REVIEW OF LITERATURE

CHAPTER 2

REVIEW OF LITERATURE

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2.1 Consumer Protection

Consumers are the vital segment of any economy. In India, they are the most neglected, unorganised, widely scattered and highly exploited (SatyaSundaram, 1985). Consumer exploitation can be ended only through consumer protection. Consumer protection is inevitable for any economy, any country. As Sherlekar (1986) puts it, "it is essential for healthy economy."

Consumer protection would strengthen consumers in the market, which then would balance the buyer-seller relationship (Sherlekar, 1986). Consumer is the weaker of the two bargains in the market. Moreover, he is not only a buyer but also a spender of money. Therefore, to get the most from his income, he must receive information, advice and protection as well (Warmke, et al. 1977; Ronald, 1982; and Sherlekar, 1986).

According to SatyaSundaram (1985), the major area of concern for consumer protection is control of price rise, which as he suggested should be shifted from retail selling point to the production point. There is need of consumer protection because there is price rise and inflation in the economy.

Today, because of countries, growing highly industrialized and its cities become larger, many consumer problems like poverty, poor

housing conditions, adulterated food and fraudulent trade practices appeared, which made consumer protection necessary (Warmke, et al 1977). Sherlekar (1986) uses the terms "consumer protection" and "consumerism" synonymously because he describes 'consumer protection' as a core of consumerism. The author opines that the root cause of consumerism is "consumer dissonance" where dissonance means after purchase doubts, dissatisfaction, disillusion and disappointment.

According to him, consumers demand four rights from the company–safety (of products), information, a choice, and a voice (redress). However, business had not been practicing this. This implies that "consumerism is a shame of marketing" (Drucker, 1969).

Highlighting the rural consumers, Singal, et al. (1990) stated that they have problems of not having adequate consumer services. While urban consumers face following problems:

- They have to choose from too many alternatives
- Exposed to more wants
- Inadequate income
- Unequal income distribution and
- Increasing expectations.

Both rural and urban consumers face problems of price rise, adulterated food, short weights and measures, poor quality products and pressure selling techniques. Therefore, to represent, promote and defend the consumer interest, there should be consumer protection (Bourgoignnie, 1998).

There are four areas of consumer protection (Sherlekar, 1986): (i) Physical protection of consumers that is, protection against products that are unsafe or endanger health and welfare of consumer, (ii) Protection of consumer against deceptive and unfair trade practices, (iii) Protection against all types of pollution for better quality of life, and (iv) Protection against monopoly and/or restrictive trade practices.

There is strong need of consumer protection in India. The reasons as given by Sherlekar (1986) are,

- To effectively organize consumers in a country as vast as India.
- A majority of population is illiterate and ignorant.
- Poverty, lack of education, lack of information and traditional outlook of Indians to suffer in silence – all these have enabled businessmen to exploit consumers in India.
- Because of increasing technical complexity of consumer goods, it becomes difficult for an amateur consumer to select the best.

2.1.1 Consumerism

Today in view of increased malpractices at the market place such as fraudulent or deceptive advertising, non-functional packaging, unsafe products and poor warranties etc., the concept of protecting consumers has assumed greater relevance. These practices have affected the sentiments and eroded the sovergnity of consumers. Persistent violation of consumer rights led them to unite to defend their interest and as a result, where of unscrupulous business firms became the target of these interest groups (Kotler, 1976).

Consumerism is the name given to consumer protection movement. Consumerism is a kind of people's movement. It is a social movement to inform consumers so that they can make knowledgeable judgements regarding purchase of goods and services.

The emergence of consumerism is directly related to the change in the marketing concept. According to Drucker (1969), consumerism challenges four important premises of the marketing concept. (i) It is assumed that consumers know their needs. (ii) It is assumed that business really cares about those needs and knows exactly how to find them out. (iii) It is assumed that business does provide useful information that precisely matches product to need. (iv) It is presumed that products and services really fulfil customer expectations as well as

business promises. Mehta and Prasad (1980) observed that marketing concept is offshoot of consumer dissatisfaction. Moreover, the marketing concept and forces labelled consumerism are incompatible. The consumerism is actually the result of abuse of the marketing concept rather than malfunctioning of it (Buskirk and Rothe 1970).

Consumerism is the public demand both for refinement in marketing practices to make them more informative, responsive, sincere, truthful and efficient and for a new concern with factors other than privately consumed goods and services that determine the quality of life (Sherlekar 1986). The role of marketing has widened from mere production oriented to societal oriented concept. These changes are consistent with underlying necessity of consumerism in which consumer satisfaction is the prime responsibility of the marketers.

2.1.1.1 Need for consumerism: According to Sherlekar (1986), the idea of consumer supremacy and consumer sovergnity is definitely fallacious in a free market economy. In reality, consumer is not a king or queen. The manufacturer or seller is dominant and his voice is all-powerful.

According to Nader (1974), exploitation reduces real income and misallocates resources by way of funds, shoddy merchandise and deceptions or bilking scheme and secondly they inflict violence on consumers by way of hazardous products, unprovided services or

environmental pollutants. Dameron (1939) explains the need for consumerism that feeling of dissatisfaction with goods and services and marketing practices involved in their distribution leads to a movement of series of efforts by people. There is a demand for information and protection in the market.

According to Feldman (1976), the main factors responsible for consumer protection in USA were (i) Market practices (ii) Technological change and (iii) Social development. In Britain, sceptism, knowledge and professionalism were the main consumer realities of the 70s, which intensified the consumer movement (Peterson 1978). In India, the modern techniques tend to dominate the consumer market, where most of the consumers are illiterate and having low-income level. In such environment consumer expects protection.

Sherf (1977) noted that consumerism was born out of consumers desire for "more". According to Nelson (1970), following three aspects have been identified for the rise of consumerism. (i) Consumer sceptism (ii) anty-hypocricy and (iii) concern for the environment. Moreover, the world consumerism connotes two instances (a) protection of interest of consumers and (b) advocacy of high rate of consumption as a basis of sound economy.

Thus, the need for consumerism was felt mainly because of consumer exploitation, consumer dissatisfaction, technological change and subsequently, concern for environment.

2.1.1.2 Origin of the concept: The concept of consumerism can be traced back to Adam Smith who pointed out a way to regulate selfish passions of producers. The United States consumers were the first who began to recognise that they had rights in the market place. This dates back in 1773, when they protested to unfair taxes against incoming tea chests (Knauer, 1987). It was noted that some consumer groups existed in the United States as early as the middle of the 19th century.

In Great Britain the consumer, movement actually began to gather momentum during the years following the Second World War through voluntary actions mostly taken by women's organisations. Right from 1947 to 1957, there was consumer's revolution in Denmark, GFR, Switzerland, Japan, Kenya, France, Hungary, Italy, Canada and Belgium. Press campaign in favour of the consumer in these countries played a significant role in the creation of the concept of consumerism (Kumar 1989). In Japan, consumer revolution took place in 1948, when Japanese Housewives Association was founded in Tokyo. Consumer movement spread to other countries from 1960 to 1969 viz Austria (1961), South Africa (1961), Luxemburg (1962), Philippines (1962), Korea

(1963), Yugoslavia (1963), Triland (W.I. 1964), Nigeria (1965), Poland (1965), Puerto Rico (1965), Malaysia (1965), India (1966), Jamaica (1966), Mauritius (1967), Pakistan (1968), Venezuela (1968), Taiwan (1969) and Spain (1969) (Sharma 1995).

In India, the history of consumerism is as old as human civilization. It emerged as reaction to exploitation by businessmen. According to *Arthashastra* of *Kautilya*, it was duty of the government to supervise sales of products at reasonable rates. During the reign of Maurya (30 B.C.), the act of adulteration was considered *adharma* and distribution of adulterated food and drugs were prohibited.

The path of consumer movement in India was carved mainly by the efforts from three directions–government, consumer organisations and business firms. Government contributed in this movement by forming legislations in favour of consumer interest. Although little legislation formed before independence, government started safeguarding consumers' with consumer pressure only after independence. Consumer protection through legislation in India is discussed with details of laws later in this chapter. Emergence of consumer organisations is the mark of consumer movement. In India, it can be traced back to 1931. Elaborate information regarding this is presented later in this chapter. In addition, role of businessmen contributes to any country's consumer

movement. In India, a few businessmen have done a remarkable job in setting various consumer affair cells, complaint offices and followed a code of conduct for their members.

It can be concluded that the origin of the consumerism is as old as the human civilization, India being no exception. Consumerism does not exist in isolation. Support of legislation is the inseparable aspect of consumerism. Considering these aspects, the concept of consumerism had grown and developed mainly in the mid of 20th century in the world as well as in India.

2.1.1.3 Definitions of consumerism: Consumerism varied in definition according to the field in which it is used. According to Sharma (1995), Vance Packard coined the term "consumerism" which was not into wide use until 1963 or 1964. According to Sherlekar (1986), the term was first coined by businessmen in the mid 1960s. Definitions of consumerism by different authors are given here.

According to Buskirk and Rothe (1970), Consumerism stands for organised efforts of consumers seeking redress, restitution and remedy for the dissatisfaction they have accumulated in the acquisition of their standard of living.

Fazal (1978) defined consumerism as a phenomenon of group awakening ushered in a social movement to fight injustice and seek a fair deal in the exchange process.

Consumerism, according to Kotler (1980), is a social movement seeking to augment the rights and power of buyers in relation to sellers. He improvised (Kotler 2000) the definition by calling it an organized movement of citizens and government rather than just a social movement.

Webster's 20th Century Dictionary (1980) definition of consumerism says, "Consumerism is the practice and policies of protecting the consumer by making him aware of defective and unsafe products, misleading business practices etc".

According to Reid (1980), consumerism is the desire for safe and reliable goods and services.

According to McMillan Dictionary (1985), Consumerism is concerned with protecting consumers from all organisations with which there is an exchange relationship.

"Consumerism is a social movement, which seeks to safeguard and strengthen the rights of the consumers in relation to the producer or supplier of goods and services" (SatyaSundaram 1985).

Sherlekar (1986) defined the term as, "Consumerism is a social force designed to protect consumer interests in the market place by organising consumer pressure on business".

Himachalam (1990) defined consumerism as a social phenomenon caused by the strain, of shortages and inflation in India.

Two common factors regarding consumerism can be drawn from the above definitions. One that it is an organised social movement and the other that it is against consumer exploitation.

Looking beyond the conventional concept of consumerism, there is a concept of consumer socialisation, which explains the role of consumers in the market. According to Ward (1981), consumer socialization is defined as process by which young people (and even adults) acquire skills, knowledge and attitudes relevant to their functioning as consumers in the market place.

Laroche and Muller (1994) defined the term consumer acculturation that it is the process whereby people who have moved to a foreign culture learn and accept the norms, behaviours and standards of that very different culture. This includes the situation of refugees and immigrants from third world countries who are trying to acclimatize to the nuances of North American market, nationally and locally (Johnson 1988).

To conclude, consumerism is the process of defending consumers in the market, consumer socialization is the process of learning to function as consumers in the market and consumer acculturation is the process of acclimatizing to the nuances of the new market. However, the common aspect of these three concepts centring on the consumer is that it prepares a consumer to strengthen his role in the market.

2.1.1.4 Relevant research studies: Studies by Subramanyam et al 1982, Chaudhri 1987, Thanuligam and Kochadai 1989, and Singh 1989 explored the developments in consumer movement. From this, it can be concluded that lack of governmental enforcement, deterioration in business ethics and consumer education were the main hindrance in the way of development of consumer movement. Consumer has to care of himself by forming consumer organisation. They also found that most of the consumer organisations were urban based and playing overlapping and conflicting roles.

The studies by Khan (1981), Anurag and Gupta (1988) and Sakalani and Dhyani (1989) conclude that businessmen give due importance to social responsibility and they admit that business are failing in certain areas such as advertising, pricing and attitude towards complaints settlement. Hoskot (1990) in his study emphasised that senior citizen can play a vital role in consumerism.

2.1.2 Consumer Rights

One of the chief objectives of consumerism is to protect consumer rights. The way for organised consumerism was paved when U. S. President John F Kennedy, on 15th March 1962 introduced four basic consumer rights: the right to safety, to be informed, to choose and to be heard. Later, it expanded to eight. The right to redress and the right to consumer education were the first additions to be incorporated, followed by concern for the environment and the right to satisfaction of basic needs (Mandana 1977, Warmke et al 1977, Wraith 1982, SatyaSundaram 1985, Goldman 1986, Sherlekar 1986, Sharon 1987, Podder 1998 and www.cgsiindia.org). More information on these rights is presented here.

2.1.2.1 Consumer rights explained: There were four basic consumer rights announced by the US President Kennedy in 1962, which then got expanded to eight over a period of time. These rights are fundamental conditions to be understood by the consumers to be able to protect themselves in the market.

i) Right to satisfaction of basic needs. Implies that all consumers should have access to the means to meet their basic needs. Consumers should be protected from unethical and illegal practices, especially in the provision of healthcare, food, housing, water, energy and other basic

services, employment, education, financial and investment services (www.cgsiindia.org).

According to Pai (1995), the most important consumer's right is that of basic needs. Nearly 40% of India's population being poor, this right has the highest priority. To protect the poor consumer there is a public distribution system, which offers essential commodities like wheat, rice, sugar, kerosene, cooking oil etc. at subsidised rates. However, the dealers' margins are low and the system is so corrupt that hardly half of the covered population actually derive the benefits. Pai (1995) described resource constraints, population pressures, deforestation and ubiquitous corruption as the factors responsible for leaving more than half of the population without the security of safe drinking water–the basic necessity.

Government of India in has launched couple of schemes for those who live below poverty line. One to provide essential commodities to the needy people on the basis of "no profit no loss" through Public Distribution System and another to serve the people under Below Poverty Line for providing 25 kgs. of grains per family per month, at Rs. 3 per kg. for rice and Rs. 2 per kg. for wheat (Times Of India 2001).

ii) Right to safety. This right deals with physical safety of consumers from the marketing of unsafe products. Right to safety means protection

against marketing of goods that are hazardous to health or life (Gordon and Lee 1972, Warmke et al 1977, Mandana 1977, SatyaSundaram 1985, Sherlekar 1986, Buch 1990 and www.cgsiindia.org). The purchased goods should not only meet their immediate needs, but also fulfil long-term interests. The consumer has the right to ensure his safety from the point of view of both product attribute and transaction of the business (Srinivasan 1984). Products should not cause any physical danger to consumers or put them in difficulty due to sudden failure (Sherlekar 1986).

There are various measures available in the consumer protection system that checks the unsafe marketing of products. These include standardisation, grading and certification process, laboratories for testing products and laws to prevent marketing of unsafe goods. Bureau of Indian Standards (BIS) has formulated quality standards for over seventeen thousand items so far (Times Of India 2001). Despite these measures, there are unsafe products available in the market. Also, high-pressure advertising has contributed to a false sense of security about the product amongst consumers (SatyaSundaram 1985, Sherlekar 1986). Sherlekar (1986) puts stress on after-sale service by saying that it is deplorable and with this regard, consumers have a right of reasonable protection.

iii) Right to information. The right to be informed is a fundamental economic interest of the consumers. Consumers must be provided with adequate, accurate and up-to-date information on the quality, performance and other vital characteristics of products (Sherlekar, 1986).

Consumer should be protected against fraudulent, deceitful or grossly misleading information, advertising, labelling or other practices, and to be given the facts the consumer needs to make informed choices (Gordon and Lee 1972, Mandana 1977, Warmke et al 1977, SatyaSundaram 1985, Goldman 1986, Buch 1990 and www.cgsiindia.org). There are two important aspects of this right. One that consumers should be protected against misleading or false information and the other that consumers must be provided with true and accurate information about the product in order to make best choice.

Various aspects can be covered in the information provided. Safety aspect, economy aspect, health aspect, also information regarding proper use, care, after sale-service, guarantee, warrantee etc. should be known to the consumer while he makes any purchase (SatyaSundaram 1985, Sherlekar 1986, Buch 1990 and www.cgsiindia.org).

The information is disseminated through various means. Labels, packets, leaflets, signboards, hoardings, advertisements in media like

print media, TV, radio, movies, seller's word of mouth and many such other means are available to the consumers.

To provide consumers reliable information, there are standard weights and measures, standardisation marks, performance testing in drugs, grade labelling, and so on.

iv) Right to choose. Means to be assured of access to a variety of products and services at competitive prices and in those industries in which competition is not workable and government regulation is substituted, an assurance of quality and service at fair price (Gordon and Lee 1972, Mandana 1977, Warmke et al 1977, SatyaSundaram 1985, Goldman 1986, Sherlekar 1986, and www.cgsiindia.org).

The consumer is having the right to choose the goods he wants from a wide variety of goods available in the market. However, very often, he fails to make a good choice, because of confounding high-pressure selling techniques. In spite of these evils associated with it, competition assures consumers the right to choose (SatyaSundaram 1985 and Sherlekar 1986).

Right to choose implies that monopoly is disliked by consumers. Right to choose encourages ample production which makes available the ample quantity and variety of products at competitive price in the market. Thus, it is the keystone of dealer's policy (Sherlekar 1986).

v) Right to be heard. Means to be assured that consumer interests will receive full and sympathetic consideration in the formulation of government policy and fair and expeditious treatment in its administrative tribunals (Gordon and Lee 1972, Mandana 1977, Warmke et al 1977, SatyaSundaram 1985, Goldman 1986, Sherlekar 1986, Buch 1990 and www.cgsiindia.org). This right assures consumers representation in forming government policy.

According to Sherlekar (1986), this right has even greater importance. There would be no real control on the other rights, if the consumer does not enjoy the right to be heard. This right implies the existence of a legal framework and Government intervention to safeguard consumer interest.

To exercise the right to be heard, consumers should form non-political and non-commercial consumer organisations, which can be given representation in various committees, formed by the government and other bodies in matters relating to consumers (Buch 1990).

vi) Right to redress. Means right to seek redressal against unfair trade practices or unscrupulous exploitation of consumers. It also includes right to fair settlement of genuine grievances of the consumer (Sherlekar 1986, Buch 1990 and www.cgsiindia.org). If the performance and quality be short of expectations, a consumer has a right to redress. Thus, this is

the right to expect every product to perform as advertised when it is used as directed. The product must be repaired, replaced or taken by the seller. The right to redress will reduce cognitive dissonance or post purchase doubts and grievances (Sherlekar 1986).

Consumers must make complaint for their genuine grievances. Many a times their complaint may be of small value but its impact on the society as a whole may be very large. Consumers can also take the help of consumer organisations in seeking redressal of their grievances (Buch 1990). In fact, the right to be heard further implies the existence of a mechanism through which other rights can be asserted in particular, by ensuring the right of redressal of legitimate consumer grievances.

vii) Right to consumer education. Means the right to acquire the knowledge and skill to be an informed consumer throughout life. Ignorance of consumers, particularly of rural consumers, is mainly responsible for their exploitation. They should know their rights and must exercise them (Buch 1990).

Consumer policies should ensure that consumer laws are written in language that is easily understood. Consumers should be informed about their rights by establishing mechanisms to monitor consumer rights awareness. Also, there should be provision of basic consumer education in schools (www.cgsiindia.org).

viii) Right to healthy environment. This right enlarges the scope and significance of modern consumerism. Consumerism in recent trend is defined more broadly as an organized expression for an improved quality of life (Sherlekar 1986). Environmental problems do affect the life of consumers. Investment decisions of industries must consider the evil effects of pollution to ensure quality of community life.

Consumers can be protected from environmental pollution by promoting the use of products, which are environmentally sustainable. The use of non-toxic products can be promoted by raising consumer awareness of alternatives to toxic products. Ethical, socially and environmentally responsible practices by producers and suppliers of good and services should be promoted (www.cgsiindia.org).

2.1.2.2 Relevant research studies: In their studies Neelkamal (1993) and Oza (1996) found that majority of the respondents had knowledge that there are rights for consumers. Among most known rights to the respondents were right to safety, right to be informed, right to choose. While lesser known rights were right to seek redressal and right to be heard.

There are numerous incidents of consumer's safety being affected by hazardous products. A complaint of deteriorating quality of BREEZE soap, product of HLL, which had not only lost its earlier fragrance but

also caused irritation to the skin, was proceeded by Consumer Guidance Society of India (CGSI 1998). Also, in case of pressure stoves used for cooking, the CGSI tested 20 samples, out of which 18 failed the safety test (SatyaSundaram 1985).

Besides products, the safety aspect extends to services also. As Shah (1985) mentioned, the case having matter that the airports and air journey by Indian Airlines are not safe was presented before the Gujarat High Court by CERC Ahmedabad.

Chaterjee (2000) reported that growing number of housewives complain against poor performance of electronic gadgets and home appliances where the main cause of complain was deficiency of after sale-services, even during the guarantee period.

Right to information has wide range of applicability to consumers. According to Krishnamachrulu and Dakshina (1981), Kapoor, Krishna and Vijayalakshmi (1983), Gupta (1988) and Anurag and Gupta (1988), most of the advertisements are misleading and do not provide adequate information about the product. They substantially affect the life of middle-income group. Most of the advertisements do not substantiate their claims.

Regarding sources of information consumers use, studies reveal that consumers depend on advertisements, friends, relatives, other

consumers and on packaging for information. Age, income and education are the variables showing significant relationship with the source of information used (Bhatia 1977, Vora 1991, Trivedi 1995 and Bhargava 1997).

About right to be heard, Saklani and Dhyani (1989) pointed out that 60% of consumers are dissatisfied with the present day products and get a little relief by way of complaining but at the same time, most of the consumers shy away from complaining.

Oza (1996) in his study reported that majority of the respondents had feeling of anger while others had feeling of sorrow and very few had no feeling when they were cheated. He also studied the steps taken by consumers on being cheated. The findings showed that about half of the respondents went back to seller to minimise the loss suffered. Among these, majority of the consumers asked for the replacement of goods, some asked for compensation while very few complained about the loss and returned the goods and demanded money back. About one fourth of the respondents did not take any step to minimise the loss suffered.

Sharma and Duggal (1989) noted that most of consumers do not use government redressal services and shy away from making complaints. Singh (1990) pointed out that most of the consumers blame themselves for their ignorance.

Regarding redressal activity of consumers Oza (1996) found that respondents approach to the seller when they receive defective goods, damaged goods, in case of over pricing and also in case of loss suffered by any other reason. While finding out consumers awareness regarding legal remedies, the researcher concluded that more than 90% of respondents had the knowledge that an aggrieved consumer can file a complain. About 12% respondents had the knowledge that any voluntary consumer organisation can file a complain while only about 2% respondents knew that state government or union territories can file complain when consumer rights are violated.

Having consumer education or knowing consumer rights and responsibilities is one of the important rights of the consumer. Agrawal (1983) and Oza (1996) in their studies, could conclude that majority of respondents did not possess knowledge about consumer terminologies, consumer rights or responsibilities. It was observed that even higher formal or informal education did not prove helpful in knowing these consumer related aspects.

2.1.2.3 Consumer responsibilities: Consumer rights imply a set of consumer responsibilities. These consumer responsibilities correspond with the consumer rights. Given here are consumer responsibilities or duties towards which the consumer is liable.

i) Solidarity. The responsibility to organize together as consumers to develop the strength and influence to promote and protect common interest.

ii) Critical awareness. The responsibility to be more alert and questioning about the price and quality of goods and services he uses.

iii) Action. The responsibility to assert him and act to ensure that he gets a fair deal. As long as he remains passive consumer, he shall continue to be exploited.

iv) Social concern. The responsibility to be aware of the impact of his consumption on other citizens, especially disadvantaged or powerless groups whether in local, national or international community.

v) Environmental awareness. The responsibility to understand the environmental consequences of our consumption. We should recognise our individual and social responsibility to conserve natural resources and protect the earth for future generations (www.cgsiindia.org).

Studies concerning consumers responsibilities (Gadkari 1993, Nailkankatte 1993 and Oza 1996) implied that majority of the respondents when asked, accepted their responsibilities as consumers. Whereas, a small percentage of respondents showed negative attitude towards consumer responsibility. According to them, it is impossible to check trade malpractices (Bhatia 1977). John (1974) found that income

and age had significant relationship with degree of awareness of consumer responsibilities.

Main factors impeding execution of consumer responsibilities were (a) foremost concern for economy (b) trust in sales people, advertisements and others and (c) valuing of convenience (John 1974).

2.1.3 Consumer protection through legislation

The idea of protecting consumers added strength to the concept of man as consumer that had been growing since the Second World War. Until the war, man was not commonly described in this particular attribute. Until nineteenth century, the public was neither safeguarded against harmful food nor protected against fraud and error. It was about the middle of the nineteenth century that the medical profession in Britain became concerned about injurious ingredients and adulterated food (Wraith, 1982).

The first government legislation in Britain was the Food and Drugs Act, 1875. In the same year, the Public Health Act was also framed to approach the problem from another angle by controlling the conditions under which the food was prepared and offered for sale in slaughter houses, markets or shops (Wraith, 1982). In other advanced countries,

also the legislation was enforced during middle and late nineteenth century to rescue the consumer.

This in brief was the general scope of the law up to the Second World War. It was designed to prevent abuse by the supplier and to secure basic rights for the consumer. Only after the war was it thought that laws and institutions should not merely ensure that the consumer enjoyed rights, but that he ought to be regarded as weaker of the two parties to bargain and should accordingly receive information, advice and protection as well (Wraith, 1982).

The status of the consumer was further fortified when U. S. President Kennedy first incorporated consumer rights in his bill of Human Rights in 1962 (Mandana, 1977; Warmke, et al 1977; Wraith, 1982; SatyaSundaram, 1985; Sherlekar, 1986; Goldman, 1986; Dee, 1987; Podder, 1998 and www.cgsiindia.org).

In advance countries, law enforcement has been strengthened in 20th century, to protect consumers from fraud and error. England has strengthened measures towards consumer protection through the Fair Trading Act, 1973. Australia has provided for consumer protection in its Trade Practices Act, 1974. Canada has amended the Investigation Act, 1952 from January 1, 1976 in order to make provisions relating to unfair trade practices more stringent and effective (SatyaSundaram, 1985).

Consumer protection has become one of the main areas of the fundamental and comprehensive reforms taking place in Central and Eastern Europe. In all of the countries, a genuine and global approach towards consumer protection policy has been adopted, which has resulted in the adoption of comprehensive Consumer Protection Acts in eight countries–the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Romania, Slovakia and Slovenia, the two–Bulgaria and Poland–being in the queue. The process of legislation with regard to consumer protection in these Central and Eastern European Countries took place between 1992 and 1998 (Bourgoinie, 1998).

In India, consumer protection can be traced back to the Indian Contract Act, 1872 and the Sale of Goods Act, 1930 that cover misdescription, misrepresentation and fraud. Since then India has a plethora of legislation on diverse subjects aiming at consumer protection. But these legislative measures suffer from serious limitations in the absence of organized resistance from the consumers themselves (SatyaSundaram, 1985).

There are two broad divisions of the law–namely, substantive and adjective. The substantive law is that part of law, which concentrates on rights and liabilities. Adjective law is concerned with the machinery created by law for the enforcement of the substantive law and the

procedure devised for its enforcement. A large bulk of Central Acts relevant to consumers falls within the domain of substantive law. However, a few of them are concerned with adjective law. And in particular, the Consumer Protection Act 1986, very largely concentrates on the creation of a special machinery for the adjudication of claims of consumers and the procedures to be followed by the forums and commissions (Kumar, 1994).

The first step to protect the interests of the consumer was taken when the Monopolies and Restrictive Trade Practices Act 1969 (MRTP) was enacted. This act aimed to regulate the trade practices of monopoly organizations, which affect the consumers adversely.

The Consumer Protection Act 1986 (CPA) provided a simple, speedy and inexpensive remedy to the consumers utilizing goods and services provided by the private or government sector (George, 1996).

Though both MRTP and CP Acts aim at the protection and welfare of consumers, their objects, the line of demarcation at times get melted. MRTP is an act to provide that the operation of the economic system does not result in the concentration of economic power to the common detriment. For this, there is provision of control and prohibition of monopolies and restrictive trade practices in the Act. MRTP thus covers (i) Monopolistic Trade Practices (MTP) (ii) Unfair Trade Practices (UTP)

and (iii) Restrictive Trade Practices (RTP) where as, CP Act is to provide for the better protection of the interests of the consumers and for that purpose to make provision for the establishment of consumer protection councils and other authorities for the settlement of consumer disputes (Suryavanshi 1992).

Singh et al. (1983) focused attention on the MRTP Act and concluded that MRTP Commission was dominated by the central government in most of the cases. MRTP Act did some work in the field of consumer protection by retaining certain practices. The Act needed certain basic changes with regards to certain definitions.

Despite these laws, unscrupulous practices by traders continued as the consumer lacked the resources to fight powerful enterprises. He preferred to forgo his claim rather than suffer the rigours of civil court technicalities, expenses, time and harassment by unscrupulous professionals added to the consumer distress (George 1996).

According to Jagdish (1995), making consumer protection effective in India is limited by two major obstacles. One the "fatalist" spirit of people that permeates in every walk of life. People accept being short-changed in every deal by attributing it to one's fate-undesirable but inevitable. Second, the regulatory bodies entrusted with safeguarding consumer interests operate in such a manner that not only do they make mockery

of the purpose of the regulations but themselves become entity from which the consumers need protection.

2.1.3.1 Various acts: There are various Acts, which protect the consumers from various abuses prevailing in the market place. An overview of these Acts is as under.

i) Indian Penal Code, 1860. The Indian Penal Code 1860 is most relevant Act, for the prevention of food adulterations. The Indian Penal Code seeks to restrict malnutrition caused by circulation of harmful food articles among the people. It deals with the fraudulent and misleading description of articles of trade and fake packages. It covers offences pertaining to counterfeit trademark. The offence of public nuisance or illegal omission, which may cause any common injury, danger or annoyance to the public or people in general is also covered.

ii)* Criminal *Procedure Code, 1898. This act provides special powers to the executive magistrate in case of violation of consumer rights.

iii) Contract Act, 1872. This Act contains the law relating to buyers and sellers, their rights and responsibilities and conditions on which the contract is to be executed. This Act has specified basic principles by which an agreement becomes a contract. The contract Act emphasises the principle of Caveat Emptor where it is the purchaser's responsibility

alone to check what he is buying is saleable and workable for intended purpose.

iv) The Sale of Goods Act, 1930. This Act provides for the settlement of consumer-seller disputes. This Act casts a responsibility on the seller to offer mercantile goods. The ordinary rule in a sale of goods is that conditions and warranty are not implied. The Sale of Goods Act provides several important exceptions to this rule. Further an implied condition that the goods are free from any charge or encumbrance, are of the description tendered and shall perform according to usage and standards. Besides return of price or free repair or replacement, damages can also be claimed for any loss or injury of suffered buyer.

v) Agricultural Products (Grading and Marketing) Act, 1937. This Act provides for quality certification popularly known as 'AGMARK' for agricultural commodities. The certification scheme is voluntary for domestic but mandatory for export purpose.

vi) Drugs and Cosmetic Act, 1940. The purpose of this law is to regulate the production, trade, distribution, import and export of drugs and cosmetics, which are up to the required standards but also being sold under misbranding.

vii) Capital Issues Control Act, 1947. The main objective of this Act is to channelise resources in planned direction on priority basis and also to protect the innocent investors.

viii) Emblems and Names (Prevention of Improper Use) Act, 1950. The Act prohibits the use of specified names, emblems or official seal for public and especially for advertising purpose.

ix) Industries (Development and Regulation) Act, 1951. It provides for representation of the interest of consumers on goods manufactured or produced by scheduled industries on the Central Advisory Council. The Act contains several provisions about regulation in price/quality, and hoarding. The central Government is also empowered to cause investigation to be made into scheduled industries in cases of marked deterioration in quality and unjustifiable rise in price of any article

x) Forward Market (Regulation) Act, 1952. It regulates forward trading in various commodities to which regulatory provisions to this Act have been applied. It takes action to curb unhealthy speculation, keeps watch over price trends of a number of commodities.

xi) Indian Standard Institution (Certification Mark) Act, 1952 (Changed to Bureau of Indian Standards Act 1986). This Act controls the standards of various goods and simplification of some to encourage standardisation. This law guarantees the replacement of substandard

goods, which are not according to the prescribed standard when carrying the ISI Mark.

xii) Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954. This Act tends to prevent advertisements, which claim miracle or magical cure of diabetes, cancer, arthritis, asthma, sexual impotency, blindness, polio etc. that are difficult to cure.

xiii) Prevention of Food Adulteration Act, 1954. It prohibits manufacturing and sale of adulterated food; adulterated food includes articles of cheaper substance injurious to health, contaminated, filthy, rotten, decomposed or diseased etc. and includes cold drinks, for human consumption. Under this Act, use of food colours derived from coal tar has been banned. PFA also places responsibility on the consumer for checking adulteration by acting as food inspector, provided certain conditions are satisfied.

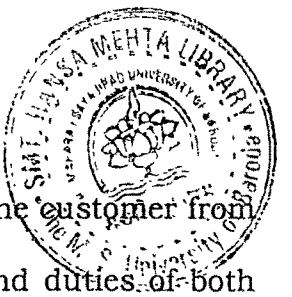
xiv) Essential Commodities Act, 1955. This law provides for the regulation of production and distribution of essential commodities by the government so that scarce commodities are available for consumption. It provides for rules and orders to govern the manufacture, distribution, storage, prices etc. of essential commodities.

xv) Companies Act, 1956. Company legislation in India protects from monopoly of large corporation by developing a system of checks and controls.

xvi) Standards of Weights and Measures Act, 1956 and 1976. This law determines the system of measurement also called metrology of various weights and measures. The Act prohibits the use of non-standard measures. Packaged Commodities Rules framed under the Act provides for printing necessary details on the packaged commodity with effect from May I, 1984. All the packed commodities for sale have to be packed according to metric system of weight and measurement.

xvii) Trade and Merchandise Marks Act, 1958. This law provides for the registration of trademarks of manufactured goods so as not only to protect the business but also the consumer being cheated due to non-identifiable products.

xviii) Monopolistic and Restrictive Trade Practices Act, 1969 (Amended in 1984). This Act has been enacted with the objective of curbing monopolistic and restrictive trade practices. Before the 1984 amendment, the MRTP Act contained no provision for the protection of consumer from unfair trade practices, such as deceptive and misleading advertising, hoarding of goods and supply of unsafe and hazardous products.



xix) Hire Purchase Act, 1972. It was passed to save the customer from exploitation by seller/owner and regulate the rights and duties of both the parties.

xx) The Household Electrical Appliances (Quality Control Order 1976 Amended in 1981). It prohibits the manufactures from sale of household electrical appliances, which do not confirm to relevant ISI standards and requires the manufacturer to take certificate from appropriate authority.

xxi) Textile (Consumer Protection) Regulation, 1988. This regulation has the provision to test any Fabric suspected to be substandard. It protects the consumers from fake stamping about various contents of Fabric (Sharma 1995).

2.1.3.2 Consumer Protection Act 1986: CP Act 1986 is one of the most progressive and comprehensive pieces of legislation, enacted for the protection of consumers.

i) Meaning and Importance of the Act. This act intends to provide simple, speedy and inexpensive redressal to the consumer's grievances. Under this act, there is quassi-judicial machinery at National, State and District level. The objective of these councils is to promote and protect the consumer (Singal, et al. 1990).

Denoting the importance of CP Act 1986, George (1996) stated that the act promotes welfare of society by enabling the consumer to participate directly in the market economy. It attempts to remove the helplessness of a consumer, which he faces against powerful business.

As Kumar (1994) explains, there are two features of this act that need attention. One that the act creates series of special forums for the adjudication of consumer disputes relating to the sale or supply of goods or services for consideration. The second feature to be noted is that the "loss" about which the consumer can complain before the special forum so created, must be a loss based on some deficiency or defect.

ii) Framework of CP Act. Salient features of the CP Act as described by George (1996) and Kumar (1994) are reported below in brief.

Consumer: Purchaser of goods or services for consideration (any payment in cash or kind) is a consumer.

Goods: Any movable property is goods.

Services: Services of any kind purchased by a consumer are services, e.g. Electricity, banking, insurance, construction of houses, professional services of lawyers, doctors, architects, etc.

Exception – contract of personal service and service provided free are the services not within CP Act.

Note: Services provided by professionals such as lawyers, doctors etc. is not contract of personal service.

Complainant: A consumer, registered consumer organisation, Central or state government and one or more consumers on behalf of other consumers similarly affected - are the four categories of complainants.

Note: Permission of the Consumer Redressal Agency is to be obtained for filing such complaints. Other consumers on whose behalf a complaint is filed are to be informed personally or through advertisement.

When to complain: Traders have adopted, Unfair Trade Practices (UTP) or Restrictive Trade Practices (RTP).

Where to complain: At the place where the seller of goods or provider of service has business establishment.

Machinery of Consumer Dispute Redressal Agencies (CDRAs): There is three-tier machinery–(i) National commission at Delhi; (ii) State commission at state level; and (iii) District forum at district level.

Monetary limits of CDRAs:

(i) Claims up to Rs. 5 lakhs – District forum

(ii) Between Rs. 5 lakhs and Rs. 20 lakhs – State commission

(iii) Above Rs. 20 lakhs – National Commission

Procedure of filing a complaint:

- Complaint should be in writing

- Four copies minimum, (6 copies minimum for National Commission)

- Give all the details of dispute

- Attach copies of documents such as bills, brochures or literature given at the time of sale correspondence exchanged after dispute, etc.

- Specify whether complaint relates to goods or services.

- Specify ground of complaint.

- Specify relief claimed.

- Check that the complaint is filed before appropriate agency i.e. monetary limits and the place of filing.

- Sign the complain, put the date and file an affidavit at the end.

Note: No court fees or stamp is required to be affixed on complaint or on affidavit.

- Keep a copy of the complaint for record and note the complaint number given to you by the office of CDRA.

iii) Limitation of the Act. The limitation of the law as per Kumar (1994) is that the CDRAs shall not admit a complaint unless it is filed within two years from the date on which the cause of action has arisen. But the CDRAs may for reasons to be recorded, entertain a complaint even after two years if satisfied that the complainant has sufficient cause for not filing the complaint within such period.

Amendments to the Consumer Protection Act 1986, the Essential Commodities Act 1955, the Standards of Weights and Measures Act, 1976 and the Bureau of Indian Standards Act 1986 have been made by the Government since they have been formulated (Times Of India 2001).

2.1.3.3 Relevant research studies: Regarding awareness about existence of legislation for consumer protection, Gadkari (1993) concluded that majority of the respondents knew that there exists government agency for consumer protection whereas, Nailkankatte (1993) and Oza (1996) found contrasting fact that majority of respondents were unaware about the act.

Gadkari (1993) reported that majority of the respondents were of the view that in the event of defective goods one can seek legal help whereas, only 39% of respondents opined that one can seek legal help in case of over pricing.

Nailkanklatte (1993) concluded that the respondents have not used the act only for small reasons due to its simplicity or easy implementation as more than three fourth of the respondents have won the cases in their favour. It was also concluded that respondents have been totally satisfied with the compensation given to them and have found Consumer Protection Act very useful. It was noted that more educated people have made use of the Act.

Regarding functioning of government agencies, Saklani and Dhyani (1989) noted that the basic facilities were lacking in government agencies.

2.1.4 Machinery providing consumer protection

There are three alternative ways and means of securing consumer protection: (i) Self help (ii) Business and (iii) Government.

The first alternative of "self help" denotes help from consumer organisations itself. Secondly, consumers can be protected by business-by self-regulation and by giving a fair deal to the resellers and consumers. Third way is the legal protection provided by the Government (Sherlekar 1986 and Sharma 1995). Numbers of laws helping consumers are framed by the government, which are discussed in brief above in this chapter. But the special jurisdiction machinery set for the most consumers friendly Act-the Consumer Protection Act-is highlighted here.

The Consumer Protection Act 1986 is an important piece of legislation in safeguarding the interest of consumers. Certain authorities have been established under the Act. They are (i) Consumer Protection Councils and (ii) Consumer Disputes Redressal Agencies.

Government has set up three-tier machinery for amendment of CP Act. It consists of District Forum at district level, State Commission at State level and National Commission at Delhi.

Consumer Disputes Redressal Agencies: The state government establishes Under the Act, a Consumer Redressal Forum also known as the District Forum. The District Forum has jurisdiction to entertain complaints where value of goods or services and compensation claims, if any, is less than Rs. 1 lakh.

State Commission: It has jurisdiction to entertain complain where value of goods and services and compensation, if any, exceed Rs. one lakh but does not exceed to Rs. 10 lakh and to entertain appeals against the orders of any district forum within the state.

National Commission: The National Commission has jurisdiction to entertain complaint where value of goods or services and compensation, if any, exceeds Rs. ten lakh and appeal against the order of any state commission.

Establishment of Consumer Protection Council under CP Act 1986.

(For the settlement of consumers' disputes and for matters connected therewith)

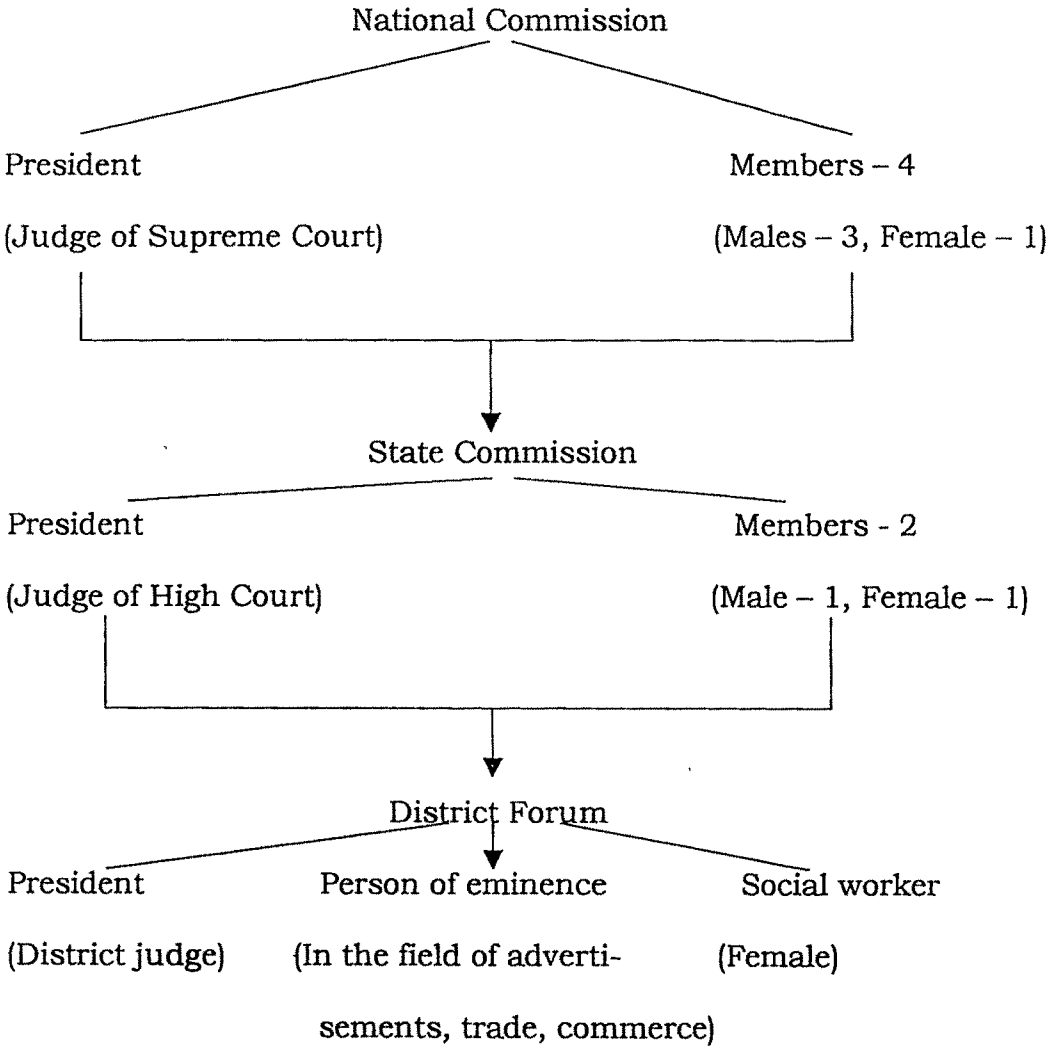


Fig. 1 Consumer Dispute Redressal Machinery

Enforcement: If the defendant fails to comply with the orders of any above-mentioned agencies, then he shall be punishable with imprisonment for a term or/and fine which shall not be less than two thousand rupees but which may extend to ten thousand rupees.

According to a report in the daily Times Of India (March 2001), National Consumer Disputes Redressal Commission has disposed of 11,841 consumer dispute cases (55.4%) so far. A State Commission has, in all, disposed of 1,24,048 consumer disputes cases (60.4%) and 11,64,315 cases (82.6%) has been disposed of by District Forum so far.

2.1.4.1 Relevant research studies: Korba (1988), Sharma and Duggal (1989), Saklani and Dhyani (1989), Reddy et al (1990) and Rao (1990) while studying the government irregularities in the functioning of government machinery concluded that government regulations are often manipulated and violated by the traders for their own benefits. Government administrative policies are stoic to consumer interest.

2.1.5 Consumer Organisations

Development of consumer organisations is the inseparable part of the consumer movement. Consumer movement was intensified with the

establishment of consumer organisations. Growing number of organisations is the sign of growth of consumer movement.

Consumer organisations pursue various objectives such as to inform, educate and organise consumers so as to enable them to secure, protect and preserve their interests and to seek right as consumer of goods and services in the society and provide a public forum for individual and to guide consumer to seek redressal from the appropriate authority. Besides these, sometimes organisation is engaged in providing a helping hand to the handicapped and poor people to get essential commodities and giving counselling services to the unemployed youth to get self- employment (Sharma 1995).

The emergence of consumer organisations was noted during Second World War but most of them were anaemic and lacked vitality. Awareness of the United States regarding consumerism dates back in 1773 when Americans protested the unfair taxes.

Then as an indication of growing strength of consumer movement, the National Consumer League was formed in 1899 (Kotler 1976).

Consumer organisations sprouted in Norway and Ireland in 1939 and 1942 respectively. In 1935, a formal consumer union came into existence in Britain. It built consumer reports thereon and enlightened the public about misleading claims (Basrur, 1995).

In 1960, the International Organisation of Consumer Union was formed in Hague, Holland by consumer groups of United States, Britain, Australia, Belgium and Netherlands with a view to promote worldwide co-operation in consumer information, education and the comparative testing of goods and services (Fazal, 1978) It now has over 160 member countries and several regional offices.

IOCU has played leading role in the Asia Pacific region ever since the founding of the Asia Pacific office in 1974 in Malaysia. The main work of IOCU has revolved around developing consumer groups in the region, providing information and representing regional interests at the international level.

In India, the history of consumer organisations starts from the Mahila Upbhokta Sangathan, which has been functioning in Lucknow since 1931. Now it is the largest Consumer Organisation with 3741 branches in urban areas.

The formal development of consumer organisation is traced back to 1949 when a consumer centre was set up in Madras by Delvai (Mehta and Sharma 1989). The Consumer Guidance Society of India, Bombay established in 1965, followed by Surat Grahak Mandal in Gujarat in the year 1969.

But it was in the seventies that the idea grew into a movement with consumer unions in Delhi (1971), Calcutta (1973) and Ahmedabad (1978).

CERC-Consumer Education and Research Centre- was started in 1978 at Ahmedabad. CERC fought battles against several institutions. The Indian Airlines, Gujarat State Transport Corporation and Gujarat State Electricity Board agreed to regulate the tariff structure. It fought with LIC and got the premium rates reduced and mortality table revised. The CERC has been softly persuading the advertising agencies to check false and misleading statements. To enlighten consumers CERC has been publishing two periodicals the "consumer confrontation" now called "insight" (English) and the "Grahak Suraksha" (Gujarati). It has organised workshops, seminars, lectures and classroom training sessions on research to the activities like consumer education, legal research, dissemination of information and other activities connected therewith, documentation, library resources, computer services, training programme and publication.

Considering the weak consumer movement in India some voluntary consumer organisations felt the need for coming together. Thus, emerged in the apex institution at The India Federation of Consumer Organisations (IFCO) in 1979. It is fundamentally concerned

with the protection of consumer interests. It collects data on price rise, methods of adulterations of consumer goods, lapses in public service like the telephones, electricity etc.

The Government of India has announced that at least one Consumer Information Centre in each district of every State/UTE shall be established over the next five years period at an expenditure of Rs. 28 crores associating the State Governments/Union Territory Administrations and the voluntary consumer organizations on participatory basis. So far, 15 such centres have been approved in different States of which six centres have started functioning and the rest are about to function shortly (Times Of India 2001).

2.1.5.1 Relevant research studies: Consumer organisations are undertaking a variety of functions such as product testing, complaint handling and lobbying for pursuing the government for interfering in the business activity and business for amending its ways. Through lobbying consumer organisations are able to influence public opinion against the malpractices followed by traders and government, lacunae in government as observed from the studies conducted by Common Cause (1988), CERC (1988), Ghose (1989) and Common Cause (1990).

Consumer Organisations are also actively involved in solving consumer complaints. They record the fact that most of them are solved.

Sen (1970), CPC (1990) and CGSI (1990) found that most of complaints are pertaining to household appliances.

Kulkarni and Divetia (1983), CGSI (1990), Garg (1988) Sarkar (1989) and Mahapatra (1990) observed that consumer organisations are providing test results to the consumers. It was further revealed that most of commodities are found adulterated. The degree of adulteration varies from product to product and place to place. Moreover, the Government departments are immune to such remedies.

Other studies support the view that 90% of complaints received belong to government undertakings (CGSI 1990, Garg 1988 and Sarkar 1989).

2.2 Disability

2.2.1 Historical Perspective

History of disabled people can be divided into two broad periods of time-the pre-independence period and the post-independence period. Social security system was very rudimentary in India and many developing nations. It is recently that India adopted organized social security against disability, old age and such other. Social security measures are a post-independence phenomenon in India.

In pre-independence era, normally, it was the joint family, which took care of the disabled members; but when there was no family to look after such individuals, religious institutions often came to their rescue. Handicapped people at that time were the objects of random charity and pity and society did not realize that they can and should lead a fuller and more normal life (Bhatt 1965 and Narsimha and Mukherjee 1986).

While this was the general attitude, there also existed the opportunistic awareness that in certain occupations, handicapped persons could be employed more advantageously than normal people could. For example, many kings and nobles employed deaf and dumb persons as servants in preference to others. This would guarantee that activities and conversations within the palace would not go out. The

practice of employing deaf and mute personal attendants in court and as spies in enemy camps have been widely spread in past times.

Further, in South India, the preparation of flower garlands, among North Indian Hindus, the art of music to earn livelihood etc. were practiced by blinds. Among Muslims, the blind earned a livelihood by teaching and reciting the holy scriptures of the Quran.

The orthopaedically handicapped however, were generally accepted as a part of normal society rather than otherwise. Congenital deformities of the limb, as well as loss of limbs due to accidents, war or penal measures were common and not looked down upon. People with loco motor disability were commonly employed in such areas as the circus, where dwarfs were popularly used as court jesters, or as tenders of cattle and caretakers of a village when the rest of the community went out for fishing or hunting.

From the eighteenth century onwards, considerable awareness had started building up in many western countries about the pragmatism of imparting a regular education and training to the blind and the deaf. Unfortunately, there are insufficient historical records to gauge the prevalent attitudes in India at this point in history. While in the mid nineteenth century, almost every country in the west had schools for the blind and the deaf, such a development occurred in India only in a second half of 19th century (Narsimha and Mukherjee 1986).

The onset of the 20th century in India also witnessed the emergence of voluntary sector providing rehabilitation services for the disabled population. Several agencies started promoting voluntary organizations in this field; some were motivated by religious and others by political ideologies. Looking to the government for finances, it appears that they were able to organize and mobilize their resources and cater to the poorer sections. Such organizations confined their services to the deaf and the blind and did not extend that orbit to that of loco motor disability.

For the orthopaedically handicapped however, no institutions came into being during the first half of the 20th century. In the west, some institutions trained orthopaedically handicapped children and also major developments were made in the treatment of crippling diseases. Towards 19th century, vocational needs of the handicapped gained importance. Around this period, interests of disabled started getting legal protection, as result of which at the beginning of 20th century, several institutions had emerged to provide vocational training and employment to the orthopaedically handicapped. Such institutions helped the war-disabled persons in rehabilitation after First World War. Later, these pioneer institutions turned their attention to the civilian disabled population. At this time, however, even the most basic aspects of rehabilitating the

orthopaedically handicapped were unknown in India (Narsimha and Mukherjee 1986).

In India, there was practically no initiative from the government to introduce any services for the handicapped population. In this period, government sector had very few institutions, where as, voluntary sector had bulk of Indian rehabilitation services. Unlike the west, there was also no demand from the disabled population either for expansion or improvement of such services, there was little public awareness or governmental interest in the various issues presented to society by the problem of disability. It was only much later that a change in social and intellectual attitudes towards disability came about in India.

Looking at the post-independence era, it was in 1950 that, for the first time, the Indian government recognized that disabled people have an equal right to participate in social and economic activities as the rest of the community. This basic right was guaranteed by the Indian constitution adopted in 1950. Immediately and thereafter, the Central and State governments began expressing their concern about the welfare of the disabled. The governments focused their effort on the prevention of disability, the training of professionals in this specialized field, development of service models and research. However, service activities were still predominantly left to the voluntary sector. Liberal financial assistance was also given to the voluntary sector to establish new service

programmes and maintain the existing schemes. It was within such a broad framework that rehabilitation services for the handicapped in India developed in the post-independence era (Narsimha and Mukherjee 1986).

At present, the Central government conducts a number of programmes for the prevention of disability throughout the country. These include tetanus-immunization for expectant mothers, DPT, DT immunization for children, prophylaxis against nutritional anaemia and blindness, nutritional supplements and programmes to educate Indian mothers in appropriate health and nutritional practices.

In public sector, the Central Government has set up a major facility to manufacture, on a mass scale, standard quality aids and appliances required by the orthopaedically handicapped population.

2.2.2 Disability: Meaning, Types and Causes

2.2.2.1 Meaning of disability: There are no universally agreed definitions for the commonly used term 'disability'. The terms "invalid", "crippled", "handicapped", "chronically ill", "long-term illness" and "physically unfit" are popular and colloquial equivalents. Despite attempts by WLO, ILO, and UN Rehabilitation unit and other agencies, the definitions have not reached to a final shape. Due to the problem of defining, the physically disabled in India have not been correctly assessed. Different projects, different fields have used the definition

according to their specific aim. It is necessary to be clear about the definition of disability, not only for assessing the correct number of the disabled but also for making any policy for the disabled (Desai 1990).

Different authors or researchers have focused different aspects concerning disability. Kessler (1970) said disability is a negative term in that it refers to an inability or incapacity to meet certain standards of physical efficiency and/or social, occupational, or economic responsibility. The positive counterpart to illness is health. The positive counterpart to disability is capability or physical fitness.

Centring on the concept of 'normal', Sussman (1977) defined disability by using the term 'impairment'. 'Impairment' is defined as any deviation from the normal, which results in defective function, structure, organization or development of the whole or any part of an individual's faculties.

Nagi (1979) emphasized social aspect and said that disability is health related limitations in performing the social roles expected of an individual, such as one's role in the family or in a job.

A set of definitions by World Health Organization (WHO) produced in 1982 is widely accepted in various fields. These definitions differentiate the social, physical and technical aspects of the disability.

The concept is illustrated as below:

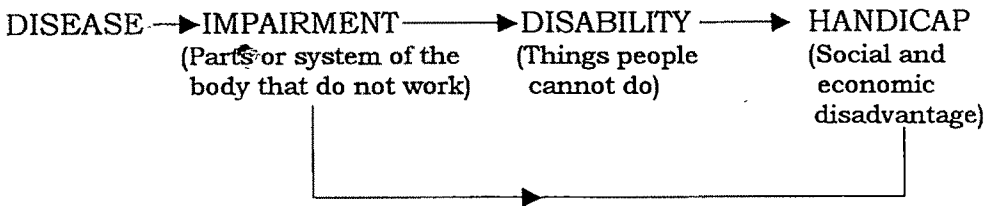


Fig. 2 A Concept of Disability

Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function.

Disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for human being.

Handicap is a disadvantage for a given individual, resulting from impairment or a disability, that limits or prevents the fulfilment of a role, that is normal (depending on age, sex and social and cultural factors) for that individual (Ramamani 1988 and Susan 1990).

But Tewari (1981) in National Survey of disabled used similar definitions earlier. Hall and Jolly (1984) reconstructed the definitions by that a defect is any abnormality of anatomical structure or physiologic process. A disability is a lack or impairment of a particular capability or

skill. A handicap is any condition, which prevents or hinders the pursuit or achievement of desired goals.

Desai (1990) focused on physical fitness and suggested that at the outset, the term 'disabled' suggests a state of helplessness: something which falls short of the norm or standard, viz., 'physical fitness' where, 'physical fitness' itself is a relative term. It is the functional capacity of the individual for a task. It has no real meaning unless the task is specified.

ILO differently expresses the term 'disabled'. According to ILO (1989) it means an individual whose prospects of securing, relating and advancing in suitable employment are substantially reduced because of a duly recognized physical or mental impairment.

According to Sengupta 2000, disability is the loss or want of abilities, temporary or permanent, due to disease, accident, genetic causes or any other reason. She further explained that the scale of abilities or the want of it is a continuum. Every person suffers from want of some abilities and every person with obvious physical, mental or emotional limitations is capable of some work or the other.

In view of the above definitions, it can be concluded that the concept of disability is subjective and situational and it deals with legal, clinical, administrative and psychological aspects, which require much

closer analysis of the activities of work and daily living in functional terms.

2.2.2.2 Types of disability: Classification of disability found mainly based on clinical aspects, although some classifications are based on its severity, working capacity, performance of activities and quality of life.

Brighouse (1946) grouped disability as auditory handicaps, cardiac handicaps, hernias, orthopaedic handicaps, respiratory handicaps, visual handicaps, multiple handicaps and miscellaneous handicaps. He further divided orthopaedic handicaps in subgroups like amputations, arthritis, deformities, dislocations, paralyses (usually following anterior poliomyelitis) and sprains. An additional subgroup included miscellaneous orthopaedic disabilities, which did not fit into any of these six classifications.

Focusing the work, Taylor and Fairrie (1968) illustrated a classification, which is based on the interaction between the state of the individual and the working world. Table 2.1 shows the classification.

Table 2.1 Classification of men with chronic conditions by working Capacity

Grade A	Unfit for any work
Grade B	Fit for modified work
Grade C	Restricted occupational choice
Grade D	No restriction except high physical fitness

Based on the cause of disability, the disabled were classified by Blaxter (1975) as: (a) Industrially induced disease or acquired in armed services and (b) by other causes.

Wood (1975) has devised taxonomies, which link impairment and handicap. He showed more concern with handicap in relation to quality of life rather than just to occupation (table 2.2 and 2.3).

Table 2.2 Classification of impairments and handicaps

Mental and Behaviour
Special senses
Internal organs and special functions
Head and trunk
Limbs – Mechanical
Paralysis
Other motor
Sensory disturbance, disfigurement, other
Transverse deficiencies
Longitudinal deficiencies

Table 2.3 Classification of impairments and handicap

I	Independence (physical)
M	Mobility
O	Occupation
S	Social integration
E	Economic self-sufficiency

Also, Agerholm (1975) classified key handicap linking the impairment (Table 2.4).

Table 2.4 Agerholm's classification of key handicap

1.	Loco motor
2.	Visual
3.	Communication
4.	Visceral
5.	Intellectual
6.	Emotional
7.	Invisible
8.	Aversive
9.	Senescence

Hall and Jolly (1984) classified disability in three main groups of clinical problems as they present in practice. The first contains those major handicapping conditions, which are likely to have a substantial and permanent effect on the child's future development. Blindness,

sensorineural deafness, cerebral palsy, and mental handicap fall into this group.

The second group includes minor defects which are also of organic origin but do not usually have a profound effect on the child's future. Examples include squint, myopia, and conductive hearing loss due to media oddities.

The third group consists of conditions known variously as developmental or neurodevelopmental disorders, developmental delays or learning disabilities. Examples include speech delay, clumsiness, and reading difficulties. These seldom fit into precise diagnostic categories and there is no proven organic basis for them.

Greenblum and Bye (1987) in their study of work values of disabled beneficiaries, categorized disability on the basis of extent of the individual's capacity to work. The groups were: (1) Severely disabled-unable to work altogether or to work regularly. (2) Partially disabled-a combination of two classifications (a) Occupationally disabled-able to work regularly but not at the same work as before the limitation or unable to work full-time; and (b) Secondary work limitation-able to work full-time, regularly, and at the same kind of work but with limitations in the kind or amount of work they can perform.

Ramamani (1988) followed the commonly used division of disability and discussed three types-blind, deaf and orthopaedically handicapped.

The author defined orthopaedically handicapped as those whose physical capacity is impaired by the loss, deformity or paralysis of one or more limbs.

The Persons with Disabilities (Equal Opportunities; Protection of Rights and Full Participation) Act, 1995 classified disability into seven groups. i) blindness ii) low vision iii) leprosy-cured iv) hearing impairment v) loco motor disability vi) mental retardation and vii) mental illness (Mathew, 1999)

Sengupta 2000 noted the Government of India categorization prescribed for implementation of various schemes/programmes and supply of aids and appliances. These are: Visually handicapped, Hearing handicapped, Loco motor handicapped, Mental retardation and Multiple handicapped. Where, loco motor disability means a person's inability to perform distinctive activities associated with moving both himself and object from place to place and such inability resulting from affliction of either bones, joints, muscles or nerves depending on the extent. The categorization would be as follows:(a) mild-less than 40% (b) moderate-40% and above (c) severe-75% and above (d) profound/total-100%.

Academicians according to its application in a particular field have done classification of disability. The bases of classification commonly found were clinical, severity and cause.

2.2.2.3 Causes of disability: When the term disability is denoted as physical defect or impairment, there lie causes behind this impairment or defect. Causes of disability commonly found are 'by birth', 'due to disease' or 'accident'.

Physical defects are categorised by Kessler (1970) as obvious or hidden and static or dynamic. Amputations, deformities, facial disfigurement, a limp or impaired function, by provoking attention and thus exciting prejudice, all fall into the category of obvious defects.

There are two kinds of hidden defects. Amputations or lost members represent one of these. These may be disguised or camouflaged by substitutes or prosthetic appliances. In other type, which involves body systems, the defect may be hidden from external view. Any body system, for example, the central nervous system (brain tumour, epilepsy), the skeletal system (bone cyst, osteoarthritis), the genitourinary system (nephritis, kidney stone), the gastrointestinal system (gastric ulcer, colitis), the pulmonary system (bronchiectasis, tuberculosis), the cardiovascular system (endocarditis, pernicious anaemia, hypertension, endarteritis), may be involved.

Static and dynamic defects or impairments are of functional significance. The loss of a finger or a leg results in a permanent or fixed condition-a static defect. The rehabilitation of an individual with a static defect is facilitated by the knowledge that no further changes are to be

expected in the physical make-up. Arrangements can then be made to utilize the remaining mental and physical skills of the individual for suitable employment or for training in an occupation consistent with his capacities. On the other hand, the patient with diabetes, tuberculosis, arthritis, or heart disease is suffering not from a stationary defect but from a progressive or dynamic one. Such a condition is subject to change for better or worse but is sufficiently active to interfere with the invidual's capacity for continuous work. Irregularity of work capacity in an industrial environment demanding continuity and stability is a potent factor in the definition of disability (Kessler, 1970).

Disability is a functional loss. To understand the causes behind functional loss, it is important to understand various aspects of functions first. There is, first of all, biological function whose purpose is to sustain life. The essential components of biological functions are: (1) cardiac, (2) respiratory, and (3) metabolic. All body systems are concerned with biochemical processes, which support the essential biological functions.

The second function is physiological. By this we mean energy expenditure and the third is specific functions such as those of the limbs and the spine (Kessler, 1970).

Bhatt (1963) described causative factors of disability into three major groups: (a) Hereditary, (b) Congenital and (c) Acquired. Each of

these was further attributed to a number of contributory causes. She distinguished between the terms hereditary and congenital by saying that a defect which is congenital (present at birth) or familial (running in a family) may not be hereditary at all. A hereditary defect is one that passes down from generation to generation because of some sort of disturbance in the working of inherent gene mechanism. Thus, a particular condition may be hereditary and yet, it may not manifest itself at birth, or for many years to come, or might not have appeared before in the individual's immediate family. The causes of disability according to Bhatt (1963) are listed in table 2.5, some of which are not commonly found now in India.

Table 2.5 Causes of Disability

Hereditary	Congenital	Acquired
	1. Maternal malnourishment	1. Birth injuries
	2. Maternal infection	2. Pathological conditions and diseases
	3. Rh factor	(a) Cerebral palsy
	4. Disease	(b) Poliomyelitis
	5. X-rays	(c) Tuberculosis of bones and joints
	6. Chemical agents	(d) Arthritis and rheumatism
	7. Glandular disorder of the mother	(e) Hemiplegia
	8. Mechanical factor	(f) Paraplegia
		(g) Multiple Sclerosis
		(h) Muscular Dystrophy
		3. Accidents
		(a) Industrial
		(b) Traffic accidents
		4. Nutritional deficiencies
		5. Postures
		6. Consequences of war
		7. Poverty
		8. Other causes

Ramarao (1978) mentioned, while discussing about prevention and early detection of disability, injury, disease or heredity as reasons of disability.

According to Narsimha and Mukherjee (1986), deformity of limbs, paralysis, dysfunction of joints and amputation are the main causes of loco motor disabilities in Indian population. About 30% of loco motor disabilities because of paralysis and deformities in rural areas are attributed to polio. This percentage was little higher in the urban areas, 40 percent. The incidence of loco motor disabilities is normally higher in the age groups-60 and above and zero to four years, than in the older age groups, in both rural and urban areas as well as in males and females.

Susan (1990) noted that in western industrial societies, increase in chronic and disabling diseases has been replaced traumatic injuries and infectious diseases as major causes of severe disablement. In addition, the causes of severe disability are arthritis, problems of the nervous system such as strokes and Parkinson's disease and mental disabilities.

According to Sengupta (2000), the causes of disability are as below:

1. Antenatal, natal and postnatal causes
2. Iodine deficiency
3. Polio
4. Genetic causes
5. Accidents
6. Mal-nutrition or nutritional deficiency

The author described causes of loco motor disability as- poliomyelitis, accidents, aging, muscular dystrophy multiple sclerosis, arthritis and stroke. A brief explanation of explanation of each is presented here.

Poliomyelitis: One of the most conspicuous childhood disease that leads to loco motor disability is poliomyelitis. Following an attack of poliomyelitis a child may suffer partial or complete paralysis of one or both lower limbs or in fact one or both upper limbs as well. In severe cases, the trunk may also be affected leading to deformity of the backbone.

Accidents: Growing industrialisation has resulted in disabilities due to accidents. These emerging areas in loco motor disability have not in the past received any attention they deserve. In the first place, a major cause of loco motor disability is by injuries related to growth of industrial, agricultural, vehicular traffic and rail accidents. Even the natural disasters cause a host of loco motor disability. Wars and local conflicts are a significant cause of loco motor disability.

Aging: India is fast growing old. By the year 2000, about 25% of its population will be about 65 years of age. At that age arthritis, weakness due to neuro muscular and other related factors create a host of loco motor problems. Another emerging factor is AIDS. Unfortunately, AIDS is fairly common phenomenon in this country. By reducing resistance,

AIDS may leave the individual susceptible to further infections and damage to the loco motor system.

In many cases, the arm or other limb of an individual is to be amputed on account of a cancer, gangrene or on account of conditions like diabetes and infections. Thus, a significant number of people with loco motor disability are amputees. Fortunately, in many cases an artificial limb can be fitted and this to some extent reduces the limitations of disability.

Muscular dystrophy: Muscular dystrophy is another condition leading to loco motor disability. This is a progressive, degenerative and genetic disease. In this disease, a certain part of the body begins to gradually degenerate affecting the movements.

Multiple sclerosis: Multiple sclerosis is a disease in which the body's own immune system destroys myeline sheath, the sheet covering the nerves. With the destruction of myeline, it is difficult for nerves to carry the messages to the brain and other parts of the body. Multiple sclerosis may affect vision but quite often results in loco motor disabilities.

Arthritis: Arthritis is one of the major causes of loco motor disability. There are two major types of arthritis resulting quite often in loco motor disability. Rheumatoid arthritis is more common among

women than in men and occurs at an early age. It commonly affects the hands leading to pain, stiffness and deformity.

The other type of arthritis is austeo arthritis commonly affecting men at a later age and involving the knee and spine leading to pain, stiffness and deformity.

Stroke: Stroke is a leading cause of disability of old age. It is associated with paralysis of one half of the body. The common risk factors are high blood pressure, old age, high blood cholesterol and heart disease. This loco motor disability may be associated with inability to speak as well.

2.2.3 Demographics of disability

The prevalence of disabilities has been variously estimated in different countries.

In Australia, in 1978, approximately 10% of the population had some form of major disability; about 75% of the people over 75 were disabled in some way. Also that for every person killed on the road, another 30 were injured.

In 1975, in Ecuador, it was estimated that 3 lakhs men and women of working age were physically or mentally disabled. Since then 8,700 more have been added to the list each year as a result either of illness or of accidents-often occupational accidents.

In late 70s in Indonesia, 4 million people were estimated physically and mentally disabled.

According to a survey in 1970, the total number of the physically disabled in Japan was 1.43 million. At the time of survey, it was seen that 3.7% disabled children below 18 years and 17.9% disabled persons over 18 years existed in every 1000 population.

In Kenya, sample surveys carried out by the division of vocational rehabilitation in 1973 and by the central bureau of statistics in 1977 revealed a disability rate of about 2 percent. These surveys, however, were limited to the obvious disabilities such as blindness, loss of hearing, orthopaedic effects and mental retardation.

The only reliable statistics on the demography of the disabled in Nepal is those provided by the sample survey of disabled persons 1980. According to this, there are 30.03 disabled persons per thousand population in Nepal. Of these, 62.63% were found to be male and 37.37% female (Tewari, 1981).

Eighty percent of people suffering from various anomalies live in the developing countries (Tewari, 1981) and also 5.21% of the population in developing countries have moderate to severe disability (Sengupta, 2000).

The prevalence rate depends to a very large extent on how disability is defined in a given area. A survey conducted by WHO showed

that only 4% in Sri Lanka had disability. On the other hand, in Austria the prevalence was estimated at 20.9% (Sengupta, 2000).

The census organisation of India had collected information on physical disabilities or infirmities in the decennial census from the very beginning (1916). But it was discontinued from 1941 onwards in view of doubts expressed about its reliability. For the first time after independence, the census organisation once again collected information on the physically handicapped in the 1981 census. The 1981 census covered three broad categories of disabilities: the totally blind, totally dumb and totally crippled. However, the census provided only a framework for subsequent detailed investigation by other agencies. No information regarding sex, age and other characteristics was collected. Mental disability was excluded from the survey. The survey estimated that about 12 million persons suffer at least from one or other physical disability. This constituted about 1.8 percent of the total population of 680 million (Social Welfare Reports 1985, Narsimha and Mukherjee 1986, Ramamani 1988, Prasad 1994, Krishna 1997, India 1999 and Sengupta 2000).

Similarly, the NSSO in its 47th round (1991), estimated population of the disabled as about 16 million in the country constituting about 1.9% of the population, amounting to a simple average of 0.4 million disabled persons being added every year. The prevalence rates of

physical disability was higher (2%) in rural areas than that of urban areas (i.6%) (Prasad1994, Krishna 1997, India 1999 and Sengupta 2000).

It is declared by the Home Minister that information on disabled population will be collected under census 2001 (Verma 2000).

2.2.4 Problems of disabled

Considering the problems of the physically handicapped, it was found that although the types and most of the causes of disabilities and basic methods of treatment are same everywhere, the social and psychological impact of disability would be different in different communities according to their differing social conditions.

"The entire spectrum of the plight of the physically handicapped in India needs to be studied against the limitless locale of the cultural, religious, social and economic milieu prevalent in different parts of the country" (Ravindran 1981).

"In the specific terms this would mean the factors like poverty, illiteracy, malnutrition, rural economy, unemployment, over population and social mores (as superstition, fatalism and unshakable faith in rebirth) must be evaluated in relation to their impact on the problem of the physically handicapped" (Wallace and Wagner 1970).

Different authors and researchers have presented "problems" in different ways. Besides physical and functional problems related to disability, many have discussed about psychological and social problems

attached to disability. Also adjustment problems are spelt out. Apart from the problems faced by the disabled person, some authors presented problems in dealing with disability as a national issue.

In First All India Conference on work for the handicapped, Merchant and Bhat (1978) highlighted the problems faced in handling disability at national level. They mentioned following problems-

1. Lack of data on demographics of disability.
2. Unclear definitions.
3. Geographical variations.
4. Presence of multiple disabilities complicates simple rehabilitation process.
5. Delivery of services.

While explaining individual psycho-social reaction of a disabled, Ramamani (1988) further said that the transition of the body from health to sickness takes only few months, but the persuasion of the mind to accept disability may take months, years or even decades. Ramamani (1988) described psychological and social problems of a disabled person. Among psychological problems, he noted that the physically handicapped individual suffers from self devaluation because he is unable to satisfy many of the basic emotional needs under normal circumstances. He therefore, feels frustrated and inferior. Secondly, the disabled person

fights against feelings of uncertainty and indefiniteness into many areas of life. Thirdly, he feels insecure with his independence.

Obstacles in complete social integration is the main social problem. First, the looks or appearance of disabled unfortunately becomes his distinguishing mark, which considerably hinders his integration into his family and community. This is particularly true in case of women with disabilities (Susan 1990 and Divatia 2000). His education and other activities also get affected resulting in social segregation. Society often interprets disability with intellectual inferiority, occupational handicap and even emotional instability (Laura 1980, Ramamani 1986, Desai 1990, Susan 1990 and Prasad 1994).

In addition to stigma of demoniac origin, social prejudice towards physically handicapped is an age-old feature worldwide (Kessler 1970). In India, it is still a common practice to give alms to the crippled. It is taken for granted that the crippling condition of a person is the result of his own Karma, i.e. actions either in the present or past births, that nothing can be done to alter his condition and that the handicapped person must suffer so that in the next birth he can be free from the deformity (Desai 1990).

While describing social problems, Desai (1990) adds that the handicapped child, who has other anxieties due to personal and environmental factors, may transfer them to his organic defect and

become too conscious about it. Also, a person who comes from a particular home background, fears a certain parent-child relation ship and has some definite attitudes towards his handicap.

According Ramamani (1988), the disabled face many social disadvantages because of their physical inadequacy, such as a feeling of inferiority, fear of social ridicule, inability to compete with the normal people, lack of self confidence, and limited social participation. The disabled have to adjust themselves to their own disabilities as well as to the uncongenial social atmosphere. Thus they are called upon to bear a double burden, social handicap in addition to the actual physical loss. Therefore, handicap is a social condition imposed upon the disabled individual. He feels handicapped and is made to feel handicapped.

Hall and Jolly (1984) pointed out the problems of handicapped teenagers. Youngsters often have social difficulties in developing independence. Physical handicaps may directly affect sexual function, as in spina bifida, or may inhibit sexual activity by making the person totally dependent on others, as for example in severely handicapped, it is unlikely that sexual relationship would develop.

While quoting the problems of crossing the road leading to Blind Men's association, the Association has asked for a subway for disabled coming to the institute, to reduce the danger of the high growth of fast vehicular traffic (Indian Express, 1998).

Another report by Press Trust of India, in the daily Indian Express (1988) reported about key board operated pen which would lessen the difficulty of the physically handicapped in writing and painting.

2.2.5 Rehabilitation

The process of rehabilitation is to bring disabled into main stream of national life. Rehabilitation has been defined by Desai (1990) as the act of restoring forfeited rights and privileges. The process is composed of three parts, (i) physical, (ii) socio-psychological and (iii) vocational (Bhatt, 1963).

According to Blame (Cited in Bhatt, 1963), "Rehabilitation when applied to the problem of physical disability, it must include methods of prevention, of limitation of disablement, of adaptation of disabled persons to their handicap, and of the necessary assistance by means of protective legislation, social security scheme and technical aids for the disabled".

According to Ruth (Cited by Bhatt 1963), rehabilitation consists of three phases-prevention, definitive treatment and rehabilitation.

It has been estimated by experts in the field that with proper treatment, rehabilitation and training 90% of the handicapped can brought back to the main stream of national life.

2.2.5.1 Prevention and early detection: The Disability Act 1995 has the provision for prevention and early detection of disability. It says

that appropriate governments and local authorities should take following steps for the prevention of occurrence of disability.

Government and local authorities should:

a) undertake surveys, investigations and research concerning the cause of occurrence of disability.

b) promote various methods of preventing disability.

c) screen all the children at least once a year for the purpose of identifying "at risk" cases.

d) provide facilities for training to the staff at primary health centres.

e) sponsor or cause to be sponsored awareness campaigns and disseminate or cause to be disseminated information for general hygiene, health and sanitation.

f) take measures for pre-natal, perinatal and post-natal care of mother and child.

g) educate the public through the pre-schools, schools, primary health centres village level workers and anganwadi workers.

h) create awareness among the masses through television, radio and other mass media on the cases of disabilities and the preventive measures to be adopted (The Persons with Disabilities Act 1995 and Mathew 1999).

Discussing the loco motor disability, Sengupta (2000) noted that loco motor disabilities are quite often easier to diagnose. A regular

medical check-up of the child and pregnant woman or adult should be undertaken to detect deformities at an early stage so that corrective measures may be taken well in time to prevent further deterioration.

For minimising the impact of disability problems in the community, the best method is to prevent disablements at their early stage to the maximum extent possible. Disability prevention would include (i) reducing the occurrence of impairments (first-level prevention) (ii) limiting or reversing disability caused by impairments (second-level prevention) and (iii) preventing disabilities from developing into handicaps (third-level prevention) (RamaRao 1978 and Narsimha and Mukherjee 1986).

Actions in each of these three levels were given by RamaRao (1978) as following:

(i) First level prevention

-"Impairment" can be prevented to a certain extent, e.g. prevention of congenital diseases.

(a) Genetic-by prospective counselling

(b) Non-genetic disorders-by preventing malnutrition and communicable diseases in pregnant mothers. Good anti-natal and natal care.

-Prevention of acquired diseases

(a) vaccination (b) pre, para and post natal care.

(ii) Second level prevention

When impairment has happened, to prevent long-term functional limitation.

(a) identify those impairments that might lead to limitations.

(b) proper care in acute stage

(c) proper care in chronic stage

(iii) Third level prevention

When long-term functional somatic or mental limitation has developed.

(a) training to increase independence in self-care

(b) educational and vocational measures aimed at achieving an economic independence.

(c) social measure for full integration into society.

2.2.5.2 Rehabilitation and welfare services: Great variation exists in the delivery of rehabilitation services among various countries. Zeitzer and Beedon (1987) studied rehabilitation services of eight different countries and concluded that depending on the particular country, the sickness fund itself may provide the rehabilitation or refer the claimant to a rehabilitation provider. This is usual procedure in Austria, Finland, Germany, the Netherlands and Sweden.

Although sickness benefits are not provided as part of the social insurance programme in Israel, the great majority of the population is insured through Labour Federation and therefore, the opportunity for

early detection exists through a similar mechanism (Zeitzer and Beedon 1987).

Desai (1990) noted that in Western countries, rehabilitation of the physically and mentally handicapped achieved a new significance after the Second World War. In some of the advanced countries, certain Acts have been passed which constitute and extend the provision for the rehabilitation, financial support and care of the social services programmes.

He further noted that in the Netherlands, emphasis is laid on sheltered employment for all kinds of unplaceable persons. In Germany, there is provision for payment of compensation and benefits. Further, a quota scheme reserves a higher number of jobs for some categories of handicapped persons. In France, a variety of therapeutical and educational facilities are provided besides a number of subsidised measures.

As compared to other countries very little has been done in India for the handicapped. Merchant and Bhat (1978) focused on the lacunae in rehabilitation programme in India. According to authors, there are following gaps to be bridged to achieve results.

(i) Qualitative gap

Lack of good rehabilitation and preventive services nearer to the patients' place of living.

(ii) Quantitative gap

Needs for services will increase and new needs will arise

(iii) Geographical gap

Rural isolation with severe personal disability with lack of rural rehabilitation services.

(iv) Trained personnel gap

(v) Inadequate national policy and legislation

(vi) Financial gap

(vii) Insufficiency of consultation and joint action between governmental and non-governmental agencies.

After independence however, the government of India assumed increasing responsibility in providing rehabilitation services to the disabled.

Governmental efforts: The first five year plan marked a turning point in the history of rehabilitation-a change from charity to rehabilitation. In Second Plan emphasis was placed on the education and employment of the physically handicapped. During this period, the government of India envisaged the schemes for awarding scholarships to the disabled students and establishing special employment exchanges for the disabled. In the Third Plan, stress was laid on the development of training facilities geared to employment and increasing the scope of employment opportunities for the handicapped. The Fifth Plan reiterated

the Third Plan emphasis on employment of the handicapped (Desai 1990). According to Habibullah (1987), in the Sixth Plan an amount of Rs. 240 million was earmarked which in the Seventh Plan (1985-90) had risen to Rs. 1240 million.

Habibullah (1987) and Desai (1990) explained that as the first step towards rehabilitation of the handicapped, the Government of India established a Special Employment Exchange for the Physically Handicapped (SEEPH) in Bombay in 1957 to provide jobs for all categories of handicapped.

Twenty-two such employment exchanges were then established at major cities of the country. Besides, 41 cells of SEEPH have been set up all over the country for the rural handicapped job seekers.

As the second step, mentioned by Habibullah (1987) and Krishna (1997), two Vocational Rehabilitation Centres (VRC) for the handicapped were established in Hyderabad and Bombay in June 1968 with the cooperation of the Health and Education Department of United States of America to provide vocational evaluation and adjustment training to the handicapped. Encouraged by the response, the Government of India set up another 12 VRCs in different cities.

The government then set up six skill training workshops at six VRCs in Ahmedabad, Bombay, Banglore, Hyderabad, Trivendrum and Madras. These workshops provide training in the trades of electrical,

electronics, general mechanics, air conditioning and refrigeration, automobile engineering, printing, book binding, arts and crafts, textiles, cutting and tailoring, secretarial practices etc. (Habibullah 1987).

To mark the International Year for the Disabled Persons (IYDP) in 1981, the Government of India launched a scheme for the distribution of aids and appliances to the poor and needy handicapped people according to their disabilities. These appliances (tri-cycles, clutches, artificial limbs etc.) are arranged through some forty-two agencies, which are divided into four zones (North, South, East and West zones) (Narsimha and Mukherjee 1986, Habibullah 1987 and Krishna 1997).

To provide national level facilities for all types of the handicapped the Government of India established "National Institutes" for each category of handicapped. They are: The National Institute for the Visually Handicapped at Dehradun; The National Institute for the Orthopaedically Handicapped at Clacutta; The National Institute for the Hearing Handicapped at Bombay and The National Institute of Mentally Handicapped at Ahmedabad (Narsimha and Mukherjee 1986 and Habibullah 1987).

The Government of India provides numerous facilities to the handicapped (See Appendix- F).

Also, The Government of India has set up the Rehabilitation Council of India to enforce uniform standards in training of professional

in the field of rehabilitation for the handicapped, maintenance of Central Rehabilitation register and other connected matters. The Rehabilitation Council of India Act has been enacted and has come in force since 31st July 1993 (Sengupta 2000).

A comprehensive law, namely, Person's with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 has been enacted and enforced in February 1996. The law deals with both prevention and promotional aspects of the rehabilitation such as education, employment and vocational training, creation of barrier-free environment, provision of rehabilitation services for persons with disabilities, institutional services and supportive social security measures like unemployment allowance and a grievance redressal machinery both at Central and State level (Krishna 1997, Mathew 1999 and India 1999).

2.2.5.3 Voluntary organizations: Voluntary organizations have unique position in the society. Without the co-operation and participation of the voluntary organizations, it is difficult for the government to meet the expected demand in this field (Merchant and Bhat 1978). The voluntary sector plays a dominant role in providing welfare and rehabilitation services for the disabled (Narsimha and Mukherjee 1978).

Prior to independence, voluntary organizations were largely dependent upon small contributions from philanthropists, rather than from the government or the large industrial houses. This trend has now changed and voluntary organizations established in recent past are mainly dependent upon grants from governmental and industrial establishments. In addition, certain private foreign funding agencies provide financial and material support for voluntary action in the country (Narsimha and Mukherjee 1986).

The directorates of Social Welfare in the various states allocate special budgetary grants to the voluntary agencies for the education and rehabilitation of the handicapped (Desai 1990). Grants-in-aid to the extent of 90% of the estimated cost for taking up projects or programmes for the education and training of the physically handicapped were sanctioned to voluntary organizations around two decades before (Social Welfare Report 1977-78).

Thus, to a great extent the growth of voluntary agencies has been nurtured by the policies adopted by the government (Desai 1990).

Narsimha and Mukherjee (1986) reported that a large number of voluntary bodies emerged after independence, in India, include several schools for the blind, the deaf and the mentally retarded. The voluntary sector has also significantly aided severely handicapped sections such as

the spastic, and many vocational centres and sheltered workshops have been set up by voluntary organisations all over the country.

2.2.6 Relevant Research Studies

Many researchers in their studies identified causes of disability (Saksena 1962, Gupta 1970, Dubey and Khanna 1972, Shivadey 1973, Jeet 1983 and Iyer 1986). Irrespective of types of disability accidents, illness and congenital disease were the commonly found causes of disability in these studies. Shah (1983) and Iyer (1986) further found that maternal malnutrition, closely spaced pregnancies, work load during pregnancy, smoking and spurt in development in the areas of locomotion and communication are the causes of disability among infants.

Shivadey (1973) and Jeet (1983) reported that more than half of the respondents had developed the disability due to accidents and illness, especially poliomyelitis.

Problems faced by disabled in various aspects of life were studied by a number of researchers. They highlighted the areas of problems such as routine activities, education, employment, marriage and other psychosocial problems. Type and extent of problems faced varied with the type of disability (Kanwar 1960, Bahtt 1963, Kaur 1969, Shivadey 1973, Ambani 1975, Vadhyar 1975, Chopra 1977, Ishtiaq 1977, Aggrawal 1979 and Dhillon 1982). Gandotra (1982) studied the

management problems of the homemakers with the disabled member in her family.

Studies showed that physically handicapped faced fewer problems as compared with other categories where as, mentally handicapped face more problems in their routine activities (Kanwar 1960, Bhatt 1963, Kaur 1969, Vadhyar 1975, Ishtiaq 1977 and Aggrawal 1979).

Studies reveal that there is low educational level found among disabled. Disabled faced difficulties in getting education in terms of mobility, prolonged medical treatment, negative reactions of the teachers and classmates, attitude of parents and sometimes financial limitations (Bhatt 1963, Ambani 1976, Aggrawal 1977 and Dhillon 1982).

Pathak (1972) studied the special educational provisions for the physically handicapped children in England and Wales. He found that the system offered an average handicapped child, irrespective of his class, creed and sex, a fairly good prospect of getting into a suitable school, which would ensure him the requisite minimum of formal and informal education, medical care, healthy environment and a fairly good chance in the experience of community life and training in good citizenship.

Employment is another aspect, which affects the independence, social integration, and self esteem of the handicapped. Earlier, employment was not much commonly found in disabled people. Bhatt

(1963) explained the reason that majority of the disabled during that period were taken care of by families. In recent times, the demand of employment among disabled of both the sex has increased largely. Ambani (1976), Chopra (1977) and Vyas (1979) stated the problems of disabled with regards of employment as low education, lack of vocational training, limitation in mobility, non-cooperative and unhelpful attitude of employers and co-workers.

Mohan (2000) from her study on employment of disabled in public sector organisations concluded that rather dismal trends in terms of the current employment practices existed in the corporate sector with regard to people with disabilities. Government's apathetic attitude is amply reflected in the miniscule percentage of disabled employees even in the public sector organizations who arguably have a larger workforce and for whom it is mandatory to have 3% reservation for disabled persons.

Rehabilitation of the disabled people was studies form different t point of views by different researchers. Shivadey (1973) and Gokhale (1977) studied rehabilitation of the physically handicapped with artificial limbs. Adiseshiah (1972) studied the rehabilitation programme for handicapped people in Madras. Jayanti (1982) studied the effectiveness of mother education programme for the rehabilitation of developmentally handicapped child. Fawcett (1998) studied the constitution social work in Britain through a case study and proposed to apply post structural

and postmodern perspectives informed by feminism to social work, focusing particularly on pertinent issues in the disability arena.

In another study, Muske (1995) examined economic well-being among disabled elderly households and concluded that the economic well-being is a function of resources, either income or education. Social security alone did not provide adequate protection against threat of poverty. He found that having multiple income sources increased the likelihood of remaining out of poverty or having higher net worth.

A report in daily Economic Times (1998) suggested to make the UGC institution more disabled friendly as new constructions were expected in the light of the passage of the Disability Act 1995. The institute proposed to have architectural barriers free building and special equipments to cope up with their day-to-day functioning.

Kashyap (1991) studied available Indian research studies on families having disabled individuals and found the gaps in research in this field. She concluded that from among the four categories of the disabled, the mentally handicapped and their families have received maximum attention from researchers.

2.3 Disabled as Consumer

Disabled persons form a substantial part of the world population and constitute a group which ought to be enabled to participate fully and equally in society. They should not be considered as mere handicapped but as promises. A vast majority of them, with a little extension of services or modifications in goods, can do wonders and contribute manifold returns to society. The disabled person must be considered and must himself behave as an equal and full member of society because they have the same rights and duties as every other member.

The obstacles in the way of disabled as consumers need to be removed they are the consumers of education, transport, electricity, aviation, banking, insurance, post and telegraph, municipal services and so on. As Shah (1994) expressed, "let the disabled have the privilege of boarding the train, the bus, the plane first-as an expression of our collective consciousness of their existence amidst us. Let the disabled park their vehicle nearest to their destination. Society needs to facilitate their access to consumer rights and ensure how best it can empower them to use these rights".

According to Susan (1990) most people with disability are handicapped primarily in the range of choices available to them-where to live, what sort of educational opportunities are around, what

employment is on offer and what sort of leisure or social activities are available to them. These primary handicapping conditions often lead on to secondary handicaps such as lack of access to material resources and the experience of poverty.

While describing the problems of blind persons as consumers, Patel (1994) said that a majority of visually handicapped persons come from the poor strata of society. Their purchasing power is restricted. They purchase simple articles of common use such as food, grains, vegetables, inexpensive fruits, linen, lanterns, kerosene, cots, chairs, etc. The blind purchaser is wholly incapable of conducting any examination of these articles. Therefore, he has to rely on the seller regarding their fitness for use. But it is experienced that unscrupulous elements among the sellers fully exploit the disability of the blind consumers. There are numerous instances of defective material being sold off to the blind consumer.

The problems of loco motor disabled as consumers are different. They need barrier free environment in the market and specially designed products as well as packaging because their limitation is with movement and mobility.

Somarno (1981) in a conference held by IOCU reported that several local consumer groups in United States assessed the accessibility of public building to disabled people. Grall (1979) reported about a

programme of comparative testing of products for the disabled. This proved that a very big need exists of objective information on products and services in this field. Disabled people tend to have more difficulties in obtaining a broad orientation before buying and very often they order by mail in United States. Data also indicated that products bought, often afterwards do not meet the requirements of daily use, regarding adjusted functioning, reliability, serviceability, social and aesthetic appearance and, as a consequence, this kind of products are not being used any more after a short time.

Dunne (1981) opined that disabled people need efficient and safe equipment and tools for living. According to Dunne, there are at least five types of products, where consumer organisations and producers can focus attention for its design and use. First, there are those which can be made in the home, do-it-yourself aids. These have particular significance in the third world. Second, commercial aid specially designed for the handicapped. Third, standard domestic and leisure equipment such as such as cookers, refrigerators, radios and the like. Then there are standard household fittings such as door handles. Lastly, architectural features such as ramps, steps, handrails, lifts etc should also be considered.

Dunne (1981) also pointed out the difficulties in standardising the products for disabled. The problem of comparative testing and standardisation is that the abilities of handicapped people vary widely.

Studies of product testing for refrigerators (Grall 1979), Portable gautries, walking frame and spring lifting cushions (Dekleyn 1980), it was found out that manufacturers often leave out safety aspects and also major faults in basic designs were found. It was suggested that consumer organisations must enter into a dialogue with manufacturer after they have done comparative tests to ensure that design is improved and any new design that emerge come into production.

There exist ample research studies on disability focusing disabled persons and their family member/s. It has been observed by the researcher that in 60s and 70s the trend of studies was more towards finding out the problems of the disabled in various aspects of life where, findings suggested less participation and social integration of the disabled. As the movement from government took pace and also because of the efforts made by voluntary organizations, the scenario then changed from finding out the problems to suggesting solutions and helping them to bring them back into mainstream of life. The last decade of 90s focused on the more discussed Act, the Persons with Disabilities

Act 1995. Researches have been conducted to prove the need of it and then lacunae in amendment of the Act.

Although it has been said many times and with different references, that disabled person should be treated as normal person, there is a dearth in research studies focusing a different role of disabled. Disabled in the role of consumer is hardly explored area. It is the demand of changing time that disabled should be studied as normal persons for common issues like consumer rights. This would help in upliftment of the mass and change in the attitude of the researchers.