Descriptive Study of Persons with Disabilities and Quality of Life

(Special Reference to Warangal District)

Subhash Kadgina

Research Scholar, Department of Sociology & Social Work, Osmania University, Hyderabad,
Telangana State - India, 500 007.
Email - Subhash.bose10@gmail.com

Abstract: *The disability is considered to be a problem of an individual that is directly caused by a disease, an injury or other health conditions and that requires medical care in the form of treatment and rehabilitation. An individual with any impairment is considered disabled, irrespective of whether the person experiences limitations in his or her life activities. Quality of life has been a topic of interest to many areas. In the context of persons with disabilities it is utmost priority of the academicians to research in terms of quality of life. How PWDs were improving their quality of life. Quality of life can be explained as sense of well-being, meaning and value. Quality of life is a holistic approach that not only emphasizes on individuals Physical, Psychological and spiritual functioning. A descriptive study was carried out to assess the quality of life of persons with disabilities in Indira Kranthi Patham (IKP) programme at Warangal district. Disability development is one of the major focused areas of the programme. 380 respondents were selected by using simple random sample technique using chits' method. Demographic profile and WHO QOL-BREF Scale, a schedule was used to collect the data and was analyzed by descriptive and inferential statistics.*

Key Words: *Persons with Disabilities, IKP & Development and Quality of life.*

1. INTRODUCTION :

PERSONS WITH DISABILITIES

Disability can be defined as the expression of limitations in individual functioning within a social context that represent a sustainable disadvantage to the individual. The World Health Organization (WHO, 1980) represented the "International Classification of Impairment, Disability and Handicap- ICIDH" model of human functioning. This model introduced three areas of experience for human functioning. Body structure and functions, activities within an individual context (skill and abilities), and activities in the social context (participation), the significance of this model was the conceptualization of disability as a multidimensional phenomenon. Three aspects of functioning Impairment, Disability and Handicap were clearly defined and linked to organize information from different disciplines (Buntinx W. H. E. et.al., 2010).

Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors), (*Leonardi M et al. 2006)*. Persons with disabilities can often experience problems arising from their health condition (*Thomas C. 1999*).

The Preamble to the Convention on the Rights of Persons with Disabilities (CRPD) acknowledges that disability is "an evolving concept", but also stresses that "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others". Defining disability as an interaction means that "disability" is not an attribute of the person. Progress on improving social participation can be made by addressing the barriers which hinder persons with disabilities in their day to day lives. The International Classification of Functioning, Disability and Health (ICF) (*World Health Organization 2001*), advanced the understanding and measurement of disability. It was developed through a long process involving academics, clinicians, and – importantly – persons with disabilities (Bickenbach JE, Chatterji S, Badley EM, Ustun TB,

(1982), 1999). The ICF emphasizes environmental factors in creating disability, which is the main difference between this new classification and the previous International Classification of Impairments, Disabilities, and Handicaps (ICIDH). In the ICF, problems with human functioning are categorized in three interconnected areas:

Impairments are problems in body function or alterations in body structure – for example, paralysis or blindness;

Activity limitations are difficulties in executing activities – for example, walking or eating;

Participation restrictions are problems with involvement in any area of life – for example, facing discrimination in employment or transportation.

1.1 DISABILITY AND DEVELOPMENT

Disability is a development issue, because of its bidirectional link to poverty: disability may increase the risk of poverty, and poverty may increase the risk of disability. (*Sen A, 2009*), It is harder for people with disabilities to benefit from development and escape from poverty (*Thomas P. 2005),* People with disabilities may have extra costs resulting from disability – such as costs associated with medical care or assistive devices, or the need for personal support and assistance – and thus often require more resources to achieve the same outcomes as non-disabled people. This is what Amartya Sen has called "conversion handicap" (*Zaidi A, Burchardt T.2005*)

People with disabilities can benefit from development projects; examples in this Report show that the situation for people with disabilities in low-income countries can be improved. But disability needs to be a higher priority, successful initiatives need to be scaled up, and a more coherent response is needed. In addition, people with disabilities need to be included in development efforts, both as beneficiaries and in the design, implementation, and monitoring of interventions (*Kett M, Lang R, Trani JF, 2009*).

1.2 PWDS DEVELOPMENT AND IKP

Since independence poverty alleviation in rural areas became one of the major concerns in all most all the five year plans of the country. It is a fact that large number of population in rural areas is poor and deprived of minimum basic infrastructure facilities. It only from seventies that various multiple development programmes have been initiated in rural areas not only for improving the basic infrastructure facilities but also for getting elimination of rural poverty among millions of people in the country. The government of Andhra Pradesh is implementing statewide Rural Poverty Eradication Programme based on social mobilization and empowerment of rural poor. This programme is popularly known as 'Velugu' or Indira Kranthi Pathakam (IKP). This project aims at enhancing assets, capabilities and the ability of the poor to deal with shocks and risks. The programme has contributed to the Improvement and development in people s empowerment at the household and community level of PWDs.

A division of IKP is responsible to address the issue of the disabled persons. The main objectives of the IKP division addressing disabled persons are:

- Identification of disable persons in the area of population
- Surgical corrections for all eligible PWDs
- Therapy support and training top all eligible PWDs and their parents /care takers
- Provision of try-cycles to the needy PWDs
- Constructing toilets for the most vulnerable people
- All eligible children with disabilities in rural areas would be enrolled in general or special schools
- Formation of Self-Help Groups of physically challenged persons
- Opening of bank accounts focusing on early intervention and prevention of disabilities
- Toll free phone facility for the empowerment of PWDs
- Suitable aids and appliances to all the needy

(Dr. L. Govinda Rao, 2012), conducted an evaluative study on IKP and PWDs development, the results showed that, in the short span of years there has been a positive development in respect of awareness levels, about the entire programme among the PWDs. They are now more confident of themselves, identify themselves in a group are demanding for their

rights and are proved of their living standards. The programme has reduced the social stigma attached to the disabled community; the disabled are non gathering in the groups regularly with more confidence.

1.3 QUALITY OF LIFE

Quality of life (QOL) is "a multidimensional construct, involving assessment of psychological, social, economic, physical, and other domains that may be targeted in rehabilitation counseling" (Bishop, Chapin, & Miller, 2008, p. 51) and is used as an outcome criterion (Aigner et al., 2006; Bishop et al., 2008) for people with disabilities. QOL has been defined by the World Health Organization (WHO) as "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns" (The WHOQOL Group, 1995, p. 1405; The WHOQOL Group, 1998; WHO, 1997).

2. RESEARCH PROBLEM :

This study used to find out the Quality of life of Persons with Disabilities under the programme of Indira Kranthi Patham at Warangal district.

3. OBJECTIVES OF THE STUDY :

- To study the independent variables of PWDs
- To find out the association between Quality of life of persons with disabilities and Indira Kranthi Patham Programme

4. MATERIALS AND METHODS

Research Design: A Descriptive Study design, was used for this study

Research setting: The setting of the study was Indira Kranthi Patham Programme at Warangal district. Under the district five mandals were selected namely, Rghunath pally, Kodakandla, Narmetta, Guduru, Eturnagaram.

Target Population: The Warangal district (undivided) has been chosen for conducting the research study. In Warangal among the 52 mandals the IKP has initiated its programmes in five mandals as a pilot project. From these five mandals the sample was drawn. The study population included the PWDs who have received IKP services form Raghunath pally, Kodakandla, Narmetta, Guduru, and Eturnagaram mandals.

Sampling Techniques

Simple random sampling technique is used to choose the respondents from total number of respondents in five mandals 380 respondents were selected based on the chits' method.

4.1 DESCRIPTION OF THE TOOL

Part-A: Socio-Demographic Variables:

This study includes the variables for obtaining personal information of the respondents' i.e. gender, age, education, marital status, caste, occupation of the family, income of the family, type of disability, Family Relationship with the PWDs, Reactions of the Society towards Disability, extent of mingling with the society, awareness about IKP, facilities of IKP, level of satisfaction of overall IKP functioning, and assistance devices provided by IKP.

Part-B: World Health Organization – Quality of life- BREF (WHOQOL) scale

The WHOQOL-BREF instrument comprises 26 items, which measures the four broad domains. Physical Health (7 items), Psychological Well being (6 items), Social relationships (3 items), and Environment (8 items) as listed below. The other 2 items measure overall quality of life and general health. Each item uses a five point Likert Type scale.

The 380 respondents were measured on the quality of life scale and scores were given to each of them. The scores ranged from 32 to 88 and on applying quartiles, the entire sample was further divided in to those with low quality of life (score 32 to 61) moderate quality of life (62 to 75) and high quality of life (76 to 88).

5. RESULTS AND DISCUSSION :

Table 1: Frequency and percentage distribution of demographic variables   N=380

Demographic Data		Frequency (f)	Percentage (%)
Gender			
a	Male	224	58.9
b	Female	156	41.1
Age(in years)			
a	Young Age (18- 30)	95	25.0
b	Middle Age (31- 50)	199	52.4
c	Old Age (51 - 65)	86	22.6
Education			
a	Illiterate	141	37.1
b	Primary	75	19.7
c	Secondary	140	36.9
d	Under Graduate	24	6.3

Demographic Data		Frequency (f)	Percentage (%)
Marital Status			
a	Married	241	63.4
b	Never Married	126	33.1
c	Divorcee	9	2.4
d	Separated	4	1.1
Caste			
a	OC	19	5.0
b	BC	189	49.7
c	SC	132	34.7
d	ST	40	10.6
Occupation of the family			
a	None (without any occupation)	1	.2
b	Daily Wage Labour	156	41.1
c	Agriculture	201	52.9
d	Private Sector Employee	8	2.1
e	Govt Employee	14	3.7
Income of the family			
a	Low Income (Rs.9100- 20,000)	132	34.7
b	Middle Income (Rs.20001- 45290)	153	40.3
c	High Income (45291- 62000)	95	25.0
Type of disability			
a	Orthopedically disabled	320	84.2
b	Visually Challenged	26	6.8
c	Hearing And Speech Impaired	6	1.6
d	Mentally Challenged	28	7.4
Family Relationship with the PWDs			
a	Good relationship	335	88.2
b	Unwholesome relationship	45	11.8
Reactions of the Society towards Disability			
a	Normal Behaviour	153	40.3

b	Neutral	129	33.9
c	Abnormal Behaviour	98	25.8
Extent of mingling with the Society			
a	No Problems	195	51.3
b	Few Problems	9	2.4
c	Many Problems	176	46.3

Table 2: Frequency and percentage distribution of Quality of life of PWDs   N=380

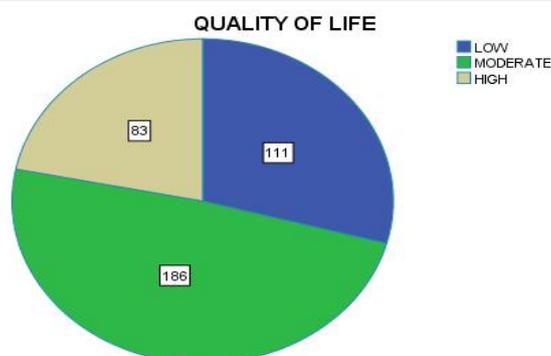|	Quality of life	Frequency (f)	Percentage (%)
a	Low (32-61 scores)	111	29.2
b	Moderate (62-75 scores)	186	48.9
c	High (76-88 scores)	83	21.9

Fig 1 Quality of life of persons with disabilities

Table 2 and fig 1 shows that out of 380 of the total respondents, about half of them (48.9 per cent) show moderate quality of life and about one third (29.2 per cent) of the respondents they show lower quality of life followed by one fifth (21.9 per cent) of the respondents are in the category of high quality of life.

The table exhibits that the total 380 number of the respondents among them the moderate quality of life shows about half or in majority and followed by low quality of life. Interestingly the respondents with high quality of life were less than a quarter in numbers.

Table 2.1
Quality of life * Awareness about IKP

Sl. No	Awareness about IKP	Quality of Life			Total
		Low	Moderate	High	
	Low	8 (7.2)	26 (14.0)	14 (16.9)	48 (12.6)
	Moderate	72 (64.9)	126 (67.7)	66 (83.1)	267 (70.3)
	High	31 (27.9)	34 (18.3)	0 (0.0)	65 (17.1)
Total		**111 (100) (29.2)**	**186 (100) (48.9)**	**83 (100) (21.8)**	**380 (100)**

Chi-Square value 28.565, Degree of freedom 4 and Level of significance .000.

Table 2.1 exhibits that among the total 380 number of respondents it was seen that a little less than one third (29.2 per cent) were found to be low in their quality of life. Among them, a majority (64.9 per cent) show moderate awareness levels about IKP followed by about one third (27.9 per cent) show high level of awareness and remaining about one tenth (7.2 per cent) of them show low level of awareness on IKP.

Out of the total of 380 respondents nearly half (48.9 per cent) of them show moderate quality of life. Among them a majority (67.7 per cent) show moderate level of awareness on IKP and little less than one quarter (18.3 per cent) of the respondents show high awareness levels, followed by about a tenth (14.0 per cent) respondents show low awareness on IKP programme.

About a quarter (21.8 per cent) of the total respondents show high quality of life. On examining them further, it was found that a vast majority (83.1 per cent) of them show moderate level of awareness of IKP followed by about one fifth (16.9 per cent) of the respondents represent low levels of awareness on IKP programme. Interestingly, none of the respondents showed high level of awareness from this group.

To understand whether these differences were by chance or do they have any statistical significance, the chi-square test was applied. The results show the chi- square value is 28.565, at degree of freedom 4, at level of significance .000, this shows that there is a significant association between awareness about IKP and quality of life. These differences are really significant among the respondents awareness about IKP and quality of life of the PWDs.

Table 2.2
Quality of Life * Facilities of IKP

Sl. No	Facilities of IKP	Quality of Life			Total
		Low	Moderate	High	
	Low	41 (36.9)	53 (28.5)	8 (9.6)	102 (26.8)
	Moderate	62 (55.9)	119 (64.0)	75 (90.4)	256 (67.4)
	High	8 (7.2)	14 (7.5)	0 (0.0)	22 (5.8)
Total		**111 (100) (29.2)**	**186 (100) (48.9)**	**83 (100) (21.8)**	**380 (100)**

Chi-Square value 28.730, Degree of freedom 4 and Level of significance .000.

Table 2.2 shows that out of the total 380 respondents little less than one third (29.2 per cent) are leading low quality of life. Among them a majority (55.9 per cent) show moderate level of utilization of facilities provided by IKP. Followed by above one third (36.9 per cent) show low utilization of facilities of IKP and less than one tenth (7.2 per cent) show high level of utilization of the facilities of IKP.

In the category of moderate quality of life, less than half (48.9 per cent) of the total respondents can be seen. Among them a majority (64.0 per cent) show moderate utilization of the facilities followed by less than one third (28.5 per cent) of the respondents show low level of utilization of facilities provided by IKP and less than one tenth (7.5 per cent) were in the category of high level of utilization.

Out of the total respondents those who show high quality of life were less than one forth (21.8 per cent). Among them a vast majority (90.4 per cent) show moderate utilization of the facilities and about a tenth (9.6 per cent) are in the category of low level of utilization of facilities provided by IKP. None of the respondents showed high level of utilization of the facilities provided by the IKP.

To understand whether these differences were by chance or do they have any statistical significance, the chi-square test was applied. The results show the chi- square value is 28.730, at degree of freedom 4, at level of significance .000. This shows that there is a significant association between utilization of facilities of IKP and quality of life. These differences are truly significant among the respondents and their utilization of the facilities provided by IKP and their quality of life.

Table 2.3
Quality of life * Level of Satisfaction of overall IKP Functioning

Sl. No	Satisfaction	Quality of Life			Total
		Low	Moderate	High	
	Low	9 (8.1)	38 (20.4)	53(63.9)	100 (26.3)
	Moderate	55 (49.5)	111(59.7)	29 (34.9)	195 (51.3)
	High	47 (42.3)	37 (19.9)	1 (1.2)	85 (22.4)
Total		**111 (100) (29.2)**	**186 (100) (48.9)**	**83 (100) (21.8)**	**380 (100)**

Chi-Square value 104.745, Degree of freedom 4 and Level of significance .000.

Table 2.3 shows that out of 380 respondents there are about one third (29.2 per cent) of respondents are leading low quality of life. Among this group about half (49.5 per cent) show moderate satisfaction and less than half (42.2 per cent) show high satisfaction. Remaining less than one tenth (8.1 per cent) show low level of satisfaction.

About half (48.9 per cent) of the respondents showed moderate quality of life among the total. Out of them a majority (59.7 per cent) of the respondents show moderate level of satisfaction followed by almost an equal proportion (20.4 per cent and 19.9 per cent) of them show low and high satisfaction levels.

The total number 380 of the respondents in high quality of life is about a quarter (21.8 per cent). Among them a majority (63.9 per cent) show low satisfaction followed by above one third of them (34.9 per cent) show moderate satisfaction and very few (1.2 per cent) were in the category of high satisfaction.

To understand whether these differences were by chance or do they have any statistical significance, the chi-square test was applied. The results show the chi- square value is 104.745, at degree of freedom 4, at level of significance .000, this shows that there is a significant association between satisfaction and quality of life. These differences are really significant among the respondents' satisfaction and the quality of life of PWDs.

Table 2.4
Quality of life * Assistance devices

Sl. No	Assistance	Quality of Life			Total
		Low	**Moderate**	**High**	
	Tricycles	35 (31.5)	70 (37.7)	45 (54.2)	150 (39.5)
	Wheelchairs	18 (16.2)	13 (7.0)	4 (4.8)	35 (9.2)
	Hand sticks	44 (39.7)	73 (39.2)	23 (27.7)	140 (36.8)
	Hearing aids	14 (12.6)	30 (16.1)	11 (13.3)	55 (14.5)
Total		**111 (100) (29.2)**	**186 (100) (48.9)**	**83 (100) (21.8)**	**380 (100)**

Chi-Square value 18.262, Degree of freedom 6 and Level of significance .006.

Table 2.4 shows that out of the total 380 respondents about one third (29.2 per cent) are leading low quality of life. In careful examination of this group above one third (39.7 per cent) used hand sticks followed by one third (31.5 per cent) respondents who used tricycles, less than one fifth (16.2 per cent) of the represents used Wheel chairs and above one tenth (12.6 per cent) of they are utilizing hearing aids.

In the category of moderate quality of life less than half (48.9 per cent) of the total respondents can be seen. Among them about an equal proportion (39.2 per cent and 37.7 per cent) showed utilization of hand sticks and tricycles. Less than one fifth (16.1 per cent) use hearing aids and less than one tenth (7.0 per cent) utilizes wheel chairs.

The respondents who show high quality of life are less than one forth (21.8 per cent) of the total. Among them above half (54.2 per cent) of the respondents utilize tricycles, less than one third (27.7 per cent) of them use hand sticks. Above one tenth (13.3 per cent) of the respondents use hearing aids and those who use wheel chairs were found to be very few (4.8 per cent).

To find out whether these differences were by chance or do they have any statistical significance, the chi- square test was applied. The results show the chi- square value is 18.262, at degree of freedom 6, at level of significance .006, this shows that there is no significant association between the appliances used and the quality of life. These differences are merely due to chance

6. CONCLUSION:

This study shows that the respondents reveled a great deal of awareness about IKP and its services, utilization of all the benefits for developing and strengthening the quality of life of PWDs. Although most of the respondents availed the services of the appliance it did not seem to be associated with the quality of life. The existing data showed that the satisfaction of the respondents is very high in availing the services from IKP. Importantly the satisfied respondents also showed high quality of life. Therefore efforts must be made to provide IKP services, make them

appropriate and relevant so that the satisfaction of the respondents is raised their by contributing to the improved quality of life.

REFERENCES :

1. Buntinx W. H. E. et.al., Models of Disability, Quality of life and individualized support implications for professional practice in intellectual disability. Journal of Policy and Practice in Intellectual disabilities, 2010; 7(4):283-29.
2. Leonardi M et al. MHADIE Consortium The definition of disability: what is in a name? Lancet, 2006, 368:1219-1221. Doi: 10.1016/S0140-6736(06)69498-1 PMID: 17027711
3. Thomas C. Female forms: experiencing and understanding disability. Buckingham, Open University Press, 1999
4. The International Classification of Functioning, Disability and Health, Geneva, World Health Organization, 2001
5. Bickenbach JE, Chatterji S, Badley EM, Ustun TB. Models of disablement, universalism and the international classification of impairments, disabilities and handicaps, Social science & medicine (1982), 1999,48:1173-1187. Doi : 10. 1016/ S0277-9536(98)00441-9 PMID: 10220018.
6. Sen A. The idea of justice, Cambridge, The Belknap Press of Harvard University Press, 2009
7. Thomas P. Disability, poverty and the Millennium Development Goals London, Disability Knowledge and Research, 2005 (www.disabilitykar.net/docs/policy_final.doc, accessed 20 July 2010
8. Zaidi A, Burchardt T. Comparing incomes when needs differ: equivalization for the extra costs of disability in the UK. Review of Income and Wealth, 2005, 51: 89-114. doi:10.1111/j.1475-4991.2005.00146. x
9. Kett M, Lang R, Trani JF. Disability, development and the dawning of a new Convention: a cause for optimism? Journal of International Development, 2009, 21: 649-661. doi:10.1002/jid.1596
10. Charlton J. Nothing about us without us: disability, oppression and empowerment. Berkeley, University of California Press, 1998
11. Dr. L. Govinda Rao, Evaluative Study of Disability Programme of SERP, IKP, 2012
12. Bishop, M., Chapin, M. H., & Miller, S. (2008). Quality of life assessment in the measurement of rehabilitation outcomes. Journal of Rehabilitation, 74(2), 45–54.
13. Aigner, M., Forster-Streffleur S, Prause, W., Freidl, M., Weiss, M., & Bach, M. (2006). What does the WHOQOL-Bref measure? Social Psychiatry Psychiatric Epidemiology, 41, 81–86