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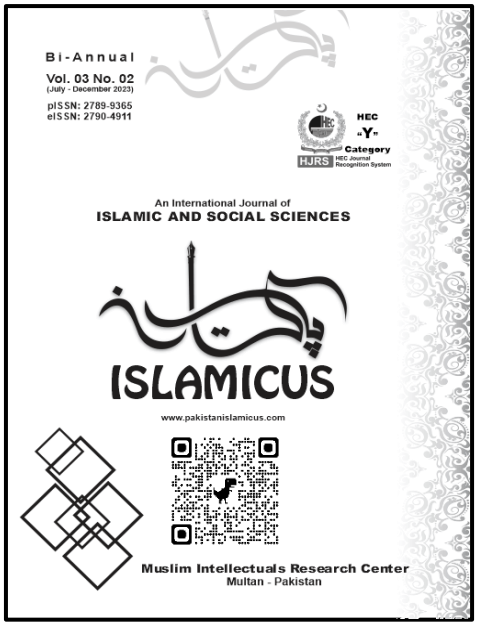

TOPIC

SOCIAL INCLUSION OF PERSONS WITH DISABILITIES: RIGHTS-BASED APPROACH

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SOCIAL INCLUSION OF PERSONS WITH DISABILITIES: RIGHTS-BASED APPROACH

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Abstract

Persons with Disabilities (PWDs) are considered the most vulnerable and less included part of society. Being the signatory of the United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD), it is obligatory for the Government of Pakistan to ensure their rights for their inclusion in the mainstream. This paper focuses to know the extent of social inclusion of PWDs in the context of the rights-based approach that emerged after the enactment of UNCRPD. The respondents were physically and visually impaired, both male and female, belonging to the age group 18-42 and presently engaged in employment either government, private and self within the territorial boundaries of Islamabad and Rawalpindi. In the present study, the gender of the respondents, their age, their marital status, their family income, their level of disability, their level of education, their residential background and the total number of PWDs in their family were independent variables, while social inclusion with respect to the right of education, health, employment, cultural, recreational, political participation, social protection and accessibility was the dependent variable. Bivariate analysis was carried out by using Chi-Square and Somer's D tests to know the association between dependent and independent variables. The results reflected more inclusion of persons with disabilities who were male, married, residing in urban areas, had mild levels of disabilities and had higher family income.

Keywords: Social Inclusion, Rights Based Approach, Persons with Disabilities

Introduction:

According to the Pakistan Bureau of Statistics (1998), there are seven different types of disabilities and of those disabilities, 18.79% are physically and 8.18% are visually impaired. The census, 1998 showed that people with disabilities made up 2.49% of the population in general and 0.2% of them lived in Islamabad, capital of Pakistan. Despite the clear need for ownership, treatment for persons with disabilities (PWDs) should be started as soon as possible and the nation's service delivery system should be strengthened. Because of social constraints and physical distinctions, persons with disabilities are regarded as being marginalized and isolated segment of society. Limited access to or exclusion from chances for basic education, healthcare, employment, political and cultural participation raise serious concerns about state obligations and the UN's charter on human rights. The consideration of all individual fundamental rights, especially those who are marginalized and underprivileged is essential to the prosperity of any country.

Disability is a discourse of human rights because people with disabilities suffer injustices, such as being refused equal access to political participation, work, or health care because of their disability. For instance people with disabilities, whether they experience assault, abuse, prejudice, or disregard because of their condition, people with disabilities are susceptible to abuses of their dignity. Some of them are not allowed to have autonomy, such as when they undergo involuntary sterilization, when they are deemed to be legally incapable due to a handicap or when they are imprisoned in institutions against their choices (WHO & World Bank, 2011).

According to United Nations Convention on the Rights of Persons with Disabilities (2006) “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”.

Social inclusion being multidimensional concept usually refers to involvement in different fields of life i.e. socio-economic, cultural and political (Khan et al., 2015). According to world social situation report (UN, 2016) mechanism to enhance contribution of marginalized community by augmenting avenues, access to means, opinion and acclaim of rights.

Westfall (2010) referred social inclusion as facilitating people through provision of rights such as education, training, employment, health, housing, exercising vote and freedom of expression. It also declares society response towards peoples’ participation by addressing their differences, fulfillment of rights and basic necessities. The notion of inclusion deliberates

access to all community resources inclusive of education, training, employment, health, housing, social, cultural, religious and recreational activities.

The UN's adoption of the Convention on the Rights of Persons with Disabilities made it feasible for people who were disabled to be included in society on an equal term. They need to be treated with respect and treated equally with other people in order to fulfill their contribution to the development of country. This vulnerable group's duties and spaces were redefined by the convention, which had an impact on society's attitudes. That accomplishment sets a global benchmark for ensuring and enhancing people's sense of dignity and identity. The convention therefore implemented their inclusion at all levels (UNCRPD, 2006).

Methodology

The present research was conducted to know the extent of social inclusion of employed persons with disabilities those possessed visual and physical disabilities in twin cities i.e. Rawalpindi and Islamabad. A cross-sectional survey was conducted to collect quantitative data from the respondents. Two strata were developed. Yamane formula (1967) as found in literature (Kharuddin et al., 2020) was:

$n= N/1+N (e^2)$

N= total population=410

e= precision level=.05

Total population of physically and visually impaired persons were 410 and the sample size calculated from total population by using the foregoing formula was 202. Thereafter, the calculated sample size was proportionally allocated to each disability and then randomly selected. The formula used for proportion allocation from the studied sample size.

$n_i= n*N_i/N$

By using this formula, the proportion of visually and physically handicapped persons were 109 and 93 respectively.

Literature Review

Despite the fact that the word disability isn't used specifically in the Qur'an, Hassanein (2015) noted that the Muslim Holy writings mandate that every Muslim, regardless of their skills or impairments, should be treated as an important member of the community. He pointed out that 10 Ayat of the Qur'an say that those who are disabled should be dealt with complete respect and should have the same person-to-person relationships as people who are not disabled.

Blanks and Smith (2009) highlighted that Islamic principles and the Holy Qu'ran clearly offer inclusion of people with disabilities in social life by condemning the view points towards

disability impurity. They also recommended that reasonable spaces may be provided to persons with disabilities to ensure their participation in religious activities.

Rights based approach was publicized for guarding human rights in pursuance of globally recognized human principles (Robinson, 2001). The approach empowered people to be decisive in their living choices (DFID, 2000). Hence, people are equipped to attain reasonable quality of life as prescribed universally by managing primary reasons of exposure and completion of tasks (CARE, 2000).

Social inclusion of persons with disabilities in line with this model based on rights based approach (Quinn & Degener, 2002; and Degener, 2016). It extends equality and inclusion of persons with disabilities followed by removal of structural and societal barriers faced by them (Palmer, 2013).

Human rights based approach robust disability discourse towards improvement in access to quality services, their role in decision making, advocacy and claim. At large, this approach paves ways for persons with disabilities to claim their rights and enhances ability of state to ensure such rights (Fennell &Khaliq, 2011).

Rights based approach gives birth to empowerment of persons with disabilities resultantly their representation is obvious rather being represented (Barron &Amerena, 2007).

Jahangir (2007) observed a shift in perspective about the social inclusion of individuals who are handicapped in the absence of the adoption of their Convention, which upholds their privileges and declares them to be equal.

The level of individual functioning, the stage of one's life, the basic health issues, and the factor of environment, all play an important role in how much support and assistance someone will need (WHO & World Bank, 2011).

The right to education for people with disabilities is recognized in Article 24 of the UNCRPD, and the States Parties are given responsibility for ensuring that this right is realized without bias and on the basis of equal chances (UNCRPD, 2006).

According to UNCRPD article 27, States Parties acknowledge that individuals who are handicapped have the same privilege to employment as everyone else, including the opportunity to earn a living through work that is freely chosen or recognized in a labour market and workplace atmosphere that is accessible, inclusive, and convenient to individuals who have disabilities.

In accordance with UNCRPD Article 25, States Parties are required to take all necessary steps to make sure that disabled people have direct exposure to gender-sensitive health services, including health-related rehabilitation (UNCRPD, 2006).

Article 28 shares that the States Parties acknowledges the right of social safety and to the pleasure of that right without unfair treatment on the basis of impairment (UNCRPD, 2006).

The UNCRPD's Articles 29 and 30 acknowledge that handicapped people have a right to participate in culture, and other leisure activities on an equal level with others, and they hold States Parties accountable for taking the necessary steps to provide those rights (UNCRPD, 2006).

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) article 9 recognizes the right to accessibility for PWDs and requires States Parties to take appropriate action to ensure that people with disabilities have equal access to the built environment, public transportation, data and communications, including communication and information technologies and structures, and other services and amenities in both urban and rural areas (UNCRPD, 2006).

Analysis and Discussion

Gender	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
Male	17 13.4%	61 48.0%	49 38.6%	127 100%
Female	32 42.7%	34 45.3%	09 12.0%	75 100%
	49 **24.3%**	**95** **47.0%**	**58** **28.7%**	**202** **100%**

The data concludes the association between gender and social inclusion which was determined on the basis of their access to right of education, employment, health, social protection, participation and accessibility. Among male respondents 13.4% had lower level of social inclusion, 48.0% had medium level and 38.6% had high level of social inclusion through their access to right of education, employment, health, social protection, participation and accessibility. On the other hand, among female respondents 42.7% had lower level of social inclusion, 45.3% had medium and rest of 12.0% reported higher level of social inclusion. The results indicate more social inclusion of male persons with disabilities as compared to female respondents. The chi-square value of 28.344 with P-value .000 indicates highly significant association between the gender of the respondents and their social inclusion. Therefore, null hypothesis of no association between gender and social inclusion stands rejected and alternate hypothesis is accepted.

Marital Status	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
Evermarried	12 12.6%	48 50.5%	35 36.8%	95 100%
Unmarried	37 34.6%	47 43.9%	23 21.5%	107 100%
	49 **24.3%**	**95** **47.0%**	**58** **28.7%**	**202** **100%**

Pearson Chi-Square: 14.587 P-Value: 0.001 df: 2

The above table signifies the association between marital status of the respondents and their social inclusion which was determined on the basis of their access to right of education, employment, health, social protection, participation and accessibility. Among married respondents 12.6% had lower level of social inclusion, 50.5% had medium level and 36.8% had high level of social inclusion through their access to right of education, employment, health, social protection, participation and accessibility. On the other hand, among unmarried respondents 34.6% had lower level of social inclusion, 43.9% had medium and rest of 21.5% reported higher level of social inclusion. The results indicate more social inclusion of evermarried persons with disabilities as compared to unmarried. The chi-square value of 14.587 with P-value 0.001 indicates highly significant association between marital status of the respondents and their social inclusion. Therefore, null hypothesis of no association between marital status and social inclusion stands rejected and alternate hypothesis is accepted.

Residential Background	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
Urban	22 15.7%	67 47.9%	51 36.4%	140 100%
Rural	27 43.5%	28 45.2%	07 11.3%	62 100%
	49 **24.3%**	**95** **47.0%**	**58** **28.7%**	**202** **100%**

Pearson Chi-Square: 23.248 P-Value: .000 df: 2

The table highlights the association between residential area of the respondents and their social inclusion which was determined on the basis of their access to right of education, employment, health, social protection, participation and accessibility. Among residents from urban area respondents with 15.7% had lower level of social inclusion, 47.9% had medium level and 36.4% had high level of social inclusion through their access to right of education, employment, health, social protection, participation and accessibility. On the other hand 43.5% , respondents from rural area had lower level of social inclusion, 45.2% had medium and rest of 11.3%

reported higher level of social inclusion. The results indicate more social inclusion among dwellers of urban areas as compared to residents from rural areas. The chi-square value of 23.248 with P-value .000 indicates highly significant association between residential area of the respondents and their social inclusion. Therefore, null hypothesis of no association between residential area and social inclusion stands rejected and alternate hypothesis is accepted.

Level of Disability	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
Mild	4 5.6%	27 37.5%	41 56.9%	72 100%
Moderate	11 31.4%	18 51.4%	06 17.1%	35 100%
Severe	34 35.8%	50 52.6%	11 11.6%	95 100%
	49 **24.3%**	**95** **47.0%**	**58** **28.7%**	**202** **100%**
Somer's D Value: -.418		P-Value: .000		

The table highlights the association between level of disability of the respondents and their social inclusion in respect of their access to rights. Among respondents with mild disability 5.6% had low social inclusion, 37.5% had medium and 56.9% had higher level of social inclusion. On the other hand, among respondents with moderate disability 31.4% had low, 51.4% had medium level and 17.1% had high level of social inclusion. While amongst respondents with severe disability 35.8% had low, 52.6% had medium level and 11.6% had higher trends of social inclusion with respect to their access to rights of education, employment, health, participation, social protection and accessibility. The Somer's D value of -.418 with P-value .000 indicates highly significant but negative association between level of disability of the respondents and their social inclusion. The results show higher inclusion amongst mild respondents. Therefore, null hypothesis of no association between level of disability of the respondents and their social inclusion stands rejected and alternate hypothesis is accepted. Hence, signifies that if level of disability is increased, the social inclusion would be decreased.

Level of Education	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
Upto matric	20 36.4%	26 47.3%	09 16.4%	55 100%
Intermediate	12 35.3%	13 38.2%	09 26.5%	34 100%
Graduation	8 17.8%	18 40.0%	19 42.2%	45 100%

Master & above	09 13.2%	38 55.9%	21 30.9%	68 100%
	49 **24.3%**	**95** **47.0%**	**58** **28.7%**	**202** **100%**
Somer's D Value: 0.173		P-Value: 0.001		

The table states the association between respondents' level of education and their social inclusion in respect of their access to rights. Among respondents with up to matric level education 36.4% had low social inclusion, 47.3% had medium and 16.4% had higher level of social inclusion. On the other hand, among respondents with intermediate level of education, 35.3% had low social inclusion, 38.2% had medium level of inclusion and rest of 26.5% had higher trends of social inclusion. Among respondents with graduation level, 17.8% had low inclusion, 40.0% had medium level and 42.2% had higher trends of social inclusion. Respondents with higher studies i.e. master & above, 13.2% reported low inclusion, 55.9% reported medium and 30.9% reported higher trends of social inclusion with respect to their access to rights of education, employment, health, participation, social protection and accessibility. The Somer's D value of 0.173 with P-value 0.001 indicates significant and positive association between education level of the respondents and their social inclusion. Therefore, null hypothesis of no association between education of the respondents and their social inclusion stands rejected and alternate hypothesis is accepted.

Age (years)	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
18-22	06 66.7%	02 22.2%	01 11.1%	09 100%
23-27	06 18.2%	17 51.5%	10 30.3%	33 100%
28-32	15 22.7%	33 50.0%	18 27.3%	66 100%
33-37	17 29.8%	24 42.1%	16 28.1%	57 100%
38-42	5 13.5%	19 51.4%	13 35.1%	37 100%
	49 24.3%	95 47.0%	58 28.7%	202 100%
Somer's D Value: 0.069		P-Value: 0.214		

The above table describes the association between age of the respondents and their level of social inclusion in respect of their access to rights. Among respondents with age group (18-22 years), the lower level of social inclusion 66.7% was observed, 22.2% had medium and 11.1% had higher level of social inclusion. Among respondents with age group (23-27 years), the lower social inclusion 22.7% was observed, 51.5% respondents were falling in medium social

inclusion category, 27.3% respondents had higher social inclusion. On the other hand, among respondents with age group, (28-32 years), the lower trend of social inclusion was observed in 22.7% respondents, 50.0% had medium level of social inclusion, 27.3% had higher level of inclusion. Among respondents with age group (33-37), 29.8% had low level of inclusion, 42.1% had medium level and 28.1% had higher trends of social inclusion. Respondents with age group (38-42), 13.5% had low level of social inclusion, 51.4% reported medium and 35.1% reported higher trends of social inclusion with respect to their access to rights of education, employment, health, participation, social protection and accessibility. The Somer's D value of 0.069 with P-value 0.214 indicates insignificant association between age of the respondents and their social inclusion. Therefore, null hypothesis of no association between age of the respondents and their social inclusion stands accepted and alternate hypothesis is rejected.

Family Income	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
Up to 40,000	19 41.3%	15 32.6%	12 26.1%	46 100%
40,001-80,000	23 31.5%	37 5.07%	13 17.8%	73 100%
80,001 & above	07 8.4%	43 51.8%	33 39.8%	83 100%
	49 24.3%	95 47.0%	58 28.7%	202 100%
Somer's D Value: 0.255		P-Value: .000		

The above figures reflects the association between family income of the respondents and their social inclusion which was determined on the basis of their access to right of education, employment, health, social protection, participation and accessibility. The respondents with income level upto 40,000 had lower social inclusion with 41.3%, 32.6% reported medium social inclusion and 26.1% had high level of social inclusion amongst family income upto 40,000. On the other hand, respondents with family income 40,001 to 80,000 had 31.5% with lower level of inclusion, 5.07% with medium and rest of 17.8% had higher inclusion. Moreover, amongst respondents with higher income level of their families i.e. 80,001 & above, it was noticed that 8.4% had lower social inclusion, 51.8% had medium level of social inclusion and 39.8% had higher trends of social inclusion with respect to their access to rights of education, employment, health, participation, social protection and accessibility. The Somer's D value of 0.255 with P-value .000 indicates highly significant and positive association between family income of the respondents and their social inclusion. Therefore, null hypothesis of no association between family income and social inclusion stands rejected and alternate

hypothesis is accepted. So it can be concluded that family income is one of the responsible factors in their social inclusion.

Total No. of PWDs in Family	**Social Inclusion (on the basis of all rights)**			**Total**
	Low	Medium	High	
1	25 18.8%	64 48.1%	44 33.1%	133 100%
2	17 40.5%	20 47.6%	05 11.9%	42 100%
3 & above	07 26%	11 40.7%	09 33.3%	27 100%
	49 24.3%	95 47.0%	58 28.7%	202 100%
Somer's D Value: -.160		P-Value: 0.029		

The table concludes the association between number of persons with disabilities in family of the respondents and their social inclusion which was determined on the basis of their access to right of education, employment, health, social protection, participation and accessibility. The single PWD in the family had lower social inclusion with 18.8%, 48.1% reported medium social inclusion and 33.1% had high level of social inclusion. Among respondents with 2 PWDs in the family 40.5% had lower social inclusion, 47.6% had medium and rest of 11.9% had higher trend of social inclusion. Among respondents with 3 & above PWDs in the family, 26% had lower level of inclusion, 40.7% had medium and 33.3% had higher trends of social inclusion with respect to their access to rights of education, employment, health, participation, social protection and accessibility. The Somer's D value of -.160 with P-value 0.029 indicates significant but negative association between number of persons with disabilities in the family of the respondents and their social inclusion. Therefore, null hypothesis of no association between number of persons with disabilities in family of the respondents and social inclusion stands rejected and alternate hypothesis is accepted. So it can be concluded that higher the number of persons with disabilities in family, lower will be the social inclusion.

Discussions

Randolph and Andersen (2004) signified subjugation in economic opportunities on account of women with disabilities because of gender base discrimination. Wang (2006) and Zhang (2000) reported less inclusion of women in employment sector comparing men with disabilities within rural and urban settings of China. Women with disabilities are provided less chance than their male counterparts considering less effective in the job sector (Barnes & Mercer, 2005). Women with disabilities are subject to discrimination in political activity which leads to their exclusion in social protection services. Their detachment and exclusion from decisions setting standard

and eligibility in such programs are reported as unresponsive meeting their needs (UNDP, 2017). Aryal Khanal (2007) reported 40% women with disabilities never attend cultural events, family gatherings and other neighborhood ceremonies. Only 30% women with disabilities participated in events to some extent while rest of 30% attended most of the time. He highlighted that 15% of women with disabilities were prominent towards decisions those had background of working with disabled people organizations while the rest of 85% had merely membership. These findings witnessed that women with disabilities required political inclusion in such organizations for their future proactive role in mainstream politics. Women with disabilities also facing gender biasness while moving towards health facilities (Smith, 2006). They even reported as low priority patients with not listening them appropriately (Gibson & J, O'Connor, 2010). Girls with disabilities also experiencing gender discrimination on account of fulfillment of their educational rights as of their male fellows both able and disabled. Even women with disabilities remain at stake of discrimination because of their impairment and gender while pursuing for education and employment (WHO & World Bank, 2011). Minckas, Shannon & Mannell (2020) illustrated that women with disabilities were less included than their male counterparts just because of gender based discrimination. Women's inclusion also affected by planning and execution of social protection schemes which address households rather women directly. When such programs are carried out with gender gaps women remain less privileged (United Nations, 2015). When perceived without analyzing cultural context, women with disabilities remain discouraged to get due benefit. Societal norms made them restricted to visit out and get payments (Ulrichs, 2016).

In Pakistan, marriage is under the influence of religion that is why it is considered as religious duty and married persons usually gained more respectful status than unmarried persons (Aman et al., 2019). Abed et al (2015) reported the significance of marriage in terms of socio-economic and emotional support of partners. It is desirable to encourage physical comfort because of maximum provision of social, emotional help and control as pre requisites for meaningful life (Choi and Marks, 2008).

Generally, persons with disabilities experienced unpredictable and informal job opportunities in rural regions where they earn less and likely to confront climate risks that is why income uncertainty remained higher in rural territories than urban. Likewise, rural populations experienced poor education, health services, basic amenities of healthy hygienic conditions, transportation and communication system as compared to the rural populations (United Nations, 2018). Persons with disabilities failed to get required services because of less availability in rural settings as compared to more availability in urban settings (Sharma, 2007).

Person with disabilities those fall under severe category were reported less included because of their inabilities to take decisions that affect them (Ward & Stewart, 2008). Sakellariou and Rotarou (2017) reported neglection of people with severe disabilities in health sector. Persons with severe disabilities usually face more challenges (Grech, 2008) and felt themselves incapacitated to join social events thus less included (Shaw et al., 2012). Persons with disabilities had to experience various forms of differentiation (Baba Ochankpa, 2010) & severely disabled people experience greater differentiation on account of indifferent attitude of people (El-Kurebe, 2010).

Education produces human capital therefore significant for personal development and welfare (WHO, 2011). Gradstein and Justman (2002) analyzed the role of education and examined that the provision of education related opportunities mitigates the social gap and resulted in balanced economy and prosperity.

Older persons with disabilities had to face issues regarding their physical and mental health which obstruct their pleasure and quality of life resultantly causing less social inclusion (Iwuagwu & Kalu, 2021). Persons with disabilities of different ages experience loneliness, isolation, detachment, lacking in access to attend recreational activities and less social participation worldwide and in Nigeria (Iwuagwu & Kalu, 2021; Holt-Lundstad, 2017 and Bonsang & Klein, 2012). Therefore, Jaiswal et al (2020) and Mick et al (2018) observed the results of studies and reported that old persons with disabilities have greater vulnerability and risks of such issues. Historically, old persons with disabilities are confronting with social isolation and exclusion because of stereotypes attached with them (Bello, 2020). The present study signifies no association between age and social inclusion but the results of the previous studies contrasted to the present study.

Communal activities remain unattended by lower income and poor people because of unaffordability of expenditures incurred upon such societal events. Hence, the state of poverty leads higher danger of social exlusion (Feng et al., 2020). The present study suggests that respondents with higher income have more opportunities for social inclusion.

Conclusion

The researcher selected employed (either waged or self employed) persons with disabilities from Rawalpindi and Islamabad those have been received services from special education institutions working in Islamabad. Education is one of the fundamental rights and significant to extend capacity of persons with disabilities but in the present study, persons with disabilities were partially empowered in terms of their education. Therefore, efforts are much needed to

augment and implement the policies and programs devised for their educational rehabilitation. In the present study, persons with disabilities were economically included but it was found that majority of them were performing low paid jobs and exploited at workplaces because of certain mindset of the employers, coworkers and peoples around them. The overall result of the health right reflected dismal picture of persons with disabilities towards their social inclusion with particular reference to their right of health because of lower level of inclusion even in the presence of national & international legal bindings. Persons with disabilities are observed to be doubled marginalized if health facilities and services remain unreceptive towards them. The data reflected that social protection services required to be enhanced for better inclusion of persons with disabilities because social protection schemes played significant role to promote opportunities and resources for full inclusion of marginalized segment of society. The overall picture of respondents' participation in cultural, recreational and political activities signified that their participation was required to be improved because their participation led to effective inclusion in the society. Keeping in view, the rights based perspective, accessibility was deemed to be most crucial component since it provides foundation for fulfillment of other rights. The results witnessed that only 33.2% respondents reported high level of social inclusion with respect to accessibility, therefore, certain articulation in the physical infrastructures were much needed to facilitate rest of the big chunk to accommodate them within the mainstream. Prior to emergence of rights based approach, the discourse of the disability was viewed under the umbrella of charity, medical and social perspectives previously. All such perspectives were required to be replaced for equalization of opportunities enabling PWDs to enjoy equal status of citizenship as of non disabled. Rights based approach robust the equalization of opportunities for excluded, marginalized and deprived segment of society. The overall results of the present study reflected partial social inclusion of PWDs which reflected that rights based approach is though effective yet much is to be done enabling this segment of society more included and less marginalized.

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