefit of children with disabilities.
- Children with disabilities shall have the right to free books, scholarship, uniform and other learning material.
- Special schools for children with disabilities shall be equipped with vocational training facilities.
- Non-formal education shall be promoted for children with disabilities.
- Teacher Training Institutes shall be established to develop requisite manpower.
- Parents may move to appropriate for the redressal of grievances regarding the placement of their children with disabilities.

Employment

- 3% of vacancies in government employment shall be reserved for people with disabilities, 1% each for persons suffering from:
  - Blindness or Low Vision
  - Hearing Impairment
  - Locomotor Disability & Cerebral Palsy
- Suitable schemes shall be formulated for
  - The training and welfare of persons with disabilities
  - The relaxation of upper age limit
  - Regulating the employment
  - Health and safety measures and creation of non-handicapping environment in places where persons with disabilities are employed.
- Government Educational Institute and other educational institutes receiving grant for Government shall reserve at least 3% seats for people with disabilities.

- All poverty alleviation schemes shall reserve at least 3% for the benefit of people with disabilities
- No employee can be asked or demoted if they become disabled during service, although they can be moved to another post with the same pay and condition. No promotion can be denied because of impairment.

Affirmative Action

- Aids and appliances shall be made available to people with disabilities.
- Allotment of land shall be made at concessional rates of the people with disabilities for

  House
  Business
  Special Recreational centres
  Special Schools
  Research Schools
  Factories by Entrepreneurs with Disability

Non Discrimination

- Public buildings, rail compartments, buses, ships and air-crafts will be designed to give easy access to disabled people.
- In all public places and in waiting rooms, toilets shall be wheel chair accessible. Braille and sound symbols are also to be provided in lifts.
- All the places of public utility shall be made barrier free by providing ramps.

Research and Manpower Development

- Research in the following areas shall be sponsored and promoted:
  Prevention of Disability
  Rehabilitation including CBR
  Development of Assistive Devices
  Job identification
  On site Modifications of Offices and Factories.
- Financial assistance shall be made available to the universities, other institutions of higher learning, professional bodies and non-government research-units or institutions, for undertaking research for special education, rehabilitation and manpower development.

Social Security

- Financial assistance to non-government organizations for rehabilitation of persons with disabilities.
- Insurance coverage for the benefit of the government employees with disabilities.

- Unemployment allowance to people with disabilities registered with the special Employment exchange for more than a year and who could not be placed in any gainful occupation.

Grievance Redressal

- In case of violation of rights as prescribed in that act, people with disabilities may move an application to:
- Chief Commissioner for Persons with Disabilities in the Centre
- Commissioner for Persons with Disabilities in the State.

Address of the Chief Commissioner:

Office of the Chief Commissioner for Persons with Disability
C/o Govt. of India
M/o Social Justice & empowerment
G-31, sector-39, NOIDA (U.P)
Telephone No. 914500282
Website: www.nic.in/ccdisabilities

Functions of the Chief Commissioner:

The Chief Commissioner shall-

(a) Coordinate the work of the Commissioners.
(b) Monitor the utilization of funds disbursed by the Central Government.
(c) Take steps to safeguard the rights and facilities made available to persons with disabilities.
(d) Submit reports to the Central Government on the implementation of the Act at such intervals as that Government may prescribe.

Without prejudice to the provision of section 58 the Chief Commissioner may of his own motion or on the application of any aggrieved person or otherwise look into complaints with respect to matters relating to

- Deprivation of rights of persons with disabilities.
- 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.

National Trust for the welfare of persons with autism, cerebral palsy, mental rehabilitation and multiple disabled

The National Trust has come into being with effect from 31.12.1999 by an Act of Parliament. The Trust is a statuary body and primarily seeks to uphold the rights, safeguard the interests and promote the development of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disability and their families. Towards this goal, the National Trust has formulated programmes that promote independence, facilitate guardianship

where necessary and address the concerns of these special persons who do not have their family support. The Trust inter alia also protects the interests of the persons in the four above mentioned categories even after the death of their parents of guardians. The Trust is empowered to receive grants, donations, benefactions, bequests and transfers.

The Trust has launched an umbrella scheme named "Reach and Relief Scheme for the Welfare of Persons wit Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities." The scheme provides the following:-

(a) Long-term/Permanent Stay institution
(b) Day Care/Respite Centre
    (i) Augmentation of home visits care giving.
    (ii) Training of care givers.

National Trust has also set up information centres in different states and is creating awareness generation. It has translated the Act into different languages and has developed material on prevention of these disabilities and rehabilitation of these categories of disabled persons in general languages.

The National Trust already has a corpus of Rs.99 Crores and uses income earned from this corpus to fund its activities. They have set up more that 250 Local Level Communities at the district level and set up 12 information centres in different states. They have also registered voluntary organizations working for persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities.

Contact for information:
The Chief Executive Officer, National Trust, IPH Complex,
4, Vishnu Digamber Marg, New Delhi-1110002.
Tel: 3217411-13
Fax- 321 471
Email: nationaltrust@ren02.nic.in

The Mental Health Act, 1987:

Under the Mental Health Act, 1987 mentally ill persons are entitled to the following rights:

1. A right to be admitted, treated and taken care of in Psychiatric hospital or Psychiatric nursing home or convalescent home established or maintained by the Government or any other person for the treatment and care of mentally ill persons (other than general hospitals or nursing homes of the government).

2. Even mentally ill persons and minors have a right of treatment in Psychiatric hospital or Psychiatric nursing homes of the government.

Under the Mental Health Act, 1987 mentally ill persons are entitled to not only be submitted, treated and taken care of in Psychiatric hospital or Psychiatric nursing home or convalescent home established or maintained by the Government or any other person for the treatment and care of mentally ill persons (other than general hospitals or nursing homes of the government) but also to live with dignity.

The police have an obligation to take into prospective custody a wandering or neglected mentally ill person and inform his/her relative and have to produce such person before the local magistrate for grant of reception orders.

3. Minors who are under the age of 16 years, those persons who are addicted to alcohol or other drugs which lead to behavioral changes and those convicted of any offences are entitled to admission, treatment and care in separate Psychiatric hospitals or nursing homes established or mentioned by the Government.
4. Mentally ill persons have the right to have regulated, directed and co-ordinated mental health services from the government which through the Central Authority and the State authorities set up under the Act have the responsibility of such regulation and issues of licenses for establishing and maintaining Psychiatric hospitals and nursing homes.
5. Treatment at Government hospitals and nursing homes mentioned above can be had either as in patient or as out-patients.
6. Mentally ill persons can seek voluntary admission in such hospitals or nursing homes and minors can seek administration through their guardians. Administration can be sought for by relatives of mentally ill persons on behalf of the latter. Applications can also be made to the local magistrate for grant of reception orders.
7. The police have an obligation to take into protective custody a wandering or neglected mentally ill person and inform his/her relative and have to produce such person before the local magistrate for grant of reception orders.
8. Mentally ill persons have the right to be discharged when cured and entitled to ‘leave’ in accordance with the provisions in the Act.
9. Where mentally ill persons own properties including land which they cannot themselves manage, the District Court upon application has to protect and secure the management of such properties by the entrusting the same to a Court of Wards, by appointing guardians of such mentally ill persons or appointment of managers of such property.

10. The costs of maintenance of mentally ill persons detained as in-patient in any Government concerned unless such costs have been agreed to be borne by the relative or other person on behalf of the mentally ill person and no provision for such maintenance has been made by the order of the District Court. Such costs can also be born out of the estate of the mentally ill person.
11. Mentally ill persons undergoing treatment shall not be subjected to any indignity (whether physical or mental) or cruelty. Nor can such mentally ill person be used for purposes of research except for his/her diagnosis or treatment or with his/her consent.
12. Mentally ill persons who are entitled to any pay, pension, gratuity or any allowance from the government (such as Government servants who become mentally ill during their tenure) are not to be denied such payments. The person who is in-charge of such mentally person or his/her dependants will receive such payments after the Magistrate has certified the same.
13. A mentally ill person shall be entitled to the services of a legal practitioner by order of the Magistrate of District Court if he/she has no means to engage a legal practitioner or his/her circumstances so warrant in respect of proceedings under the Act.

The Rehabilitation Council of India Act, 1992.

1. To have the right to be served by trained and qualified Rehabilitation professionals whose names are borne on the Register maintained by the Council.
2. To have the guarantee of maintenance of minimum standards of education required for recognition of rehabilitation qualification by Universities or institutions in India.
3. To have the guarantee of maintenance of minimum standards of professionals conduct and etiquette by rehabilitation professionals against the penalty of disciplinary action and removal from the Registrar of the Council.
4. To have the guarantee of regulation of the profession of rehabilitation professionals by as statutory council under the control of the Central Government and within the bounds prescribed by the statute.

4.20 ORISSA RELIEF CODE 1996

In every disaster the relief code has become an important component. This section attempts to look at the Relief Code of Orissa in relation to the Disabled.

Relief Measures

As soon as major natural calamity access and particular area is declared by the Government to be distress or affected the following measures may be

under taken subject to the director of the Board of Revenue/Special Relief Commissioner.

a. Labour intensive work including relief work.
b. Gratuitous relief.
c. Nutritious supplementary feeding programmes.
d. Relief measures by non- official organizations.
e. Care of orphans and destitute
f. Strengthening of public distribution system (PDS)
g. Health measures and veterans measures.
h. Agricultural measures including credit supply.
i. Special relief to weavers and artisans.
j. Arrangement of foodstuff and stocking of food grains.
k. Provision for drinking water.
l. Provision for immediate irrigation facilities.
m. Remission & suspension of collection of Land Revenue & Loans
n. Grant of educational concession.
o. Inquiry into starvation and prompt action on such report,
p. Action in press report.

Additional Building Grant
According to ORC 1996

- On receipt of the disaster damage report from the collector, the Board of Revenue/Special Relief Commissioner initiates steps for allotment of funds for payment of house building grant.

  In relation to this it is recommended that the sanctioning authorities should allocate additional funds to disabled families to make their house barrier free putting slops, constructing best-suited latrines, signage etc.

- Accordingly to the relief code the assessment report regarding damages of houses has to be sent to Govt. through collector for sanction of fund.

  It is suggested that the collector and assessment official should ensure that completely collapsed, partially collapsed houses of PWDs are being indicated in damage assessment report, which would enable the grant sanctioning authorities to sanction additional fund for PWDs.

Warnings

- The Meteorological Department issues weather bulletin as routine.
- A system of two stage warnings has been introduced by the meteorological deptt. by which collectors of coastal districts are given warning of depression and cyclonic storms.

- The first warning is generally issued 48 hours before the commencement of bad weather and second about 24 hours.
- The people in the area are warned through the regional 'All India Radio Station' and 'Doordarshan' which are requested to broadcast and telecast special storm bulletins. These special weather bulletins are also supplied to the press for publication in the daily newspapers.
- The police wireless grid is another medium for dissemination. Temporary police wireless stations are installed in the vulnerable areas.
- The control room functions in the Revenue Department all around the year. Similar Control rooms normally functions all concerned officials including the office of collectors, Revenue Divisional Commissioners (RDCs) Board of Revenue and Special Relief Commissioners. The Control Rooms also communicates such warnings, soon after receipt to their subordinate officers by quickest means of communication.
- The collectors disseminates the warnings to the public, through sub-collectors, Tahasildars, Block Development Officers (BDO), Public Relation Officers, Chairman of Panchayat Samittees, Sarapanchs and other Government and non-government agencies in time.
- As far as possible, the local officers/TFC inform people through beat of drum or bangara or sirens or any other technically sophisticated warning system.

It is suggested that Doordarshan should telecast special news bulletins in sign language with pictorial/written clipping in local language for hearing impaired people. A videocassette on warning, regarding different disaster, should be prepared in consultation with Meteorological Department, NIHH, Mumbai, AICD, New Delhi, Doordarshan, CRC/SRC, and NIDM etc. The all centre of Doordarshan Kendra should keep preserve this cassettes safety for telecasting special bulletin during disaster situation. Few copies of the cassette should be provided to CRC/SRCs/NIDM, NIMH for onward transmission. The orientation-training programme should be organized for HH. Disaster warning and response system should be part of syllabus of special schools of deaf.

The field functionaries (Collector/Sub-collector, Tahasildar, BDO, PD DRDA, PRI (Local Government) and NGOs/CBOs) should ensure that warning in accessible format (audio, pictorial, large print and Braille has been discriminated to PWDs/their families on priority basis.

Emergency Relief

The government provides dry food, clothing, tarpaulin, kerosene, matchbox, temporary shelter and other articles of life necessities. These articles are generally transported to reachable areas by waterways, roadways, even Air dropping is also made under 'Emergency Relief".

The collector is competent to sanction emergency relief and can delegate the power of sanction to the sub- collator for a period of three days only. The RDC may extend the period of distribution of gratuities relief upto seven days. The member, Board of Revenue/SRC can extend it upto a period of 15 days inclusive of the period sanction by the sub-collector, the collector and the RDC.

Suggestion for Adhoc Gratuitous Relief:

- *Adhoc gratuitous relief for a very short period not exceeding in a fortnight can be sanctioned by collector to the people affected by natural calamity to avoid starvation, extreme hardship etc. as in the following cases: -*
- *Persons whose attendance on the sick or infant children is absolutely necessary.*
- *Able-bodied person but temporarily weak due to want of food malnutrition as result of illness.*
- *Besides above PWDs particularly sever/profound disabled or their families should be considered/included.*
- *Special needs of PWDs should be included.*

Gratuitous Relief on Cards:

Gratuitous relief on cards is sanctioned by government for a longer duration depending on the intensity of a natural calamity as conditions as may be prescribed.

This relief is ordinarily limited to where there has been crop loss of 50% or above and privates charities cannot cope up with the need.

Idiots and lunatics, cripples or invalid persons, blind persons children below 12 years helpless widows, all persons who due to advance age or physical infirmity are incapable of earning their living, except those who are getting old age pension, political pension or both social security benefits, all persons whose attendance on the sick or infant children absolutely necessary and able-bodies persons but temporary rendered weak due to want of malnutrition or a result of illness are eligible for the relief.

It is recommended that the PWDs and the person who are attendant of PWDs and absolutely necessary should be eligible for gratuitous relief on card.

Since Block is the administration unit and BDO is responsible for proper administration of the scheme under supervision of sub-collector so the BDO should include PWDs while preparing house/village/gram Panchayat wise list.

The location of gratuitous relief center varies from ½ km to 3 km. It is suggested that home delivery should be ensure to LH (QP, TP, wheelchair bound, bed redden, SCI etc) severe/profound categories of MR & totally blind people.

The relief cards should be issued to PWDs on priority basis in accessible format (TVH- Braille & Written, LV-Large print, HH/LH- written).

Apart from the above suggestions followings are the additional recommendations which may be taken into account during various relief and rescue operation in disaster situation.

Rescue

Locating severe/profound PWDs and identification of their relatives, villages, homes, workplace etc. becomes difficult task because of their limitation of vision, speech, hearing, mobility, mental impairment and psychiatric disabilities. Some PWDs may be more disoriented, confused and less access or no-access to immediate communication about evacuation process. VTFC, block and district level emergency responses managers should adopt well planed strategies to local PWDs and to ensure proper disaster relief services.VTFC should maintain a list of PWDs, comparing of brief information such as age type and extend of disability, mode of mobility and communication, special aid & appliances used etc.

Transporting PWDs

We should remember that PWDs vary in type and severity. They have residual ability and limitations too. The notion that, all PWDs are totally dependent and need to be rescued is a myth. Many PWDs are capable of assuming responsibility for their own evacuation and emergency power needs. On the other hand many PWDs needs support. Majority PWDs do not have specialized transport issues (VH, HH, LD having upper limbs deformities, Mild Moderate MR). So physical assessment of PWDs should be conducted to known their capabilities and limitations.

Transportation Issues:

There are some specific transportation issues, which may be faced by PWDs during disaster situation. Some main issues are:

i. Transportation routes, which PWDs were using and were oriented for using, may no longer be available, as pathways roadways gets damaged due to disaster.
ii. The PWDs who may have had accessible Vehicles/ Mobility aid (Tricycle, Wheelchair, and motorized tricycle) may no longer exist for use.
iii. Some categories of PWDs such as SCI/Multiple fractured case etc. can not use normal transport such as tractor, bullock carts unless they are being handled properly. Mishandling and improper transportation will be worsening disability.

- PWDs should be trained individually, with prior information and clear instructions when, where, how, they have to move.
- Some categories of PWDs such as serve/profound MR/CP/QP/PT cannot be trained. So parents/ member of VLTC should be trained along with clear information about shelter, food water medication, transportation etc.

In case people becomes disorientated or confused, unnecessary discussion should be minimized/avoided. The basic & urgent focus should be on the action to complete the task of safe & timely transfer of PWDs to safe and accessible places.

Training

To cater the need of the PWDs during disaster, it is essential to impart two type of training to volunteer and Govt. staff and people who will assume leadership role during disaster.

(i) General disability sensitivity training(GDST)
(ii) Disability specific training (DST)

In GDST the participants should be sensitized about disability related issues and role of volunteer, Govt staff and people who will assume leadership role. They may be oriented about categories of disability, causes, prevention, early identification, intervention, referral and limitations (mobility, vision, speech hearing, intellectual etc.) of PWDs.

DST training program should include common problems of various types of PWDs with a focus on hardships/ difficulties that PWDs may face (Warning, Evacuation, Rescue, Relief & Rehabilitation) in disaster situation. The training should include inclusive and exclusive resources at village, Gram Panchayat, Block, District and State level, more particularly exclusive Govt. schemes for PWDs and expert/exclusive institutes for PWDs and such PWDs can avail these schemes/resources. This information be given under six heads, as given below

i. Brief about the scheme/resource
ii. Who are eligible
iii. Documents require.
iv. How to apply
v. Whom to apply (Address, Phones, Fax, Email ID etc.
vi. Reference of Notification/ MO etc. of Govt.

The following people may be imparted GDST/DST training.

a. Sub Collector
b. Tahasildar /Revenue Inspector
c. BDOs
d. District Emergency Officer PD-DRDA
e. Police, Fire Personnel
f. Doctors/Auxiliary Nurses/Paramedical Staff
g. Emergency Officers
h. ICDS functionaries (AWW/Supervisor/CDPOs)
i. Members of SHGs
j. Youth organizations such as NCC, Scout Guide, NSS etc.
k. School Teachers.
l. PRI Members & Local Community Leaders
m. Priests/ Padaries/ Maulvies etc.
n. Village Level Workers (VLWOs)
o. NGOs/CBOs Workers
p. Volunteers
q. PWDs and their Parents/Guardians
r. Members of VLTC Committee

Warning Communication Bulletins

Persons with disabilities have inquire needs in disaster situation because of their visual, hearing, speech, intellectual limitations. Therefore it is essential that they receive information/warnings in accessible formats to act quickly, properly and minimize false exceptions. The common points which may be kept in mind by TFC/family members of PWDs for communicating warnings/information's in disaster situations are:

i. Warnings, information's should be simple, direct, realistic and accurate.
ii. The mode & format of the information must be accessible to the widest range of PWDs in the most direct and straight forward manner upto extent possible (auditorial, pictorial, visual).
iii. Bulletin disseminated by the emergency operation centes should include information about services and accessibility provision for PWDs.

Local agencies working for PWDs should be in touch with PWDs to share information provided by emergency centers.

VTFC should nominate one person specifically for PWDs who will co-ordinate information working system.

The agencies working for PWDs or community should share information about problems unmet need of PWDs and feasible solutions on disaster response.

Periodical training for PWDs on warning issues should be conducted, preferably disability wise.

PWDs may loose confidence may become uncooperative, furious disoriented in disaster & stressful situations because of lack of timely information clarifications, responses in accessible formats.

Orphans & Destitute Children with Disabilities (CWDs)

- In disaster (Cyclone, Tsunami, Tidal incidence, Earthquake etc.) many children with disabilties (CWDs) may become orphans or destitute. A census of such person should be undertaken under supervision of the collector.
- The disabled children have special needs and they need services of special teachers, professionals, therapist etc., the Block/District administration should utilize the service of the professional usually working in exclusive Govt./Non-Government institutes/Centers.
- Many CWDs especially illiterate HH, severe/profound categories of MRCs/CPCs, mentally ill children, cannot speak/express detail of their parents and address. Vide publicity should be made through available mode so their parents/guardians may know and can take them back to homes.
- A register along with photo of CWDs and their parents may be prepared well before the disaster. This register should be updated at regular interval. DSWO may be assigned this responsibility.
- If the parents or relatives cannot be traced, attempted should be made for their adoption or adaptation for support.
- Experiences shows that people who are willing to adopt CWDs are negligible so CWDs should be sent to those orphanages where facilities of education/training are located nearby. Totally blind, totally deaf, and MR CWDs should be sent to residential special school/ training centres.
- Severe and profound categories of MR/CP CWDs cannot attend their needs and they need life long support. The Government should create suitable facilities for such CWDs.

- A prioritized attempt should be made to chennalise orphan CWDs in appropriate vocations, earning activities to make them economically independent.
- The possibilities of rape and trafficking of disabled girl child are very high which need to be prevented.
- Request/ask your network to practice the plan at regular interval, which will help them feel more comfortable during an emergency.

MODULE VIII

PART: A PHYSICAL TRAUMA

This part analyses different methods of management of physical trauma in natural disasters by way of safe rescue, primary intervention at site and proper referral for further specific management so as to reduce mortality and long term permanent disability.

Definition:
Trauma is a state of condition caused by a physical or emotional shock for which the subject is unprepared.

Trauma in Natural Disasters

Natural disasters that cause physical trauma and mass casualties are Cyclones, Floods, Tsunamis, Earthquakes, and big Fires etc. The most common reasons for traumas in the above said disasters are –

1. House Collapse / Building Collapse
2. Fall from height in which a person has taken refuge
3. Jumping down from buildings that has caught fire
4. Drowning
5. Homeless, being in water and exposed to bites and stings.

Common Types of Injuries Occurring in Natural Disasters
The common types of injuries occurring in natural disasters are:

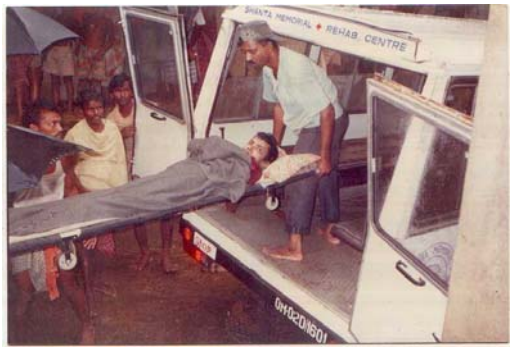
1) Head Injury
2) Chest Injury
3) Abdomen Injury
4) Pelvis Injury
5) Spinal Cord Injury
6) Limb Injury

7) Wounds & Bruises.

Factors to be considered in Rescue after a Disaster

- Recognition of injury
- Knowledge of what happens after injury
- Management at the site of injury
- Planning Evacuation
- Proper and fast referrals
- Prevention and reduction of complication and disabilities

Priority of Rescue and Evacuation



In a natural disaster with mass casualties the priorities of rescue, immediate management and proper referrals can be categorized according to the severity and urgency of medical attention.

Category-1. In cases of Loss of Consciousness, Absence of Breathing or Heartbeat.

Category-2. In cases of severe Head injury, Chest, Abdomen or Pelvis Injury.

Category-3. In cases of Multiple Fractures of limbs and Spinal Cord Injury.

Category-4. In cases of single limb fractures and small wounds & bruises.

CATEGORY-1.

- Life threatening situation
- Top most priority in rescue
- Immediate management measures like CPR to be undertaken
- as fast as possible
- Highest priority for transport to hospital / health center.

CATEGORY-2.

- Possible life threatening situation

- Should get priority in rescue
- Management measures and proper referrals as early as possible
- To be transported to hospital on a priority basis.

CATEGORY-3.
- Not immediate life threatening situation
- Priority in rescue after Category-1 & 2.
- Referral when situation is conducive for referrals.
- Immediate arrangement for intravenous fluids required.

CATEGORY-4
- Non life threatening situation
- Last priority in rescue
- Last to be transported to hospital if possible.
- Can be managed at the local site for 2 – 3 days.

The most common situations seen after injury are given below:

A. Loss of consciousness
B. Difficulty in Breathing
C. Shock due to defective or deficient circulation
D. Severe Bleeding
E. Fractures
F. Inability to move limbs / having no sensation in limbs.
G. Abdominal Injury / Pelvis Injury.
H. Combination of two or many of the above.

A. LOSS OF CONSCIOUSNESS:
- This usually takes place in Head Injuries, Cervical Spine Injuries, Chest injuries etc. and after Shock.
- Try to identify and recognize the cause of unconsciousness by examining for injuries in head, bleeding from nose and ear, cervical spine, chest or abdomen.
- If the person is not breathing give Artificial Respiration.

- If no heartbeat start Cardio-pulmonary Resuscitation.(CPR)
- Call for an ambulance or any other suitable vehicle.
- As a head injury may be associated with an injury to the cervical spine, look for tenderness / injury to the neck.
- If bleeding arrange for intravenous fluids and take measures for control of bleeding.
- If the person still does not recovers then the person must be taken to the nearest health center for emergency medical
- treatment.

Consequences of not taking appropriate and accurate care in cases of loss of consciousness:

- Loss of consciousness is a life-threatening situation commonly associated with obstruction to breathing and there is a high risk of mortality or death. If not resuscitated early may result in death.
- An unconscious person must be given first priority in rescue and also must be given priority in transportation to nearest health center.
- Prolonged lack of oxygen results in irreversible brain damage & permanent disability.

B. **DIFFICULTY IN BREATHING**:

- This usually takes place in multiple fractures of the rib, injuries to the chest
- If Pneumothorax (air entering into the chest) a drain has to be put into the chest
- Call for an ambulance or appropriate vehicle immediately.
- If associated with severe bleeding IV fluids have to be given.
- Requires priority in emergency transfer to hospitals
- Should get priority in treatment when arrived at a hospital.

Consequences:

- If not properly managed may result in death.

C. **SHOCK DUE TO DEFECTIVE OR DEFICIENT CIRCULATION**:

- Usually takes place in severe bleeding and fluid loss from the body after Abdomen injury, Pelvic injury, Chest injury or Multiple fractures
- All measures must be taken to control and prevent bleeding.
- Check if the person has passed urine. Passing adequate urine means he/she has good fluid balance in the body.
- IV fluids should be given to maintain and compensate for the fluid loss.

- Call for an ambulance or suitable vehicle and transport to hospital.
- Should be given priority when transported to health center.
- Will require urgent blood transfusion.

Consequences:

- If not managed early and properly may result in shock and death.
- If not managed early and properly may result in further damage to vital organs resulting in more complications.

D. SEVERE BLEEDING:

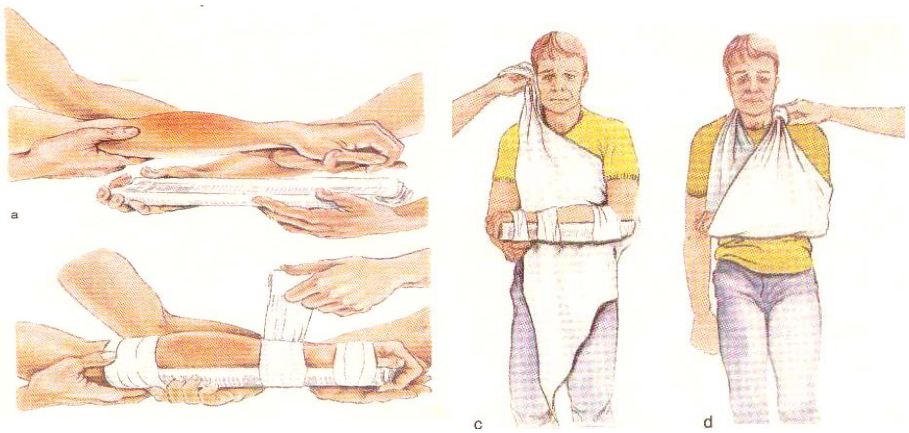
- These take places in all injuries were there are massive limb injuries, rupture of arteries, abdomen and pelvis injuries with damage to organs.
- All measures must be taken to control bleeding by way of dressings, pressure bandages and elevation.
- IV fluids must be given.
- Elevate the leg end of the bed
- The person can be transported to hospital when ambulance / help arrives.

Consequences

- If not identified and treated early may result in shock.
- May result in infections if not taken proper care in dressings and bandages.

E. FRACTURE: (Broken bones / Deformity of a limb)

- The first thing to do is not to move the fractured limb
- Reassure the person.
- Low priority for transfers in case of single long bone fracture.
- Multiple long bone fractures requires high priority in transfer to hospital / health center.
- Look for any wound, bruise or bleeding and treat it accord



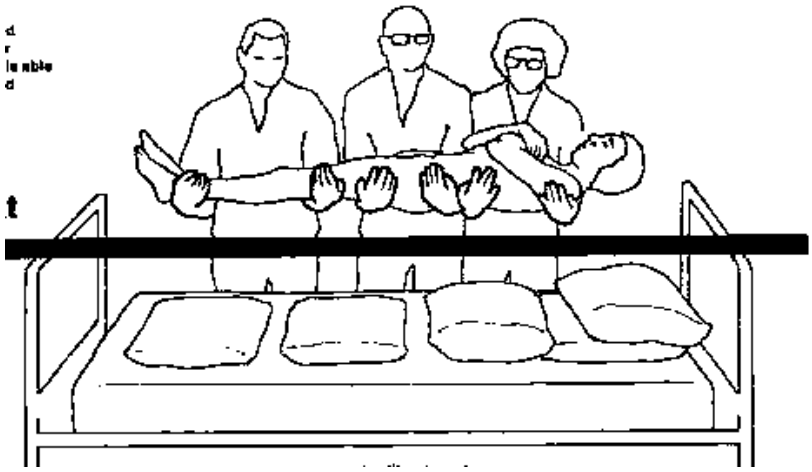
- Properly immobilize the affected limb by splinting. This helps in prevention of
  further bleeding from fracture ends.
- In multiple fractures the person can go into shock.
- Take the person to the nearest health center for intravenous fluid and splintage.

Consequences:

- If not treated and splinted early may result in shock, damage to muscles, vessels leading to gangrene.

F. INABILITY TO MOVE LIMBS / HAVING NO SENSATION IN LIMBS:

- Takes place when the spinal cord is injured after injury to the neck or back.
- The casualty will not be able to move his/her legs or both arms and legs and will have excruciating pain at the point of injury and below.
- He/She may not have sensation or control of Urine and Stool.
- Such persons must be rescued carefully with 3 or 4 people without any movement of the injured spine.



- If there is neck injury the neck has to be immobilized by collar or appropriate splint.
- For management of bladder a catheter has to be inserted.
- If person is breathing problems then low priority for transfer.
- Management of spinal cord injury can be initiated at the site.
- An ambulance or appropriate vehicle has to be brought which has the capability to transport a spinal cord injured person to an operation theatre or an acute care center.

Consequences

- If not taken proper care of the injured spine in rescue, lifting and transportation it can further damage the spine and result in long term permanent disability. In cervical spine injuries improper lifting may result in death.
- Correct knowledge of symptoms and accurate diagnosis at the site of injury helps in reducing disability and in some case mortality.

G. ABDOMINAL INJURY / PELVIS INJURY:

- See, feel and examine for signs of injury by loosening all clothing and checking the entire body.
- In chest injury there may be fracture of multiple ribs restricting breathing
- In abdominal injury there may be a fracture of the pelvis bone or damage to organs resulting in severe bleeding.
- In such cases the person must be given IV fluids.
- He/She must be transported to hospital as fast as possible.
- Do not move the person unnecessarily as movement at the fracture site increases bleeding.

Consequences

- Possible life threatening situation if not managed early.
- The person can go into shock due to bleeding / loss of fluid.

H. COMBINATION OF MANY OF THE ABOVE:

- People having two or more of the above injuries (in a natural disaster) is common and each has to be managed respectively in the prescribed manner and by prioritizing the most severe / life threatening injury first.

SPECIFIC CONDITONS OCCURING IN NATURAL DISASTERS

1) HEAD INJURY:

A fall from a height of 3 feet or more OR a fall of a heavy object on the head results in head in injury.

Diagnosis – Symptoms and Signs:

i. Visible bleeding of skull, forehead or face, Nose, Ear.
ii. Fracture of skull.
iii. There may be blood or fluid coming out of the ear.
iv. Occasionally there may be loss of memory or incoherent speech.
v. There may be blurring of vision
vi. There may be abnormal response to commands

Severity of head injury:

The following factors determine the severity of head injury in descending order.

I. Loss of consciousness and this may be associated with loss or difficulty in breathing and / or loss of heartbeat.
II. Conscious but with severe bleeding
III. Conscious, no bleeding or minimal bleeding but having blurring of vision and abnormal response to commands.

Rescue and Management:

- Priority of rescue in mass casualty of head injury depends upon the level of severity; an unconscious person requires immediate and emergency attention.
- Check for breathing and heartbeat and start artificial respiration or CPR if required.
- Initiate steps to control bleeding by way of dressing and bandages. This also helps to prevent the person from going into shock
- Call for an Ambulance
- If lot of blood or fluid is lost the person may be given IV fluids.
- Must be referred or taken to an intensive care center equipped to deal with life threatening head injury situations.

Consequences, Precautions and Prevention of Disabilities:

- Giving early and timely CPR prevents mortality
- Not taking measures to control bleeding will lead the patient to shock.
- Not giving appropriate medicines and medical treatment early will result in permanent damage to the brain which will in turn result in permanent disability or impairments in vision, hearing or movement of limbs.

2) SPINAL CORD INJURY:

Spinal Injury is essentially damage to the spinal cord, which is enclosed in the vertebrae or the backbone and may cause paralysis of either hands & legs or both the legs.

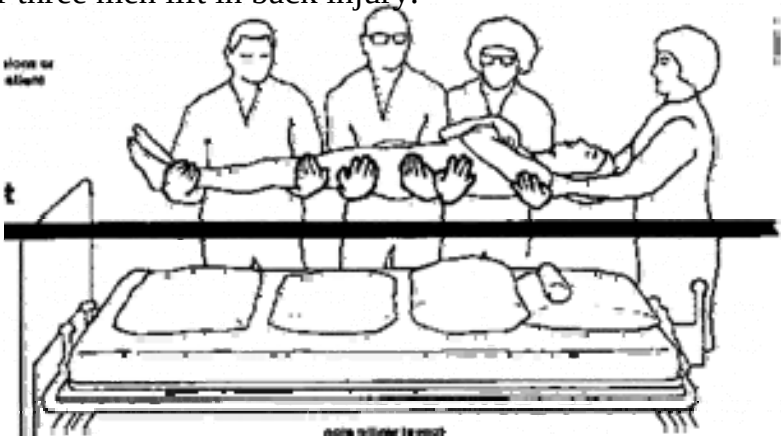
Diagnosis – Symptoms and Signs:

- Person may complain of excruciating pain in the neck or back.

- There may be tenderness and visible wounds in the spine at the area of injury.
- The person may lose sensation of limbs.
- He/She may have tingling sensation in the limbs
- Hands and legs may feel heavy or stiff
- The person may not feel or have no control of urine or stool.

Rescue and Management:

- Always suspect cervical spine injury when there is severe facial injuries
- Ask about movement and feeling in arms and legs.
- Make sure that the patient does not move and ensure that they do not nod their head when responding to questions.
- Lift to stretcher by a four-man lift in case of a cervical spine injury or three men lift in back injury.



- Support neck with collar or splint.
- Person should be taken / referred to spinal care unit in appropriate ambulance.
- If not able to transfer it is safer to manage on site.
- Check whether the person is able to pass urine by himself.
- A catheter has to be inserted for bladder management if no control or
  sensation of urine.

Consequences, Precautions and Prevention of Disabilities:

- A spinal cord injured person's spine should not be moved as this aggravates and further damages the spinal cord.
- All lifting, turning and transporting a spinal injured person must be carried out in the specified manner to avoid further damage to the spine and future permanent disabilities.
- Spinal cord injury may result in permanent paralysis of the hands & legs OR at legs only.

3) FRACTURES:

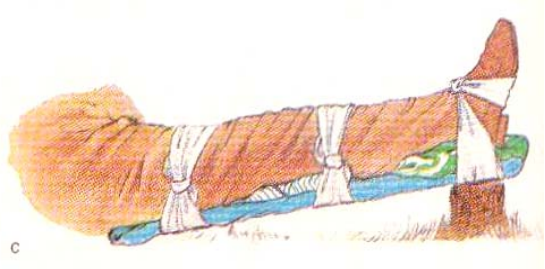
A broken or a cracked bone is considered as a Fracture.

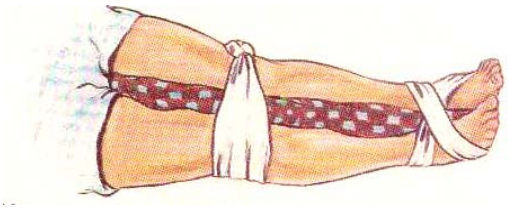
Diagnosis – Signs and Symptoms:

- You can make out the fracture by feeling the limbs.
- Person will complain of severe pain of the injured area.
- The injured area may appear deformed and in some cases the broken bone may protrude out of the skin.
- Person will experience difficulty in moving, along with tenderness and swelling in the injured area.

Rescue and Management:

- Take care not to move the fracture part in rescue and lifting.
- If bleeding take measures to stop bleeding by use of pressure bandages and dressings.
- The casualty should be treated in the position he/she is in.
- Immobilize the injured part to the sound part of the body or by strapping it to a wooden slab.





Seek medical care

Consequences, Precautions and Prevention of Disabilities:

- If not splinted properly and immobilized may result in further bleeding
- Inadequate treatment can cause vascular impairment and may cause gangrene.

4) DROWNING:

Drowning is described as inhaling water into the lungs and the closing of the airway due to spasms induced by the water.

Diagnosis – Signs and Symptoms:

- The person will have pale, cool skin and possibly blue lips.
- Respiration may be absent.
- The person may have a weak or absent pulse and may even be unconscious.
- The person's temperature will be below normal.

Rescue and Management:

- Check for breathing and heartbeat of the person.
- Check whether the airway is clear from water or any other obstruction.
- If necessary begin artificial respiration or cardio-pulmonary resuscitation(CPR).
- Keep the person warm by covering with bed sheet or blankets so as to increase the body temperature.
- If the person does not recover by CPR he/she must be taken to hospital for further treatment while continuing the CPR during transportation to hospital

Consequences & Precautions:

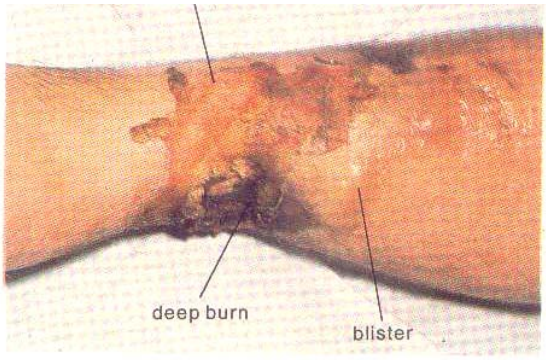
- Do not attempt to save some one in water if it means putting yourself in danger.
- If CPR is not started early may result in death.
- CPR is tiring and help must be asked when required.

5) BURNS:

A burn is damage to the tissues caused by excess heat, chemical agents, electricity etc.

Diagnosis – Signs and Symptoms:

- Injured area becoming red, swollen and blistered.
- Damage to the superficial or sometimes deep layers of the skin resulting in resulting in oozing of fluid from the tissues.



- Severe pain and irritation.
- Asphyxia
- Irritation of the respiratory tract and eyes from smoke and chemical burns.

Rescue and Management:

- DO NOT try to rescue a person if it means putting your life in danger.
- Call the fire department
- Ask all people to stay away from the vicinity or outer perimeter of the fire.
- Remove / wet all combustible materials from near the fire to prevent the fire from spreading.
- Remove the casualty from danger.
- Remove hot or burnt clothing.
- In severe burns person will need IV fluids.
- If burns seen on the chest, abdomen or head immediately make arrangements to take the person to hospital having facility to treat patients with burn injuries.
- If other burns hold burnt area under cold running water until the temperature of the part has returned to normal.

Consequences & Precautions:

- DO NOT apply any lotion, ointment or oily dressings
- DO NOT pinch or break blisters, this increases risk of infection and delays healing.
- If casualty is thirsty give small amounts of water or milk.
- If not taken proper care after burn it may result in infections and also may result in contracture thus accounting for various disabilities.
- After acute care the person should be rehabilitated for prevention of contracture and improvement of range of motion.

PART: B PSYCHOLOGICAL CARE

"Disasters are first and foremost a major threat to development, and specifically to the development of the poorest and marginalized people of world. Disaster seeks out the poor and ensures that they are poor"

DIDIER CHERPITEL
Secretary General of the International Federation of Red Cross and Red Crescent Societies.

Sometimes disasters knock before they come (drought, cyclone), sometimes they don't (earthquakes, tsunamis, floods, tropical cyclones, cloud burst etc.). disasters do not discriminate between unequals. If we are adequately prepared, the hazards do not becomes disasters.

Disaster leaves a deep scar on the lives of the affected people. It has a deep adverse impact on various segments of life of the survivors. Besides physical, social and economic, disaster disturbs the psychological equation of survivors. Psycho-traumatic experiences cause stress, grief, guilt, elation, restlessness which is often beyond the coping capacity of people both disabled or non-disabled.

The survivors do experience a wide range of distressing emotional reactions which are normal reactions to abnormal situation. It is a common and natural phenomenon that if psycho-traumatic conditions are severe the stress both physical and psychological, will be more severe on the survivors. It is well-established fact worldwide that if proper psychological intervention at right time takes place the impact of disaster can be reduced up to a great extent. Thus early psychosocial intervention and proper psychological care for fast recovery of psychological implications/problems becomes an important component of the comprehensive and holistic care.

Types of Psychological trauma :

Disaster creates two types of traumas :

Individual Trauma :

It manifests in stress, grief reactions, fear, anxiety, guilt, depressions, excessive crying.

Collective Trauma :

Social ties with in community provides effective and meaningful psychological support in stressful situation, when these social ties breake down the survivor visualise vacuum and seeks to rebuild linkages between individual and groups. Majority of the population pull together and work together during the aftermath of a disaster but their effectiveness is diminished.

Need of psychological intervention:

Psychological problems touch upon many facets of human experience. They are not limited to the experience of a handful of people, but rather they are part of the life of every survivor of disaster. Not only is the individual with the problem deeply troubled; the family is disturbed, the community is moved, and society is affected. The degree of impact depends in part on the nature of the problem and in part on dynamics of psychological care.

Psychological implication of disaster survivors often tend to be neglected because they are invisible. The entire efforts are focused on rescue, relief, rehabilitation and reconstruction, leaving behind emotional problems of disaster survivors. We must essentially keep in mind that the survivors are surrounded by emotional problems like tension, anxiety, panic, shock or numbness, wandering, grief, PTSD, depression, somatisation, suicidal thoughts etc. which need psychological intervention to minimise the psychological problem or overcome it.

Rescue, relief, rehabilitation and reconstruction are important phases of disaster management. Similarly psychological cure is an essential and integrated part of disaster management.

Understand Emotional Reactions (UER)

Though emotional reactions in psycho-traumatic situations are almost similar in disabled and non-disabled survivors but degree of emotional reactions either by very high or very low because of physical injury and mental impairment.

REMEMBER

The emotional reactions are normal responses to an abnormal experience;

The reactions are common and experienced by everyone; the few categories (HH, MR, CP) disabled people manifest their reactions in different ways which can be understood by professional/experts only.

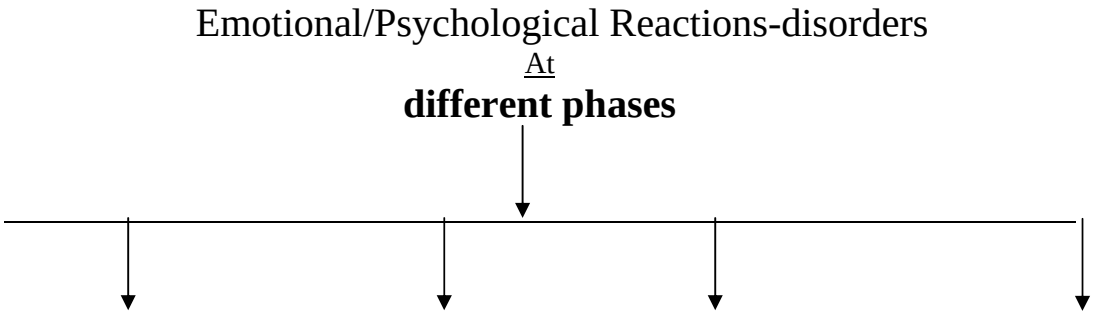
Professionalism and expertise is needed to understand and address the emotional reaction of PWDs;

Specialised services, to cater psycho-social need of PWDs, are existing which need to be identified and coordinated;

Interpreter who knows sign language is very much essential for providing ventilation, initiating interaction with deaf-dumb people;

Referral also integral part of psychological intervention.

The emotional reactions among the survivors are different at different phases. For appropriate and effective interventions, it is important to have clear understanding of the emotional reactions of the survivors at different phases of disaster.



Tension & anxiety	Grief	Dissociative Reflections	Somatization
Panic disorder	PTSD	Depression	Illicit sexual relations
Shock/disbelief	Empathy	Frustration	Somatoform disorders
Numbness/empty	Suicide	Prolong Grief	Marital discord
Relief, elation, euphoria	Vigilance		
Guilt	Phobia		
Flashback, nightmares & Arousal			
Disorientation, wanderingand aimless talking			

Immediate Reaction (With in few hours)

Tension and anxiety :

The disaster occurs so suddenly. There is hardly any time to think. The common and often immediate reaction is to run away for own safety and if possible safety of own nearer and dearer. Fear is the predominant feature seen. Palpitation, conflict, aggression, restlessness, apathy, fantasy, irritation tempers, sweating, inability to speak clearly fast heart beat, , forget ness, unconsciousness, dryness of mouth, muscular, fatigue etc. are the common feature usually seen in disaster situation. Disabled exhibit these features double because some (Blind) can not see what is happening, some can not hear (HH) that what the instructions/directions and some can not cope up due to restricted mobility.

Anxiety is a state of fear and apprehension.

A disabled on wheel chair :
"*Mo parivaar loke katha houthile, chari aade pani aasi jaichhi, jor paban houchhi, ei kotha ghar bhasi jibo, ettaru samaste nije-nije palaye jiba. Sheeghra aaso, pani aau paban baddhu chhi. Samaste nije bishayare chinta karuthile, mo bishayare kei bhabunathile. Mote bahuta chinta hela, la, mu kemiti jibi ? Mate kei sahajya kariba ? Matae kehi sahajya kariba nahin, mu bhasi jibi."*

My family members were discussing that there is water all around, strong winds blowing. This house will be swept away. Water and wind was increasing gradually. Hurry up ! All have to run away. Everybody was talking about his/her own safety, no one thought about me. I was in extreme tension. My anxiety doubled. How will I go ? No one will help me. I will be swept away ---

b. Panic Disorder :
Stressful situation leads to panic tendency and in turn it creates confusion, increases queries, repeated questions & confirmations. The VH persons repeat their questions/queries to confirm the answers. Panic situation creates confusions amongst HH persons because they do not get desired information in accessible format. The locomotor/CP people panic too much because they develop sense of insecurity and helplessness because of restricted mobility and dependency on others.

Panic disorders sensations include shortness of breath, hyperventilation, dizziness, choking, heart palpitations, trembling, sweating, stomach distress, feeling of unreality, sensation of numbness, chest discomfort, fear of dying, losing control.

Ashok is having lower limb disability and uses tricycle for outdoor mobility. His wife has gone to gather information in search of better safe place and path. The villagers are running away. Ashok became panic. He felt that he was unsafe even in a safe house. He took his 4-year-old daughter on tricycle and ran away, but the path, which was in use before cyclone, was broken. He was in between, neither he could go ahead nor came back and later swept away along with his daughter.
*"Jhada battya badhuchi, pani assi jibo, ei kotha ghar madhya bhasi jibo. Mo ishtree koaade palayela? Mu bhee mo jhion ku nai tricycle re palaye jibi." (*Speed of the cyclone increasing, water will come, this pucca house will sweep away. I do not know where my wife has gone ? I along with my daughter also run away by tricycle.)

What was wrong: Isolation, loneliness, delayed response, feeling of insecurity and helplessness lead to panic disorders which is natural response in unnatural situation.
What was required:

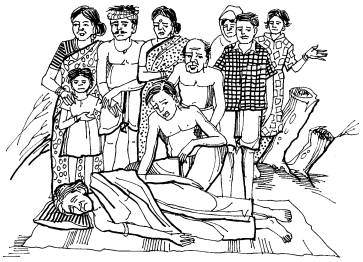
c. **Shock/disbelief:**
Disaster due to tsunami, earthquake, tropical cyclone, cloud burst etc. strikes all of a sudden and at the most unexpected hours when people are not at all prepared to face it. In this situation the survivors exhibit shocking behaviours. They also feel that it was not real but a bad dream and they disbelieve the reality. According to Coleman (1981) the tendency to avoid or deny unpleasant realities is related to the perceptual defence --- The survivors tend to avoid those aspects of situation which are traumatic or contradictory to their assumptions. They avoid unpleasant ideas, memories and experiences, discussions and criticisms. The PWDs specially blind and the deaf exhibit this shocking & disbelieving tendency for a longer period because in disaster situation

either they are being marginalised or proper psychological intervention does not take place.

30 years old blind woman:

"*Mo swami banchi achhi, sei mari naahanti. Mu andha, sei mote banchai parle sei kaun nija ku banchai pariba naahi kie ? Mu taa taanku dekhi nahin, sei bhasi jaichhe . Tama maane bholo bhabare mo swamiku khoju naahanti." (*My husband is alive. He has not died. The person who could save his blind wife, could not be in position to save himself ? I have not seen that he was swept away. You are not trying sincerely to search my husband.

Numbness or being empty:



Psycho-traumatic situation creates numbness and emptiness amongst the survivors. They fail to feel anything even the losses including loss of near and dear ones. They may not eat, sleep, interact, react for couple of weeks/months. They may dissociate themselves from all kinds of activities.

'N' lost his entire family (son, daughter, wife) in super cyclone. His old mother became Q.P. due to serious multiple injuries. Reactions of 'N' were numb. He was silent for couple of months. Even he could not arrange medical care for his mother who later died. He stopped talking, interacting reacting with others. He neither cried nor laughed. He dissociated himself from all social religious, rituals, activities including funeral of his mother.

e. **Relief, elation and euphoria :**

Some survivors may have feeling of happiness that they could survive the disaster, while many others in his/her family/village have died.

"*Bahuta loke marigale. Mu akshyam hoi madhya banchi gali, seta houchhi chamatkar, bhagawaan Jagannathankara kripa. Jie banchiba katha sia banchi chhi. Jia mariba katha sia mari chhi. Mariba-banchiba sabu bhagawaan Jagannathankara kaam. Eithi dukha ba sukkha ra katha nahin. Sabuthu bada katha – mu banchi gali."* Many people died. Despite my disability I could survive, this is miracle, blessings of God Jagannath. The people those should die have died, and those should survive, have survived. This is not a matter of pleasure or sadness, the great thing is that I have survived.

f. **Guilt :**

The survivors repeatedly blame themselves particularly if they have lost their near and dear ones. The PWDs keep on blaming themselves that though they wanted to save their near and dear ones but because of disability they could not save them. Feeling of guilt and self-condemnation arising out of socially and morally unacceptable activities.

Fifty years old Shasikant (locomotor disabled) who lost his wife expresses his feelings, fully imbibed with guilty :

"*Mo akshyamata pain mo stree ebong mo jhio-puo bhasi gala, Karam moro stree abong mo jhio-puho mata takee-takee kothaghare naikee aasilae, bahut samaya nast haila. Taapare se maane moro wheelchair nabaa pain gale. Mo aankhee saamane se maane bhasigala, sei maane kahuthila – 'banchao-banchao-. Mu se maanku banchai parili*

nahi. Mu aur mo disability yahapain daai. Sei maane abong bhagawan mote kshama kariba nahin. "

My wife, daughter and son were swept away because of my disability. My wife, son and daughter brought me here by lifting which consumed lot of time. Thereafter they went back to bring my wheel chair, meanwhile water wave came and they were swept away in front of my eyes. They shouted, cried, asked for help but unfortunately I was helpless. I could not save them. I and my disability are responsible for their cruel death. Neither they nor the God will pardon me.

g. Disorientation, wandering & aimless talking :

Survivors may encounter situation of disorientation about what is happening. This may be comparatively more in deaf and dumb because they do not understand oral communication of people. Few may have reactions like aimless wandering.

Flashbacks, nightmares and arousal symptoms :

After some period of time, anywhere from days to months, the event repeatedly intrudes into the person's consciousness. The individual becomes hyper vigilant, overwhelmed by graphic and terrifying illusions and hallucinations (called flashbacks) nightmares.

Often survivors remember, recollect or re-live the experiences of the disaster repeatedly. Small incidents may flash their bad and shocking memories. This happens more in night. The shocking memories may be accompanied with several symptoms such as palpitations, wrong irregular heartbeat, heavy sweating, unusual behavior. This leads to sleeplessness and restlessness.

Forty years old 'R', who lost his wife and son in super cyclone, use to get bad dreams

during nights. His wife is crying for help. His son has drowned in deep sea water. No one came to rescue them. These bad dreams cause sleeplessness and restlessness to 'R'.

Grief :

Grief is the reflection of deep sorrow, loss of some one (near or dear one) or something leads to grief situation. Grief manifest – deep sorrow, feeling of misfortune, expression of death wishes, loss of appetite and sleep, lack of interest in performing any activity.

"*Mu nije andha. Mo parivar loke thele more aalok. Se samaste bhasigale. Mu kahinki banchili ? Eva chaariyade andhar. Ehi andharare mu banchiba paain chahuni. Prabhu Jagannath mote seeghra ehi sansararu neijaantu. Mu jamma banchibaku chahuni*." (I am blind. My family members were light for me. They all have been swept away. Now there is deep darkness all around. I do not want to live in deep darkness. God Jagannath take me away from here at the earliest. I don't want to live even for a second.)

Post-Traumatic Stress Disorder (PTSD) :

People who suffer from PTSD continually re-experience a traumatic event or series of events although they desperately try to avoid reminders of the event.

PTSD sufferers have a variety of psychological symptoms of anxiety such as trembling, inability to sleep, hypersensitivity to noise. Anything associated with traumatic event provoke great emotional distress; even the anniversary of the event may stir up intense psychological and physical disturbance . generally speaking, the greater the trauma the greater the risk of developing PTSD.

A 45 year old C.P. person says –

"*Mu jadi tikke pawan aur chhata megha tiye bhi aakaasare dekhuchhi, tahale mote laagucvhhi puni thare jhad battaya aasigala". (*Even if I see slight wind or small clouds in the sky, I become very

scared. I feel that another cyclone has come.)

Empathy :

Sympathy is – ' I understand how you feel'. Empathy is – 'I feel how you feel.' Empathy is very important personality character. When you share sorrow, it divides; when you share happiness, it multiplies. Empathy generates understanding, loyalty, peace of mind.

Suicide :

People who reach this point feel that they lack the resources to cope with their problems. In some cases, a suicide attempt is said to be a "call for help" . For example, a young girl who has been exploited sexually may swallow 20 aspirin tablets and then inform to her relatives. That reflects her ambivalence about dying and her desire to be helped. People who feel hopeless about their lives are at the highest risk for suicide. Among depressed people, suicide is more likely for people who have suffered from stressful life vents such as death of spouse.

There are two basic strategies for treating suicidal individuals : providing social support and helping them regain a sense of control over their lives. Allow for ventilation of feeling, reinforce positive responses, provide alternative avenues, negotiate a "no-suicide" contract.

Reetu, 22 year old locomotor disabled unmarried girl lost her entire family including house, food grains, cows in super cyclone. She was good

looking, having pleasant and attractive personality. While staying in shelter she was influenced by negative influences like – "Jadi baapa maa thaante, Reetu ro bhalo baahaghar haithanta, se maane chaligale, eve reetunkar jeevan nark saman heijibo. Lok mane taanku bahut asubidha re pakaibe, Toka maane heiraan karibe, ---" *(If parents would have been survived, they could have arranged good marriage, but they died in super cyclone. Now Reetu's life will go to hell. Young boys will exploit her --- Meanwhile, Reetu got little affection, assurance and social support from her neighbour who gradually attempted to exploit her sexually. Thereafter Reetu committed suicide.)*

Vigilance :

The survivors become hyper alert or vigilant. They pay serious attention to each and every sound or light in the surrounding. They listen/watch warnings, weather news broadcasted/telecasted through radio/TV or local means of warnings. Hyper alert tendency creates psycho-somatic problems like irritable and angry behavior, difficulty in sleeping, floating of unusual unhealthy thoughts. This is nothing other than protective behavior, having descending order and decreases gradually. The blind becomes panic if they hear unusual sounds where as deaf becomes furious when they see lights.

Traumatic Phobia :

Phobia is an irrational and unabating fear of a particular object, activity or situation. Phobia denotes an abnormal fear. Normally fear is a reaction to dangerous conditions or objects. A person having a phobia has no proper cause of his fear. Thus, phobia is fear without any basis. People afflicted with phobia are afraid of enclosed space, height, water, fire, winds, dark places etc. Phobia dates back from some singular traumatic condition which has occurred probably in infancy when survival has been severely frightened.

Phobias can be classified into two types :

Neurotic Phobia :

Neurotic Phobia represents a strong tendency and persistence for the fear to generalize objects or events. A fear of flood may spread to sea/pond/river water.

Traumatic Phobia :

Contrast to neurotic phobia, in traumatic phobia, a single traumatic event is sufficient to establish a severe fear for a life time.

Solution :

When the phobic reaction arises out of severe traumatic experiences desensitization and extinction have been reported to be effective. This programme involves encouraging the phobic person to face the phobic situation with someone in whom he has got enough confidence.

Active deconditioning procedure may also be tried. In this method the feared objective may be associated with some stimulus which is pleasant to the person.

Dissociative reflections :

These are disorders in which anxiety or conflict is so severe that part of the individual's personality actually becomes separated from the rest of conscious functioning. The mother who is obsessed with the unconscious desire of killing her son is actually deeply devoted to her child in the conscious life. This unconscious desire is completely dissociated her conscious personality. Dissociative reflections can be said to be as departure from normal states of consciousness.

42 year old Rashmi lost her husband and two children in the super cyclone. She was maintaining total silence, avoiding discussions / interactions, crying often, blaming those who saved her. While crying her body will be stiff, limbs, mouth closed tightly, trembling body, rigid neck, rolling eyes.

Depression :

Major depression is characterised by depressive episode in which survivor suffers a variety of somatic and psychological symptoms. The somatic symptoms include lethargy, psychomotor agitation or retardation, feeling of loneliness, emptiness, isolation, self pity & sadness, appetite disturbances, and disruption of sleeping patterns. The psychological

symptoms include feeling of worthlessness and low self-esteem, intense and unreasonable guilt and preoccupation with suicide. Depression is more common in women than men. Depressed individual looses a sense of the ability to control the events in their lives and unrealistically attributes their misfortunes to their own failings.

Frustration:

Frustration is the result of failure of satisfaction of any need. It is a state of hopelessness and disgust. It destroys enthusiasm leading to complete despair. It is expressed in various reactions such as – creation or increase in emotional tension, increase in effort, feeling of inferiority, aggressive behaviour and mental mechanisms (Fantasy, compensation, identification, projections, rationalisation and sublimation). The causes of frustration are – objective beyond one's power, lack of requisite efforts, competition, social & cultural obstacles, physical causes. Major frustrations arise out of the physical environment such as storm, drought, cyclones, fires, injures, flood, accident, death of near and dear ones. Reactions to frustration are – aggression, withdrawal, rationalization, anxiety.

Prolong Grief :

Grief is emotional reaction to loss, which is unbearable. Grief is a combination of many emotions of loss, sense of insecurity, helplessness, fear. Manifestations of grief are – guilt, sadness, profound irritability, suicidal attitude, distress, loss of appetite, sleep, death wishes etc.

Stress Reflections :

Stress is the feeling that one's resources are inadequate to meet the demands of a situation. A traumatic experience is a disastrous or extremely painful event that has severe psychological and physiological effects.

Each traumatic event carries with it a toll of human sufferings, as the survivors cope with the loss of close ones who were victims of the disaster, and the loss of property when homes are destroyed. Survivors must cope with the painful memories of the traumatic event, which often involves vivid images of seeing other people killed or seeing their own lives nearly ended.

Fortunately, most survivors of such disasters or traumatic events are able to return to a normal life after some period of adjustment ranging from days or months to year or more. Others, however, don't seem to recover and develop post traumatic stress disorders. (PTSD).

Sense of insecurity, inadequate living condition, constant feeling of irrecoverable losses, sad memories etc. lead to unbearable stress. Stress causes unhappiness and loses of all kinds of interests of living beings. Stress prevents them from doing meaningful and productive activities. If we react to various things/happenings around us with negative emotions like anger, fear, hatred, jealousy, revenge, worries, irritation, frustration, anxiety, they are bound to create stress. If anybody suffering from stress and anxiety may not talk about his/her stress, existence of stress can be recognized through different symptoms given below :

1. **Emotional Reactions :**

Guilt
Irritability
Repetitive memories of traumatic situation
Hopelessness
Fear
Anxiety
Sadness
Suicidal thoughts
Helplessness
Forgetfulness

2. **Behavioral Reactions :**

Restlessness
Sleep disturbances
Loss of interest in life
Consuming intoxicants/drugs
Decrease of activities/energy'inconcentration'flashbacks

3. **Physical reactions:**

Tense muscles

Irregular heartbeat

Headache, pain in abdomen

Poor appetite

Unidentifiable pain in arm, leg, chest etc.

Vomiting sensation

4. **Changes in relation & social support system :**

Change in role & responsibilities

Poor social support system

Lack of mutual trust

Dependency

Somatization disorder :

Somatization disorder involves the expression of psychological issues through bodily problems that have no basis in physiological dysfunction. Symptoms of somatization are – pain in the hands/feet, back pain, seizures, blurred vision, loss of voice, apprehension, threat, stress, choking sensations, paralysis, amnesia, shortness of breath, difficulty in swallowing, vomiting, chest pain, irregular malnutrition. Not surprisingly, the disorders can cause significant work and social impairment.

Seema (35 years-low vision) lost her (husband, 1 year old son and 5 years old daughter) entire family in cyclone. She often keeps saying :

"*Mo hath, goro bindhuchhi, peethi re darda hauchhi, jhapsa-jhapsa disuchhi. Mu kaama kari paru nahi. Moro gote godo kharab thila kintu evea laguchhi ki moro duita haath godo, kharaab heigalani. Moro deha theruchhi, mu kichhi kam kari paru nahi."*

(My hands and legs have pain. I also feel back pain. I have blurred vision. I am unable to do some work. Earlier my one leg was impaired but now I feel impairment in all the limbs. There is shivering in my entire body. I even can not perform any activity.

Illicit sexual relations and trafficking :

Many young widows, unmarried destitute girls, adolescent girls either develop illicit sexual relations (as mark of gratitude willingly or forcely) or are being trafficked. The possibilities of sexual exploitation is higher in categories of MR & deaf dumb girl because MR girls do not understand its consequences where as deaf-dumb girl can not protest orally.

Reena, a 23 year old blind girl lost her entire family in the disaster. She was left all alone to live her rest of life. She found herself helpless. She was surrounded by tension, anxiety, guilt, grief, depression, frustration, stress etc. A young man of her distance relation – Anil started catering her psychological, social, emotional and economic needs. She started sharing her feeling with that man. Later developed physical relationship and in turn she was pregnant. After sometime Anil started avoiding Reena and one day left her house without any information and never came back. Now Reena feels unhappy, sad and guilty. She never believes/trust any man. Her life has become so critical.

Somatoform Disorders :

Somatoform disorders involve the expression of psychological conflict in physical symptoms. That have no medical basis . individual can show motor disturbances, sensory disturbances, symptoms that simulate physical illness or complicated physical illness. They are the product of conflict or stress, which, instead of being expressed through emotional outlets, takes a physical route of expression . A supportive therapeutic relationship is seen as the most effective method to deal this.

Marital Discord :

Marriage of disabled as usual is a great problem. This problem becomes further complicated in disaster situation. Though it may be good, if non-disabled may accept to get married with disabled but practically success rate, particularly where husband is non-disabled and wife is disabled, is poor. The ideal matching is deaf-dumb should get married with deaf-dumb because they can communicate each other, can share feelings. Blind may choose locomotor disabled partner. Broadly and practically speaking –

disabled should choose disabled life partner as they can understand abilities and disability related issues empathetically not sympathetically.

Soni – 22 years old deaf-dumb good looking girl, lost her entire family in the super cyclone. She was forced to get married to an unemployed non-disabled man. Few months they had good relation but later they had quarrel, developed misunderstanding and ultimately marriage broke down. The deaf girl Soni expressed her sad feeling. *"Mo jiban bhasi gala. Mu bahut baro bhul kari deli. Se mo kath bujhi parila nahi. Mu taah katha bujhi parili nahi. Seea moro bhasha jani nahi, mu taharo bhasa jani nahi. Mo gaon loke moro jiban taa ku barbad karideli. " (*My life is ruined. I have done a blunder. Neither my husband could understand my feeling nor I could because of language/ communication gap. My villagers have spoiled my life.)

Role & Responsibilities
Of
Community Level Workers (CLWs)

CLWs play very immediate and important role in rescue, relief and rehabilitation work in disaster situation. CLWs are best human resources because they belong to the same community and are acquainted with geographical area, social setting and having close liaisoning with community. These CLWs are :

Gram Panchayat members
Village Level Workers (VLWs)
Health Workers
ICDS network/Anganwadi workers
Self Help Groups (SHGs)
Auxiliary Nurse Midwives (ANMs)
Local Community Leaders
Neighbours
Workers of NGOs/CPOs
School teachers/Special Educators
Social Education Organiser (SEOs)
Priests/Padries
NCC, NSS, Scout Guides students

The CLWs may play important role in minimising psychological implications in disaster situation, through simple psychological interventions.

Emotional Reactions		
Sl. No.	Cognitive Behavior	Treatment
1.	**PANIC DISORDER**	**Expose to threatening situations while**

	A "fear of fear" leads people with agorciphobia to become afraid of developing a panic attack when symptoms are first evident.	**being relax.**
2.	SPECIFIC PHOBIA **Fear to specific objects or situations are due to individual's unrealistic thoughts about the objects or situation.**	**Exposure to phobic objects or situation while being cured to relax or stop anxious thoughts to Encourage more rational thoughts and increase feelings of self- efficacy.**
3.	SOCIAL PHOBIA Fear of performing others in front of others due to exaggerated fear of criticism and embarrassment.	Exposure therapy cognitive restructuring **and social skills training.**
4.	ANXIETY Establishment of a worry cycle in which small anxieties and concerns become magnified.	Increasing confidence in the ability to control worrying with the goal of breaking the worry cycle.
5.	*POST-TRAUMATIC STRESS* DISORDERS (PTSD) Two-factor conditioning model; maladaptive ways of attempting to manage stress.	Coping methods to teach effective ways to reduce stress, flooding and desensitization.
6.	DISSOCIATIVE DISORDERS *Traumatic events at any point in life can* cause dissociative symptoms. They developed dysfunctional beliefs about their role in contributing to their misfortune.	Hypnosis or other relaxation inducing *techniques to facilitate recall of motionally charged memories, bolster the individual's sense of self-efficacy and counter dysfunctional beliefs.*
7.	SUICIDE Suicidality caused by factors such as alienation, attempts to communicate distress, and feeling of hopelessness, stress and depression.	Careful assessment of suicidal intent and lethality combined with efforts to provide social support and restore sense of control.
8.	SLEEP DISORDERS Emotions such as depression, anxiety and anger can interfere with sleep. Certain sleep disorders due to negative expectation about sleep which create a vicious cycle of worry and impaired sleep.	Behavioral and cognitive behavioral methods can be used to help clients establish sleeping patterns and breakout of the cycle caused by worry over sleep. Relaxation, biofeedback and stress management.

9.	ADJUSTMENT DISORDERS Life events and the perception of situations as overwhelming cause stress. Adjustment disorders result when coping efforts are unsuccessful.	Provide support during periods of crisis; teach coping strategies used to manage stress focused either on changing one's emotions or changing the situation.

When you work with PWDs

Provide opportunity to ventilate their feelings and experiences, this will help in releasing their emotions.

Caution them to listen authentic information and avoid rumours.

Warn them (specially deaf, MR women, girls) to stay with family members/relatives who are alive or people of the same village/community to prevent sexual exploitations, trafficking.

Engage them in relief, rehabilitation and reconstruction work which will help them in eliminating depressions, sad memories, grief.

Encourage them to resume routine life with required change, as soon as possible.

Arrange aids & appliances through Govt. / NGOs which will enable them (tricycle/wheel chair/crutches/calipers/artificial limbs etc. in indoor-outdoor mobility where as hearing aid will enhance their both way communication level) to take part in meetings, discussions, rebuilding programs, advocacy activities etc.

There are exclusive expert institutes for PWDs (Govt. and NGOs) with expert professionals like Psychologist, special educators, therapists, medical & para medical staff, technicians , social workers, interpreters liaison and co-ordinate with these institutes to utilise their service up to optimum level.

Organise recreation activity (games, musical items, art, dance) which will help them in relaxing and keeping them in pleasant and good mood. You must plan these activities in such a way that each PWD participates equally. (for deaf- Art, dance, Mimicry, pantomim, indoor-outdoor games, VH- song, debates, games. Locomotor – Art, dance, musical items, indoor games. MR – Art, dance, musical items, games).

Assist them in getting relief and rehabilitation package. Encourage them to be optimistic and complete their tasks independently as much as possible. You support in completion of these tasks only which can not be completed by PWDs due to physical, intellectual and sensory limitations.

Provide guidance and counselling to PWDs to avoid alcohol, intoxicants, smoking, illicit sexual relations.

When you work with their families:

The CLWs should work with surviving families. Encourage them to adopt the following activities :

To share feelings, experiences and losses amongst themselves. Encourage them to involve disabled family member too in such sharing.

To contact relatives, friends as they may extend support and facilitate recovery.

To perform rituals.

Engage in recreational activities.

To take up meaningful and productive activities together regularly.

To involve disabled family member in all possible activities invariably keeping his/her need and limitations in mind.

Working with the community / Groups:

Rebuilding community life and setting up social support system becomes essential test in disaster situation, which helps in long term rehabilitation process. CLW may initiate following activities :

Organise group mourning which reflects solidarity of the grief stricken and facilitate unity and collective action. The frequency of this activity may be weekly and gradually monthly.

Arrange cultural programs such as folk songs, dramas, mono acting, mimicry, etc. focused on the losses due to disaster.

Organise survivors and engage them in devotional activities such as devotional songs/bhajans, puja, yoga etc.

Ensure group participation of each survivor including disabled, for rebuilding activities such as construction of houses, cooking food for others, ventilation of emotions etc. these activities help the survivors to recognize that there are helping hands around them to help and they are not alone.

Form SHGs of PWDs with 5 members only which will help them rebuilding their lives .

Organise sensitization programmes and create awareness among masses on inner abilities and limitations due to disability. This brings a feeling of confidence and normalization among them.

When you are planning group activities keep in mind that there are some PWDs of different categories. You plan activities including livelihood in such a way that PWDs are also involved actively at equal footing . this will help them to gain confidence to overcome their grief and use their innate ability to constructive activities.

Organise exclusive meetings of disabled to share their experience and talk about their success stories. This sharing will motivate others. Exclusive meetings of deaf-dumb can be organised separately to ensure interaction/communications in their language (sign language).

Ventilation

Traumatic survivors use to have powerful emotions such as tension, anxiety, panic, shock, disbelief, guilt, depression, grief etc. which need to be ventilated through expression/interaction, otherwise suppression of traumatic emotions will lead further worsening of psychological equation and the person may breakdown.

The CLWs should meet traumatic survivor and allow them to speak freely. While listening the CLWs should keep following broadbase guidelines in mind :

An empathetic relationship
Listen carefully and attentively
Avoid interruption
Keep eye contact and reasonably close distance
Recognise distress & feelings
Respond occasionally whenever require
An atmosphere of mutual trust
Establish rapport

Be optimistic
Do not ask them to stop crying/weeping.
Extend support like holding hands, patting on the shoulders. Cultural & social barriers should be kept in mind.

This will help CLW to build rapport and gain confidence of survivor.

> Remember
> Deaf-dumb people need interpreter to express their emotions. Take the help of special educators who knows sign language. The family members who also acquire skills to communicate with their deaf-dumb member up to some extent maybe involved in this process.

Active Listening

Attentive listening is an important skill to provide emotional support to the survivor. This involves not only noting the things that they say but also a whole range of other aspects of communication.

The CLW should formulate questions during the interaction on the basis of the survival's verbal responses as well as such non-verbal behaviours as eye contact, body position, tone of voice, hesitations, and other emotional clues.

There are basically three aspects of listening – linguistic aspect of speech, body language and facial expression.

Empathy

Empathy is the ability to stand in the other person's shoes- to see the world as they see it. In the end, we can never emphasize completely. Empathy involves a certain 'forgetting of self'.

Positive Regard

Unconditional positive regard is necessary and sufficient conditions for therapeutic change. The CLWs positive feeling for the client must not be conditional. CLWs must be broad minded and not prone to easy judgement of other people.

A sense of humour

A sense of humour can rescue most situations. It does not mean the CLW should become some sort of stand-up comedian, nor takes lightly what the client has to say. Gentle use of humour can help the client to regain sight of the large canvas. The CLW who has a light approach can often ease tension and help the client towards a greater sense of perspective.

16 year old Rahim, a deaf-dumb boy lost his all family members. (father, brothers, sisters) except mother to whom he was very much attached. Survivor mother has gone

under severe traumatic situation. CLW – Ram could reduce traumatic emotional feeling through appropriate stimulus where as CLW – Sohan though tried level best but could not decrease traumatic emotional feeling of Rahim, because neither he knows sign language nor he involved his mother.

Broad Guideline for Effective Listening :

Personal warmth
Sit squarely in relation to the client
Maintain an open position with arms and legs uncrossed
Leaning slightly towards the client
Maintain comfortable eye contact
Keep a relaxed position'thoughtfulness'optimism
Cheerful disposition
sense of humour

A sense of the tragic

Almost paradoxically, along side a sense of humour goes a sense of the tragic. We are human having human limitations. We create, for ourselves dramas of sometimes epic proportions. We are often unable to sort those dramas. A sense of this tragic side of being human can help the CLW to retain his or her own humanity and to remain humble.

Identifying possible solutions

Once feeling has been relieved, the next stage involves helping the survivor to identify ways to deal with or cope with the problem(s). it is the survivor who should identify solution to problem. The CLW should encourage this process by brainstorming sessions. The client should be encouraged to be creative, recreational, spontaneous, thoughtful, logical and sensible.

Client Status	CLWs role
The client feels 'blocked, inability to express.	Listen, accept, do not offer advice, help the client to focus on feelings.
Changes conversations very specifically from 'I sometimes get very upset' to 'I am very upset'	Listen and encourage the expression of emotions.
Expression of tears, anger, fear or laughter.	Be supportive and allow full expression.
Sits and reflects quietly, following the cathartic release. This may be lengthy process.	No intervention. You remain supportive & quiet.
Feels refreshed and more able to move on to identifying priorities and to problem-solving.	Take cues from the client and allow the relationship on at the client's pace.

Referral for holistic approach

CLWs should adopt holistic approach rather than concentrating on the emotional aspect of the rehabilitation/reconstruction work. Holistic approach will help minimising psychological implications. Areas for which referral need to be done are :

Sl.	Issues	Agencies
1.	Medical Care	PHCs, District Hospital, Medical Colleges, NIRTAR, RSIC
2. 2a.	Therapy OT/PT	District Hospital, Medical Colleges, NIRTAR, DRC, DDRCs, RSIC, SMRC, IHSs
2b.	Speech Therapy	TCTD, Special Schools, NIRTR, Medical Colleges, HIS, few Govt. hospitals (Capital Hospital), Private hospitals.
2c.	Psycho Therapy	NIRTAR, DRC, DDRC, VRC, TCTD, NGO, Medical college, few district hospitals, private hospitals.
2d.	Disability Certificate	District Medical Board
3.	Arrangement of aids & appliances	NIRTAR, DRC, ALIMCO, DDRCs, DSWO, NGOs
	Livelihood issues/vocational assessment	DSWO, IPO, BDO, DRDA, MVSN-NHFDC, DIC, OSFDCO, NABARD, Financial institutes.
4.	Education(Inclusive/Exclusive)	Local school, DPC-SSA, Special Schools, ICDC, DSWO, SEO, AWW
5.	Vocational Training	VRC, it is, Polytechnic, Engineering colleges, Medical colleges, CT/B.Ed. Institutes, professional educational institutes.
6.	Housing	Local authorities like BDO, Tahasildar, Revenue Inspector
7.	Social Security benefits : (Disability Pension, widow pension, Balika Samrudhi Yojana)	DSWO, SEO, ICDS network
8.	Disaster Compensation Issues	Designated authority (SDO, Tahasildar,RI etc.)
9.	Poverty Alleviation Program (SGSY, SJSRY, IAY, SGRY)	Palli Sabha, BDO, DRDA

Sl.	CLW can handle	Need Referral
1.	Alertness/awareness : If aware of : Who she/he is ?	If unable to : Tell his/her name
	Where he/she is ?	With whom he/she is staying.
	What has happened ?	Remembering place he/she is from Recollect events of past 24 hours
	If only slightly confused or dazed, or exhibits slight difficulty in thinking/speaking clearly or concentrating on a particular subject or task.	Complaints of forgetting names, numbers, things and objects.
2.	Behaviour	
	Is restless, mildly agitated and excited	Is depressed and shows agitation, restlessness and paces up & down
	Has rapid or halting speech	Is apathetic, immobile & unable to move around
	Has sleep difficulty	Is discontent and mutilates him/herself

	Wrings hands or appears still rigid or clenches the fists.	Uses alcohol or drugs excessively Is unable to care for him/herself even ADL Repeats ritualistic acts.
3.	Emotions	
	Is crying and weeping with continuous retelling of the disaster Has blunted emotions, hardly reacts to what is going on around him/her right now. Showing high spirits, laughs, excessively. Is easily irrigated and angered over trifles.	Is very quiet, shows no emotions. Unable to be aroused and completely withdrawn. Is excessively emotional and shows inappropriate emotional reactions. If talks of suicide If obviously mentally ill.
4.	Other Issues	When you feel out of your depth and unable to help any further Issues, that you know little about legal issues.

Case Study-1

Meena – a 20 year old smart & very beautiful blind girl of lower socio-economic background, working as teacher in blind school got married to a locomotor disabled of a very rich family just 6 months ago of super cyclone. She got caring husband running a big electronic shop, unique family having empathetic attitude and all facilities to enjoy life which she never dreamed. Unfortunately, she lost her husband including in-laws in super cyclone. The dad bodies of members of her in-laws were recovered except her husband's body. She feels sad, cries all the time, her sleep & appetite has been affected. Painful memories of her past keeps on haunting her. She is unsure about future. She is staying with her parents. Meena refused to believe and accept that her husband is no more. She repeatedly says – '*Mo swami mari naahanti, jie marijai thela tahara mala dehati milichhi, mu andha, taanku kemiti khojibi, mate kehi sahajja karunahanti." (*My husband has not died. Whoever have died their bodies have been recovered. I am blind. How I will search him ? No one helping me.)

Key aspects of the case :

A very young blind women from lower socio economic background married with caring husband, loved by in-laws & rich status.
Faced multiple loss
Reports to feel sad, helpless, sleep & appetite disturbed.
Unsure about her future.
Believes that her husband is not dead.
No interest in life, refuses to join duty in blind school.

How to help her ;

CLW, preferably female CLW should meet regularly to ventilate her feelings.
Realise her that her husband is no more. She has to start new life.
Tell success stories of blind girls.
Inform parents to keep close watch on her, to prevent suicide tendency.
Give positive reinforcement about future life.
Motivate her to resume duty in school.

Caste Study – 2

27 year old Ramesh was married with a very beautiful and educated woman Sonia when he was 20 years old. Though Sonia wanted to be a teacher but Ramesh refused to work as he has enough earning. Unfortunately they did not have any child. But she conceived a month before but did not inform her husband. Though both survived but Ramesh became paralytic wheelchair bound person, loosing urine control too, because of spinal injury in super cyclone. Sonia, who never went out after marriage, was forced by the situation to look after indoor-outdoor work including meeting community members., Govt. officials, NGO/CBO workers for obtaining relief & rehabilitation assistance. Many officials came to her house for gathering required information, verification of data and holding interaction with her. Meanwhile her husband Ramesh became non-cooperative, refused medical care, lost mutual trust, blamed her wife having illicit sexual relation with others. Ramesh asked Sonia not to go out, and no one should come at home including medical/para medical people too.; gradually Ramesh developed critical psychological problems, deterioration of health. His wife Sonia had shocking experience, planned for abortion, leading to frustration, depression, helplessness, tension, suicidal tendency.

Key points :

Late onset of disability
Loss of trust on wife
Total non-cooperative attitude of Ramesh to cope with changed situation.
Sonia had shocking experiences leading to frustration, depression, helplessness

How to help :

CLW should ask to their relative preferably aged female to intervene, allow ventilation to both and provide deep counselling and guidance. Firstly one to one counselling than group counselling.
Emphasise the need of mutual trust.
Make him understand to accept reality that he will be wheelchair bound and changing situation has forced Sonia to look after outdoor work for survival.
Change the environment through shifting Ramesh to a medical college or RSIC for treatment along with wife.
Provide positive reinforcement to both as both have developed psychological problem, if necessary take the help of clinical Psychologist.

Loss of productivity :

It has been observed that survivors lose their productivity, interest in work. They use to complain of fatigue, weakness, body tremors, and inability to work.

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Annexure - I

Final evaluation questionnaire

Please note that you should not put your name on the questionnaire, and that all the information that you give will be completely confidential. This is so that you can write freely what you really think.

Our hopes for this course

As a group, our hopes at the start of this course were as follows:

- To become more aware of the situation of disabled people
- To increase the independence of disabled people
- To share our experiences and opinions with each other
- To enable us to support (other)disabled people effectively
- To contribute to creating a better future for disabled people, and the realization of our/ their rights.
- To discover together ways of designing workshops suitable for our society

Q.I. How far do you feel that we have met these hopes through the course?

(Please mark I-5, next to each of the above hopes: I mean that we did not meet

the hopes, 5 means that we met it completely.)

2 Your participation

Q.2.I. How involved did you feel in the following (please tick the answer that applies in each case):

	very involved	involved	partly involved	not at all involved
In whole-group discussion?				
In exercises?				
In the practice facilitations?				
Overall?				

Q.2.2 What did you like most about being in the group?

Q.2.3 What did you like least about being in the group?

3. Course content

Here is a summary of the topics that we covered in the two parts of the course:

Part I: Training in facilitation skills

- Forming the group (introduction, hopes and fears, getting to know each other, agreeing group guidelines)
- Respect and listening skills; self-esteem; participation
- What is facilitation? The role of the facilitators, and the skills required
- Learning process and rates; how adults learn; learning styles
- Practice in facilitation
- Designing training session: deciding on topic, content (skills, knowledge, attitudes, methods)
- Planning skills: planning an event
- Prejudice/diversity/valuing different people's contributions
- Role of Local Action Groups and role of disabled people in LAGs
- Methods of evaluation

Part 2: Disability equality

- Human rights/ disabled people's rights
- Models of disability
- Barriers to equal participation/overcoming barriers
- Gender and disability
- Independent (self-determined) living; assertiveness
- Images of disability
- Language of disability
- Cause and prevention of disability (from a human-rights perspective)
- Feelings about being or becoming disabled

Q.3.I Was it helpful to you to have the course devided into two parts like this?

Yes No Partially (Please circle)

If No or Partilly, please say how you think we could have it down it better.

Q.3.2 Do you fill that we respected the priorities for topics that you set at the beginning of the course? (please mark 1-5 ; 1 means that we did not meet them at all, 5 means that we did meet them completely.)

Q.3.3 Which two topics did most enjoy in each part?

Part 1

Part 2

Q.3.4 Which two topics did you least enjoy in each part?
Part 1

Part 2

Q.3.5 Which two topics in each part were most useful to you as a LAG member?
Part 1

Part 2

Q.3.6 Which two topics in each part were least useful to you as a LAG member?
Part 1

Part 2

Q.3.7 Which two topics in each part did you find easiest to understand?
Part 1

Part 2

Q.3.8 Which two topics in each part did you find hardest to understand?
Part 1

Part 2

Q.3.9 Please name any topic that did we not cover which you think should have been
covered.

Q.3.10 Please assess the visual information (e.g. flipcharts, diagrams) used during the
workshops. Was it

a. Understandable ? (please mark 1-5; 1 means not understandable, 5 means very understandable) -------
b. Relevant? (please mark 1-5) ------
c. Too much? Too little? The right amount? (please circle which one applies)

Q.3.11 Please assess the handouts that were given to you to take home, Were they

a. Understandable ? (please mark 1-5; 1 means not understandable, 5 means very understandable) -------
b. Relevant? (please mark 1-5) ------
c. too many? Too few? The right number? (please circle which one applies)

Q.3.12 Could you understand the language used by the facilitators/ interpreter during workshops
always / nearly always / sometimes / almost never / never ?
(please circle which one applies)

Q.3.13 Do you think that there were enough opportunities for you to practice facilitating during the course?
YES NO (please circle which one applies)

Q.3.14 Which difficult or sensitive issues did we deal with appropriately?

Q.3.15 Which difficult or sensitive issues did we not deal with appropriately and why?

Q.3.16 Did you learn any thing about yourself during the training?
NO / YES (please circle which one applies)
If YES, please explain.

4 Facilitation methods
The working methods that we used generally were the following:
Brainstorms
Whole group discussion
Whole group exercises.
Small group discussion

Annexure-II

TOP 16 NATURAL DISASTERS SINCE 1000 AD (excluding purely agricultural Famine) - by numbers of deaths

1556 Feb 2, The worst earthquake in history devastated China's Shanxi Province, killing 830,000 people.
(PCh, 1992, p.190)(www.kepu.ac.cn/english/quake/ruins/rns03.html)

1737 Sep 19, In India's Bay of Bengal a cyclone destroyed some 20,000 ships. It was estimated that more than 300,000 people died in the densely populated area. Later research indicated the population of Calcutta at the time to be around 20,000. An estimate of the number of deaths was revised down to about 3,000.
(http://cires.colorado.edu/~bilham/gif_images/1737Calcutta.pdf)

1755 Nov 1, An 8.7 earthquake hit Lisbon, Portugal, and killed some 70,000 people. Heavy damage resulted from ensuing fires and tsunami flooding in Morocco and nearly a quarter of a million people were killed.
(SFEC, 4/26/98, p.T7)(HN, 11/1/98) (http://neic.usgs.gov/neis /eqlists/ eqsmosde.html)

1850 Sep 22, An earthquake in Sichuan, China, killed some 300,000 people.(www.geohaz.org/member/news/signif.htm)

1887 China's Huang Ho (Huang He, Yellow River) flooded and killed about 900,000 people. (http://en.wikipedia.org / wiki/ Death_toll) no 900,000 flood Huang Ho river China 1877… this was a drought year, see above

1908 Dec 28, Some 70,000-100,000 people died in the Messina earthquake in Sicily. The government hired a number of steamships, including the Florida, to ship survivors to America. (WUD, 1994, p.899)(WSJ, 2/8/99, p.A21)(http://neic.usgs.gov/neis/eqlists/eqsmosde.html)

1920 Dec 16, In China an 8.6 earthquake in the northwestern provinces of Gansu and Shanxi caused massive landslides and the deaths of 100,000-200,000 people. (SFC, 1/800, p.A8)
(www.ig.utexas.edu/research/projects/eq/faq/world.htm)

1923 Sep 1, The Japanese cities of Tokyo and Yokohama were devastated by the Great Kanto earthquake that claimed 99,000-143,000 lives. The 7.9-8.3 quake off Tokyo's shoreline killed some 99,300 people.
(AP, 9/1/97)(www.ig.utexas.edu/research/projects/eq/faq/world.htm)

1927 May 27, An earthquake in China's Qinghai (Xining) Province left some 200,000 dead.
(www.ig.utexas.edu/research/projects/eq/faq/world.htm)

1931 Jul-Nov, The Huang He River (Huang Ho, Yellow River) in China flooded more than 40,000 sq. miles and more than a million people were killed. (HFA, '96, p.71)
(http://socialstudiesforkids.com/articles/geography/huangheriver.htm)
1201 Jul 5, An earthquake in Syria and upper Egypt killed some 1.1 million people.(www.geohaz.org/member/news/signif.htm)

1948 Oct 6, A 7.3 earthquake hit Ashgebat, Turkeminstan, and killed an estimated 110,000 people. Stalinist media at the time claimed only 35,000 deaths. (http://neic.usgs.gov/neis/eqlists/eqsmosde.html)

1970 Nov 12-13, A 240 KPH cyclone hit the Ganges delta. Flooding followed and an estimated 300,000 in East Pakistan (Bangladesh), were killed.(SFEC, 9/5/04, p.6)(www.emergency-management.net/cyclone.htm)

1971 Aug 20-21, In Vietnam heavy rains flooded the Red River delta and some 100,000 people were killed.
(www.infoplease.com/ipa/A0001440.html)

1976 Jul 28, In China a 7.8-8.2 earthquake in the northern city of Tangshan killed at least 242,000 people. This was reported as the deadliest earthquake in the last 100 years. (AP, 7/28/97)
(http://history1900s.about.com/od/horribledisasters/a/tangshan.htm)

1991 Apr 30-31, A cyclone in Bangladesh killed an estimated 131,000 people. 9 million were left homeless. Thousands of survivors died from hunger and water borne disease.
(AP, 4/30/97)(SFC, 5/19/97, p.A13)
(www.emergency-management.net/cyclone.htm)

2004 Dec 26, The world's most powerful earthquake in 40 years triggered massive tidal waves that slammed into villages and seaside resorts across southern and southeast Asia killed. The initial estimated death toll of 9,000 soon rose to more than 157,663 people in 12 countries. The magnitude 9.0 earthquake was the world's fifth-largest since 1900 and the largest since a 9.2 temblor hit Prince William Sound Alaska in 1964. The epicenter was located 155 miles south-southeast of Banda Aceh, the capital of Aceh province on Sumatra, and six miles under the seabed of the Indian Ocean. (AP, 12/27/04)(SFC, 12/28/04, p.A1)(AP, 1/14/05)

Annexure-III

Disaster Supplies Kits and Other Essential Supplies

Basic Disaster Supplies Kit

There are six basics you should stock for your home: 1) water, 2) food, 3) first aid supplies, 4) clothing and bedding, 5) tools and emergency supplies, and 6) special items. Keep the items that you would most likely need during an evacuation in an easy-to-carry container.

Essential

- Battery-operated radio and extra batteries
- Flashlight and extra batteries
- Do not include candles. Candles cause more fires after a disaster than anything else.

Water

Store water in plastic containers, such as large soft drink bottles. Avoid using containers that will decompose or break, such as milk cartons or glass bottles. A person who is generally active needs to drink at least two quarts of water each day. Hot environments and intense physical activity can double that amount. Children, nursing mothers, and ill people will need to drink even more. Store three gallons of water per person (one gallon for each day and for each person). Keep at least a three-day supply of water (two quarts for drinking, two quarts for food preparation and sanitation) for each person in the household.

Food

Store at least a three-day supply of nonperishable food. Select foods that require no refrigeration, preparation, or cooking and little or no water. If you must heat food, pack a can of Sterno and matches. Select food items that are compact and lightweight. Include a selection of the following foods in your disaster supplies kit:
Ready-to-eat canned meats
Canned fruits, dried fruits, and nuts
canned vegetables

First Aid Kit

Assemble a first aid kit for your home and one for each car. A first aid kit should include the following:
____ Sterile, adhesive bandages in assorted sizes
____Assorted sizes of safety pins
____Cleansing agent/soap
____Latex gloves (2 pairs)

____Sunscreen
____2-inch sterile gauze pads (4-6)
____4-inch sterile gauze pads (4-6)
____Triangular bandages (3)
____2-inch sterile roller bandages (3 rolls)
____3-inch sterile roller bandages (3 rolls)
____Scissors
____Adhesive tape
____Tweezers
____Needle
____Moistened towelettes
____Antiseptic
____Rubbing alcohol
____Thermometer
____Tongue blades (2)
____Tube of petroleum jelly or other lubricant
____Extra eye glasses

Nonprescription Drugs

____Aspirin or nonaspirin pain reliever
____Antidiarrheal medication
____Antacid (for stomach upset)
____Syrup of Ipecac (use to induce vomiting if advised by the Poison Control Center)
____Laxative
____Activated charcoal (use if advised by the Poison Control Center)

Sanitation

____Toilet paper, towelettes
____Soap, liquid detergent
____Feminine hygiene supplies
____Personal hygiene items
____Plastic garbage bags, ties (for personal sanitation uses)
____Plastic bucket with tight lid
____Disinfectant
____Household chlorine bleach
____Facial tissues

Clothing and Bedding

____One complete change of clothing and footwear per person
____Sturdy shoes or work boots
____Rain gear
____Blankets or sleeping bags
____Hat and gloves

____Thermal underwear
____Sunglasses

Tools and Supplies
____Mess kits or paper cups; plates and plastic utensils
____Cash or traveler's checks, coins.
____Nonelectric can opener, utility knife
____Pliers, screwdriver, hammer, crowbar, assorted nails, wood screws
____Shutoff wrench, to turn off household gas and water
____Tape, such as duct tape
____Compass
____Matches in a waterproof container
____Aluminum foil
____Plastic storage containers
____Signal flare
____Paper, pencil
____Needles, thread
____Medicine dropper
____Adhesive labels
____Safety goggles
____Heavy work gloves
____Whistle
____Heavy cotton of hemp rope
____Patch kit and can of seal-in-air
____Videocassettes
____Disposable dust masks
____Plastic sheeting
____Map of the area (for locating shelters)

For Baby
____Formula
____Diapers/wipes
____Bottles
____Powdered formula, milk, or baby food
____Medications

Important Family Documents
Keep these records in a waterproof, portable container:
____Copy of will, insurance policies, contracts, deeds, stocks and bonds
____Copy of passports, Social Security cards, immunization records
____Record of credit card accounts
____Record of bank account numbers, names, and phone numbers
____Inventory of valuable household goods, important telephone numbers
____Family records (birth, marriage, death certificates)
____Copy of Supplemental Security Income award letter

Medical Needs
____Heart and high blood pressure medication
____Insulin
____Prescription drugs
____Denture supplies
____Contact lenses and supplies

Items for Service Animals/Pets
____Food
____Additional water
____Leash/harness
____Identification tags
____Medications and medical records
____Litter/pan

Entertainment
____Games and books

Other Disaster Supplies

Assemble the supplies below in addition to your basic disaster supplies kit. Combine these with your disaster supplies kit as you need them, and store them somewhere that is easy for you to get to.

Disability-Related Supplies and Special Equipment
Check items you use, and describe item type and location.
____Glasses:
____Eating utensils:
____Grooming utensils:
____Dressing devices:
____Writing devices:
____Hearing device:
____Oxygen:
Flow rate:
____Suction equipment:
____Dialysis equipment:
____Sanitary supplies:
____Urinary supplies:
____Ostomy supplies:
____Wheelchair:
Wheelchair repair kit:
Motorized:
Manual:
____Walker:
____Crutches:
____Cane(s):
____Dentures:

____Monitors:
____Other:

Service Animal and Pet Supplies
____Food
____Extra water
____Leash/harness
____Collar
____Identification tags
____Medications
____Vaccinations and medical records

Portable Disaster Supplies Kit
____Emergency information list/other lists
____Small flashlight
____Whistle/other noisemaker
____Water
____Extra medication
____Copies of prescriptions
____Extra pair of glasses
____Hearing aid
____Sanitary supplies
____Pad and pencil or other writing device

Annexure -IV

Disability Register Format

Village:_____ **Block:_____**
GP: _____
District:_____

Sl No	Name	Type of disability	Name and address of the carer	Age	Sex	Need

Annexure: V

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