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Review of

Government Flagship Programmes

From the perspectives of Persons with Disabilities

Solution Exchange is an initiative of United Nations agencies in India. The Gender Community is co-facilitated by UNICEF India Country Office and UN Women Office for India, Bhutan, Maldives and Sri Lanka.

CBM is the leading disability and development organisation in India. CBM has more than 100 years of experience in improving the quality of life of people with disabilities. CBM India is part of the CBM South Asia Regional Office with more than 145 projects in India, Bangladesh, Nepal and Sri Lanka.

Report prepared by Solution Exchange for Gender Community and CBM.

About this Review

13 flagship programmes have been reviewed, to see its emphasis on persons with disabilities, missing links or gaps from the perspective of persons with disabilities and their families. It also suggests improvement with a set of recommendations on how persons with disabilities may be included in these programmes.

The programmes reviewed are as follows:

SARVA SHIKSHA ABHIYAN (SSA)

Introduction

Sarva Shiksha Abhiyan (SSA) was initiated in 2001 by the Ministry of Human Resource Development. It is Government of India's flagship programme for achievement of Universalization of Elementary Education (UEE) in a time bound manner, as mandated by 86th amendment to the Constitution of India making free and compulsory Education to the Children of 6-14 years age group, a Fundamental Right. The implementation of SSA is in a Mission Mode. The SSA programme attempts to provide an opportunity for improving human capabilities to all children, through provision of community-owned quality education. There is flexibility offered to each State by the programme to adopt approaches and strategies to achieve the ultimate objective of inclusion. The State missions are capacitated to deliver a wide range of quality services. SSA emphasises: enrolment, retention, and quality of education. The SSA has established the "Inclusive Education of Disabled" cell for ensuring coverage of all children with disabilities under primary education. There is special allocation of Rs. 3000 per child with disability per year for this purpose.

SSA Guiding Principles

- Holistic view of education: as interpreted in the National Curriculum Framework 2005, with implications for a systemic revamp of the entire content and process of education with significant implications for curriculum, teacher's education, educational planning and management.
- Equity: to mean not only equal opportunity, but also creation of conditions in which the disadvantaged sections of the society – children of SC, ST, Muslim minority, landless agricultural workers and children with special needs, etc. – can avail of the opportunity.
- Access: not to be confined to ensuring that a school becomes accessible to all children within specified distance but implies an understanding of the educational needs and predicament of the traditionally excluded categories – the SC, ST and others sections of the most disadvantaged groups, the Muslim minority, girls in general, and children with special needs.
- Gender concern: implying not only an effort to enable girls to keep pace with boys but to view education in the perspective spelt out in the National Policy on Education 1986 /92; i.e. a decisive intervention to bring about a basic change in the status of women.
- Centrality of teacher: to motivate them to innovate and create a culture in the classroom, and beyond the classroom, that might produce an inclusive environment for children, especially for girls from oppressed and marginalised backgrounds.
- Moral compulsion: is imposed through the RTE Act on parents, teachers, educational administrators and other stakeholders, rather than shifting emphasis on punitive processes.
- Convergent and integrated system: of educational management is pre-requisite for implementation of the RTE law. All states must move in that direction as speedily as feasible.

Some Key Features

- SSA ensures no child is left out of education system adopting a zero rejection policy. The emphasis of SSA is also on providing quality education to all children.

- A principal concern in SSA is education of girls, especially those belonging to the scheduled castes and scheduled tribes and minorities.
- A focus on the inclusion and participation of children from SC/ST, minority groups, urban deprived children, children of other disadvantaged groups and the children with special needs, in the educational process.
- The programme calls for community ownership of school based interventions through effective decentralisation, augmented by involvement of women's groups, Village Education Committee (VEC) members and members of Panchayati Raj Institutions (PRIs).

SSA and Children with Disabilities

SSA has a focus on special groups for their inclusion and participation which includes children with special needs (CWSN) in the educational process. It is because of SSA, that the schools across the country have opened doors to special needs children and based on its success, the Parliament has amended the Right to Education Act, 2009 mandating, extending free and compulsory education of children with disabilities. Under SSA, every child with special needs, irrespective of the kind, category and degree of disability, has provision for meaningful and quality education. SSA ensures no CWSN should be deprived of the right to education and should be taught in an environment, which is best, suited to his/her learning needs. These include special schools, Education Guarantee Scheme and Alternative and Innovative Education scheme (EGS & AIE) or even home-based education. A notable feature of SSA has been an increased and a sustainable school-community linkage by actively involving parents in the educational process of their CWSN.

A specific allocation of funds has been made for covering children with disabilities. Guidelines for ensuring coverage of children with disabilities under Right to Education Act, 2009 (amended 2012) have been developed. The Rehabilitation Council of India has been involved in conducting Foundation Course for regular class room teachers. To promote inclusive education of children with disabilities further, the Ministry of Human Resources Development has constituted the National Committee on Monitoring of Education of SC/ST/OBC and Children with Disabilities.

Success/Impact

- Because of SSA, schools across the country have opened doors to special needs children
- Based on success of SSA, Parliament has amended Right to Education Act, 2009 mandating extending free and compulsory education of children with disabilities
- To promote inclusive education of CWSN further, the Ministry of Human Resource Development has constituted the National Committee on Monitoring of Education of SC/ST/OBC and Children with Disabilities.
- An impressive increase was observed in the enrolment of differently abled children from 0.43% of the total enrolment in 2003 to 1.17% in 2007 in rural areas (Planning commission, 2010).
- Besides increasing the physical coverage, the expenditure on inclusive education in SSA has also shown an upward trend. From a mere 26% expenditure in 2003-04, the States have shown an overall expenditure of 78.88% on CWSN inclusion related activities in 2009-10.

Missing Links

CWSN are covered under SSA, yet, severe implementation gaps between policy, planning and practice exists:

- Gaps in identification and enrolment
- School based but not children based
- Lack of support services – curriculum adaptation, testing methods and teaching learning materials, resource rooms
- Lack of barrier free access
- No detention policy without intervention
- Lack of general teacher skills
- Inadequate special teacher competencies
- Lack of teacher educators
- Lack of clarity on home-based education
- Lack of thrust on vocational education
- No scope for providing child preparatory services
- NGOs have been involved in SSA, however the number of NGOs involved with education and of children with disabilities is very small in comparison to the need.
- A monitoring and evaluation mechanism regarding the performance of NGOs in SSA is also lacking.
- Serious gaps in spending as only 1% under SSA was spent on inclusive education for children with disabilities which is lower than the prevalence rate of CWSN (World Bank, 2008).

RECOMMENDATIONS

- Specific inclusion of girls with disabilities whether belonging to SC/ST/Minorities and other disadvantaged groups is needed.
- Developing incentives for admitting CWSN especially girls with disabilities to schools.
- Proportionate allocation in admission for girls with disabilities with maintenance of records as prescribed for the utilization of such allocation.
- Developing indicators for monitoring the admission, retention, progress and completion of schooling of CWSN is essential as majority of services for CWSN are located in/near big cities or district headquarters. CWSN in rural areas are mostly left out or do not benefit from quality educational services.
- Developing school environments which are non hostile and safe for girls with disabilities. There should be a Zero Tolerance Policy.
- Appropriate age relaxation as PWD Act provides for free and compulsory education till 18 years.
- Promoting convergence of SSA for CWSN with schemes which are inter-related like the Kasturba Gandhi Balika Vidyalaya (KGBV), Mid Day Meal Scheme (MDMS), National Programme for Education of Girls at Elementary Level (NPEGEL)
- Extension of MDMS to CWSN receiving services in BRCs and home based education
- Identify and promote good practices to increase enrolment of CWSN, especially girls with disabilities through workshops and meetings, where good strategies for enrolment, monitoring and improving quality of education of CWSN could be shared. It is important to provide empirical evidences for inclusive education.

- Amendment of the Guidelines on barrier free access under SSA as it lacks infrastructural access for children with disabilities other than locomotor disabilities where just ramp and toilet is considered as essential access feature. Quality barrier free features also need mention.
- CWSN have variety of learning needs, which need to be addressed simultaneously by providing educational books, curriculum and material in accessible formats, along with other educational services.
- Inclusion of CWSN must be a parameter in accreditation for all schools.
- There is need to bring in standardization in the way data is collected, maintained and reported under the various educational bodies, census data, etc. Inconsistent data on the magnitude and educational status of CWSNs makes it very difficult to understand, ascertain realities and plan appropriate interventions.
- Implementation models for inclusion vary from State to State and there is a need to study the different frameworks and also the roles and collaborations among various organizations in the educational processes to have clear implementation plans and prevent duplication of services. General mainstream school teachers need to play a key role in inclusive education and Special Educators need to play a supportive role.
- Special teacher: Student ratio is high and in some places more than 1:100. With increased workload on teachers, quality time is not spent in teaching and meeting needs of CWSNs which needs to be looked into.
- Current focus of the government seems to be on infrastructure building at schools, construction of toilets, nutrition, etc., but not on 'Quality'. There is need for the Government to do a need analysis on the same to bring about strong implementation plans for quality education of CWSN.
- State grievance cell to address issues concerning issues of CWSN (admitting 25% from weaker sections in private schools, bridge courses, penalties for those failing to comply with the Act, ramification of zero rejection policy, etc.)
- Children with disabilities are found to drop-out from the mainstream schools and enrolled in special schools as it was preventing them from participating fully in classroom interaction and benefiting adequately from school instruction. This need to be looked into for making Inclusive Education (IE) a reality.
- To bring inclusion as one of the key strategies, there is need to build the capacity of teachers and ensuring that trained professionals are available at the community level. There is therefore a need of Pre-service/In-Service teacher training, including a paper on disability in B.Ed courses, Management and resource support with hands-on-training for regular teachers to enrich learning environment and meet the requirement of CWSN in the classroom; further, implementation of one faculty in colleges of education having specialization on disability.
- In order to consider better utilization of available special educators in the country and to meet the dearth of teachers in government schools, it is recommended that standards 1-5 can be taught by Special D.Ed. teachers and classes 5-8 can be taught by Special B.Ed. teachers in the government schools. This will support in bringing down the existing inappropriate Student: Teacher ratio.

http://mhrd.gov.in/schemes
http:www.ssa.nic.in
http://www.pecuc.org/pdf/299603558_SSA%20Framework.pdf

INCLUSIVE EDUCATION FOR DISABLED AT SECONDARY STAGE (IEDC)

Introduction

Scheme of Inclusive Education for Disabled at Secondary Stage (IEDSS) was launched by the Ministry of Human Resource Development in the year 2009-10. This Scheme replaces erstwhile Integrated Education of Children with Disabilities (IEDC). Since 2013, the Scheme has been merged with Rashtriya Madhyamik Shiksha Abhiyan (RMSA).

IEDSS is a the flagship program of Government of India to enable children and young persons with disabilities access to secondary education and to improve their enrollment, retention and achievement in the general education system to achieve the goal of universalisation of secondary education (USE). The IEDSS scheme aims to enable all students with disabilities completing eight years of elementary schooling an opportunity to complete four years of secondary schooling (classes IX to XII) in an inclusive and enabling environment; provide educational opportunities and facilities in the general education system at the secondary level (classes IX to XII); and support the training of general school teachers to meet the needs of children with disabilities at the secondary level.

IEDSS Guiding Principles

- Universal Access: Access is to be envisaged in physical, social, cultural and economic terms – all interwoven in a common concept.

- Equality and Social Justice: The two fundamental principles in the Constitution through secondary education can empower children with disabilities adequately to initially understand, then question and finally deal with inequality and injustice, and be in a position to continue to seek equality and social justice in their lives after the school.

- Relevance and Development: Secondary education in an inclusive and enabling environment for children with disabilities helps in unfolding their full potential and plays the role of linking their development with the society and its political, productive and socio-cultural dimensions.

- Structural and Curricular Aspects: Curricular reforms need to be linked with structural reforms. A common curriculum is required for building citizenship in a democracy and for linking the 'world of knowledge' with the 'world of work'.

IEDSS emphasizes ensuring quality improvements, equity, reducing socio economic, gender and disability barriers. The IEDSS scheme is being implemented by different organizations/divisions under the Education Departments of State Governments/Union Territory (UT) Administrations. It is implemented either by State Governments directly or through State Implementation Societies created for the purpose which may be headed by the Education Secretary to State Government. States may involve Non Governmental Organizations (NGOs) having experience in the field of education of the disabled in the implementation of the scheme. Collaborations with the S.C.E.R.T.s, State and District Resource Centres, block, cluster level resources are developed for this purpose. University Departments, I.A.S.E.s and C.T.E.s are also involved wherever available.

Some Key Features

- The IEDSS scheme specifically acknowledges the importance of secondary education for students with disabilities.
- Special focus and efforts are made for girls with disabilities under the scheme to help them gain access to secondary schools, as also to information and guidance for developing their potential.
- Provisions for relaxation of rules relating to admissions, minimum or maximum age limit for admission, promotion, and examination procedure so as to facilitate in improving access of students with disabilities to education.
- Involvement of Non Governmental Organizations (NGOs) having experience in the field of education of the disabled.

IEDSS and Children with Disabilities

IEDSS is exclusively for children with disabilities. It covers all children passing out of elementary schools and studying in Secondary Stage in Government, Local Body and Government aided schools, with one or more disabilities as defined under the Persons with Disabilities Act (1995) and the National Trust Act (1999) in the age group 14+ to 18+. The Scheme also covers children with mental retardation at the secondary school level.

There is specific allocation of Rs. 3000 per student per annum for specified items. There is a provision of a monthly stipend of Rs. 200/- for Girls with Disabilities, provision for Special Educators in the ratio of 1:5 for all children with disabilities. Appointment is only of those Special Educators who have RCI recognized qualification or are willing to complete the same within 3 years of appointment.

The Scheme is being implemented in a number of States from the year 2009. Out of 35 States/UTs, 16 States/UTs started implementation of IEDSS in 2009-10, seven States/UTs started it in 2010-11 and four States/UTs started it in 2011-12. Seventeen States/UTs have established the administrative cell for implementing this scheme (NCERT, 2013).

Enrolment has increased in 11 States from 2009-10 to 2011-12. The enrolment of girl students with disabilities is between 40 to 43 % from 2009-10 to 2012-13. In Manipur the enrolment of girls is more than boys and in Daman & Diu it is equal. An increase in enrolment over the years is seen in Andhra Pradesh, Haryana, Manipur, Mizoram, Madhya Pradesh, Odisha and Rajasthan (NCERT, 2013).

Missing Links

IEDSS covers education of children with disabilities with 100% assistance from the central government yet not all States/UTs are implementing it. As it is a centrally sponsored scheme with no scope for continuity of support after 5 years, most State Governments have not implemented the scheme. As the scheme is sanctioned from year to year basis, most State Government have not shown interest in implementation of the IEDSS scheme. State Governments are implementing the scheme according to their own convenience as there are no uniform guidelines for implementation.

The missing links/gaps identified in SSA between policy, planning and practice are observed in IEDSS also. Focus in choice of streams/groups in XI standard is on the impairment category than on the actual learning needs. Students with disabilities (visual, hearing, cognitive, multiple) are restricted in their choice of subjects and are forced to take up arts subjects. Schools are judged for the percentage of results they achieve hence managements are apprehensive that the ranking of their schools during the X and XII class board examinations will be affected. This poses significant stress for students with disabilities.

RECOMMENDATIONS

- Parents and Community mobilization and sensitization to enroll girls with disabilities
- Promoting convergence of IEDSS with inter related schemes - Scheme for setting up of 6000 Model Schools at Block level as Benchmark of Excellence, Scheme for construction and running of Girls Hostel for Secondary and Higher Secondary Schools, National Scheme for Incentive to the Girl Child for Secondary Education
- Ensuring safety of girls with disabilities by providing escort allowance, transport facilities, hostel facilities and adapted toilets through the facilities earmarked for this purpose
- Appropriate extension of interventions for focus groups mentioned in Rashtriya Madhyamik Shiksha Abhiyan (RMSA) to girls with disabilities in IEDSS.
- Developing life skills based curriculum for girls with Intellectual and Multiple Disabilities
- Developing tracking mechanism for transition planning of children with disabilities
- Extending existing facilities to Open and Distance Education to meet learning needs of out-of-school children with disabilities
- Flexible, need based education and vocational training facilities
- Instead of implementing it as a Centrally Sponsored Scheme, it should be implemented as a regular education provision/activity with direct budget allocation in the State Budget
- The MHRD should develop and circulate uniform guidelines for implementation of this scheme

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INTEGRATED CHILD DEVELOPMENT SCHEME (ICDS)

Introduction

Integrated Child Development Services (ICDS) was launched by the Ministry of Women and Child Development on 2nd October 1975. It is the flagship scheme of Government of India to tackle malnutrition and health problems in children below 6 years of age and their mothers. ICDS is designed to promote holistic development of children under six years, through the strengthened capacity of caregivers and communities and improved access to basic services, at the community level. Within this group, priority is accorded to addressing the critical prenatal-under-three years age group, the period of most rapid growth and development and also of greatest vulnerability. The programme is specifically designed to reach disadvantaged and low income groups, for effective disparity reduction.

ICDS provides the convergent interface / platform between communities and other systems such as primary healthcare, education, water and sanitation among others. The programme has the potential to break an intergenerational cycle of malnutrition as well as address the multiple disadvantages faced by girls and women with adequate investment and enabling environment.

ICDS is a Centrally Sponsored Scheme. ICDS is a universal scheme open to all children below 6 years of age, girl child up to her adolescence, pregnant and lactating mothers. The Ministry of Women and Child Development is responsible for budgetary control and administration of the Scheme at the Centre. At the State level, Department of Social Welfare, Women & Child Development or the Nodal Department, as may be decided by the State Government, is responsible for the overall direction and implementation of the programme. The Administrative Unit for the location of an ICDS Project is a Community Development Block in the rural areas, a Tribal Development Block in pre-dominantly tribal areas and ward(s) or slums in urban areas. The scheme is implemented through the States/UTs on a cost sharing basis in the ratio of 50:50 for supplementary nutrition programme (SNP) and 90:10 for other components except in the case of North Eastern States where the share of Central and State Government is in the ratio of 90:10 for all the components including SNP.

ICDS Key Principles

The key principles and strategies of the revised national implementation framework are:

- Restructuring ICDS institutional management at national, state, district, block and village level
- Strengthening basic infrastructure facilities and service delivery in Anganwadi Centres (AWCs)
- Decentralized planning and management to allow States to formulate context specific child care approaches
- Targeting children below three years more effectively and promote infant and young child nutrition (IYCN) practices and micronutrient supplementation interventions
- Targeting children three to six years more effectively and strengthening the pre-school education component
- Promoting convergence of inter related services viz. Reproductive Child Health (RCH)-II/National Rural Health Mission (NRHM), Sarva Siksha Abhiyan (SSA), safe drinking water and sanitation etc.

- Strengthening partnerships with Panchayati Raj Institutions (PRIs), non-governmental organizations (NGOs)/community based organizations (CBOs), Public and Private Sector
- Strengthening the capacity of ICDS functionaries
- Promoting community participation
- Strengthening monitoring and evaluation (M & E) framework with emphasis on community based monitoring

Objectives

- Improve the nutritional and health status of children in the age-group 0-6 years;
- Lay the foundation for proper psychological, physical and social development of the child;
- Reduce the incidence of mortality, morbidity, malnutrition and school dropout;
- Achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and
- Enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

Some Key Features

- Integrated package of services
- Convergence of services
- Holistic development of children
- Community participation
- Gender equality

The package of services includes supplementary nutrition, immunization, health check-up, referral services, pre-school non-formal education and nutrition & health education. Supportive Services and Convergence such as Safe Drinking Water, Environmental Sanitation, Women's Empowerment Programmes and Adult Literacy can be covered. ICDS has child centered approach based on the rationale that childcare, cognitive and psycho - social development, and the child's health and nutritional wellbeing mutually reinforce each other. For effective implementation of the programme, members of the community i.e. members of panchayati raj; mahila mandal & youth club; religious and local leaders; voluntary organisations and primary school bodies etc. should be actively involved. The gender promotion of the girl child by trying to bring her at par with the male child is a key component of the ICDS scheme.

ICDS and Persons with Disabilities, Missing Links

At present persons with disabilities are not covered specifically under ICDS, hence there is no special provision for their inclusion in the package of services. There are no suitable guidelines from the Ministry of Women and Child Development to State Governments as regards to coverage of children with disabilities so most states have not started covering children with disabilities. ICDS Mission the broad framework for implementation, 2013 has included children with disability as a focus group.

RECOMMENDATIONS

- Inclusion of children with disabilities in early childhood care and development services through the AWCs
- Screening, Assessment and Referral services for children with disabilities should be a part of the package of ICDS services
- Facilitating a gender perspective of disabilities in all planning and implementation aspects of ICDS.
- Effective supportive system needed to monitor infanticide and child-trafficking in rural areas through a watch-dog committee
- Proportionate allocation for girls and women with disabilities in ICDS schemes and programs
- Extension of crèches and preschool education to children with disabilities
- Special emphasis on vaccination for preventing Rubella
- Special safe motherhood extensions for pregnant girls with disabilities
- Recruitment of Women with Disabilities as Asha /Anganwadi workers and in other cadres
- Special training for all Anganwadi workers for early screening and detection of children with disabilities, to identify those requiring special attention for disabilities and need for early action through short term training programmes
- Referral services should be set up involving the AWW, with the help of the ASHA for further care to the Primary Health Centre (PHC), Community Health Centre (CHC), Nutrition Rehabilitation Centre (NRC), District Disability Rehabilitation Centre (DDRC) or any other tertiary care facility
- Enhance PHCs and CHCs to cater to needs and issues related to disability at ANC and PNC level
- Linking services for children with disabilities with existing service provisions through District Disability Rehabilitation Centre (DDRC), Block / Cluster Resource Centre (BRC & CRC) under SSA or any other provisions
- Maintenance of extensive and comprehensive data on key indicators of disability at different locations – rural and urban
- Track progress towards achievement of gender parity of disabilities in enrolment of all ICDS services
- Promoting convergence of ICDS and other State programmes with SSA and ECCE, KGBV and MDMS, NRHM, TSC and NRDWP
- Involvement of local bodies PRIs, Municipal Bodies, NGOs, CBOs, DPOs, Community, Teachers, Parents and other stakeholders in services for children with disabilities
- The ICDS should seek involvement of Department of Health and Family Welfare for assessment and certification of children with disabilities
- The publicity material developed under ICDS should depict specific needs and nature of disability of children with disabilities
- The Ministry of Women and Child Development should develop and disseminate guidelines on coverage of children with disabilities under ICDS.

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THE NATIONAL MIDDAY MEAL SCHEME (MDM)

Introduction

National Programme of Nutritional Support to Primary Education, popularly known as the Mid-Day Meal Scheme (MDM) was started in 1995 in an attempt to enhance enrolment, retention and attendance while simultaneously improving nutritional levels among children in school. MDM covers all children studying in government schools, including local body, government-aided primary and upper primary schools and Education Guarantee Scheme (EGS)/Alternative and Innovative Education (AIE) centres. It currently covers nearly 12 crore children.

Objectives

- To provide hot cooked meal to children of primary and upper primary classes
- Improve the nutritional status of children in classes one through five in government schools and government aided schools
- To encourage children from disadvantaged backgrounds to attend school regularly and help them concentrate in school activities
- Thereby increasing the enrollment, retention and attendance rates
- As well as provide nutritional support to students in drought- ridden areas throughout summer vacation

Key Features

- Promoting school participation
- Preventing classroom hunger
- Facilitating the healthy growth of children
- Intrinsic educational value
- Fostering social equality
- Enhancing gender equity
- Ensuring psychological benefits

Provisions

The entitlement norm per child per day is:

- Primary Class I to V – Rice/wheat 100 grams; Dal 20 grams; vegetables 50 grams; oil and fat 5 grams to provide 550 calories and 12 grams of protein
- Upper Primary Class VI to VIII – Rice/wheat 150 grams; Dal 30 grams; vegetables 75 grams; oil and fat 7.5 grams to provide 700 calories and 20 grams of protein
- In case of Micro nutrients (Vitamin A and Iron-Folate) tablets and de-worming medicines, irrespective of the Primary or Upper Primary, the student's entitlement is in convergence with school health programme of NRHM.

Success/Impact

Research findings on MDM scheme conducted by independent agencies reported that MDM is a visible programme and has helped in increase in attendance and enrolment of children particularly girls. It is also reported that there is an increase in retention, learning ability and achievement as well as greater social equity among caste, creed and gender groups in the schools. The main research findings are as under:

- Research findings of Pratichi trust (2010) of Prof. Amartya Kumar Sen indicate unlike many other Government programmes, implementation of MDM has been a success throughout the country. Though the quality of food needs to be improved, it must be said that with active participation of the beneficiaries, it has become a community programme.
- The major findings of the Public Report on Basic Education (PROBE, 2006) report indicated that 84% of households reported improved enrolment rates.
- Mid Day Meal Scheme in Madhya Pradesh by National Institute of Public Cooperation & Child Development (NIPCCD, 2007) Indore has reported that MDM has shown marked improvement in enrollment pattern of children in primary schools, increased school attendance and retention of children in schools for a longer period. The scheme has played a crucial role in reducing drop out, especially among girls.
- An empirical study conducted on Mid Day Meal scheme in Khurda district of Orissa (2008), revealed that cooked mid-day meal has increased socialization among the children and helped in increasing enrolment and afternoon session attendance. MDM has created new employment opportunities for underprivileged sections.
- Annual Status of Education Report (ASER, 2010) reported increase in enrollment.
- Supreme Court Commissioners have observed increase in enrollment and attendance of children in primary schools has been noticed after the introduction of MDM.

MDM and Persons with Disabilities

As the MDM scheme is for all school children in the primary and upper primary classes, it is an inclusive scheme that involves children with disabilities.

Missing Links/Gaps

- Irregularity in serving meals
- Irregularity in supply of food grains to schools
- Caste based discrimination in serving of food
- Poor quality of food and hygiene
- Poor coverage under School Health Programme
- Poor infrastructure (kitchen sheds in particular)
- Poor community participation
- Children with disabilities receiving home based services in SSA are excluded.

RECOMMENDATIONS

A Review of the Scheme by Supreme Court Commissioners during 2010-11 gave the following recommendations:

- Timely release of funds to school/implementing agencies.
- The mid-day meal should be expected to cover all children in the school going age irrespective of whether they are enrolled in school. The location of meal served can continue to be the school; this might further encourage those out of school to join schools.
- The provision for cooking costs under the mid-day meal should be increased based on Price Index developed for Mid-Day Meal Scheme to counter the effect of inflation.
- Proper infrastructure for mid-day meals should be mandatory, including cooking sheds storage space, drinking water, ventilation, utensils etc.
- Mobilization for kitchen garden in school premises should be encouraged.
- Priority should be given to disadvantaged communities (especially Dalits and Adivasis) in the appointment of cooks and helpers. All cooks and helpers should be paid not less than statutory minimum wage.
- Mid-day meal should be linked with nutrition education and related educational activities. State Government should be encouraged to adapt their text books for this purpose, as the NCERT has already done for some text books.
- Nutritious items such as eggs and green vegetables should be provided regularly.
- Serious action should be taken in the event of any form of social discrimination in mid-day meal such as discrimination against dalit children or dalit cooks.
- Community participation in the monitoring of mid-day meal should be strengthened, particularly to prevent corruption and ensure quality.
- Mid-day meal should be integrated with school health services, including immunization, de-worming, growth monitoring, health checkups and micronutrient supplementation.
- Grievance redressal mechanism must be within easily reachable distance of complainant and should therefore be decentralized to Panchayat level. It could also consist of mobile camps that reach out to each village.

OTHER RECOMMENDATIONS

- Urgent need for training, capacity building at every level in order to professionalize the human resources engaged in Mid-day meals
- This scheme should also be extended to children with disabilities receiving home based services in SSA
- A task force should be set up to detail all the above recommendations, to monitor and evaluate implementation
- Safety aspects need to be enforced. (Eg.: Precaution in case of fire in kitchen, closing of open wells or cooking areas which had led to death of children and adults, etc)
- Maintaining health and hygiene in preparation of MDMs should be promoted, which should be under the governance of the school development committees, parents/Self-Help groups or local panchayat. This should include provision of clean and potable water for cooking; proper storage of water, storage of vegetables, grains, etc., in proper storage facilities.

References: http://mdm.nic.in/Files/OrderCirculars/Findings_of_Research_studies.pdf

NATIONAL RURAL LIVELIHOOD MISSION (NRLM)

Introduction

National Rural Livelihoods Mission (NRLM) - Aajeevika - was launched by the Ministry of Rural Development (MoRD), Government of India (GoI) in June 2011 as a restructured version of Swarna Jayanti Gram Swarozgar Yojna (SGSY).

NRLM is the flagship program of Government of India for promoting poverty reduction through building strong institutions of the poor, particularly women, and enabling these institutions to access a range of financial services and livelihoods services. NRLM is designed to be a highly intensive program and focuses on intensive application of human and material resources in order to mobilize the poor into functionally effective community owned institutions; promote their financial inclusion and strengthen their livelihoods. NRLM complements these institutional platforms of the poor with services that include financial and capital services, production and productivity enhancement services, technology, knowledge, skills and inputs, market linkage, etc. The community institutions also offer a platform for convergence and partnerships with various stakeholders by building environment for the poor to access their rights and entitlements and public service.

NRLM Guiding Principles

- Poor have a strong desire to come out of poverty, and they have innate capabilities.
- Social mobilisation and building strong institutions of the poor is critical for unleashing the innate capabilities of the poor.
- An external dedicated and sensitive support structure is required to induce the social mobilisation, institution building and empowerment process.
- Facilitating knowledge dissemination, skill building, access to credit, access to marketing, and access to other livelihoods services enables them to enjoy a portfolio of sustainable livelihoods.

Core Values

- Inclusion of the poorest and meaningful role to the poorest in all the processes.
- Transparency and accountability of all processes and institutions.
- Ownership and key role of the poor and their institutions in all stages – planning, implementation and monitoring.
- Community self-reliance and self-dependence.

The implementation of NRLM is in a Mission Mode. NRLM adopts a demand driven approach, enabling the States to formulate their own State specific poverty reduction action plans. NRLM enables the State Rural Livelihoods Missions (SRLMs) to professionalize their human resources at State, district and block level. The State missions are capacitated to deliver a wide range of quality services to the rural poor. NRLM emphasises: continuous capacity building, imparting requisite skills and creating linkages with livelihoods opportunities for the poor, including those emerging in the organized sector, and monitoring against targets of poverty reduction outcomes. The blocks and districts in which all the components of NRLM will be implemented, either through the SRLMs or

partner institutions or NGOs, will be the intensive blocks and districts, whereas remaining will be non-intensive blocks and districts. The selection of intensive districts will be done by the states based on the demographic vulnerabilities. All blocks in the country will become intensive blocks over time.

Some Key Features

- NRLM is promoting a major shift from purely 'allocation based' strategy to a 'demand driven' strategy wherein states have the flexibility to develop their own plans for capacity building of women SHGs and Federations, infrastructure and marketing, and policy for financial assistance for the SHGs.
- NRLM will identify the target group of poor through a 'participatory identification of the poor' process instead of using the BPL list to ensure that the voiceless, poorest of poor are not ignored.
- NRLM will promote the formation of women SHGs on the basis of affinity and not on the basis of a common activity.
- NRLM has taken a saturation approach and will ensure all the poor in a village are covered and a woman from each poor family is motivated to join the SHG.
- SHG Federations: All SHGs in a village come together to form a federation at the village level. The village federation is a very important support structure for the members and their SHGs. The cluster federation is the next level of federation. A cluster consists of a group of villages within a block. The exact configuration will vary from State to State, but typically a cluster consists of 25 - 40 villages. The Village federations and the Cluster federations are the two critical support structures for the SHGs and their members in their long journey out of poverty.
- NRLM will provide continuous hand-holding support to SHGs, and their federations. Under NRLM this support will be provided to a great extent by capacitating the SHG federations and by building a cadre of community professionals from among the poor women. The federations and the community professionals will be imparted the necessary skills by the mission.
- The objective of NRLM is to ensure that SHGs are enabled to access repeat finance from Banks, till they attain sustainable livelihoods and decent living standards.

NRLM and Persons with disabilities

NRLM has a special emphasis on socially excluded groups which include persons with disabilities. NRLM recognizes that poverty and disability are closely linked to each other and therefore takes efforts to address specific needs of individuals as well as families of persons with disabilities. Under NRLM at least 3% of the total households covered would be persons with disabilities. There is also a provision for groups to be formed with persons with disabilities, and other special categories like elders, transgenders, to have both men and women in the self-help groups.

NRLM has advised States to undertake participatory vulnerability assessment process while undertaking social mobilization at the community level. This entry point activity at the village level with a specific focus on identification of households with persons with disabilities shall ensure greater inclusion of these individuals and families into the NRLM network.

SRLMs such as SERP - Andhra Pradesh, Kudumbashree - Kerala and Pudhu Vazhavu - Tamil Nadu have demonstrated best practice models on empowering and mainstreaming persons with disability by proactively including them during social mobilization and institution building processes, thereby providing livelihood opportunities, quality of life and securing their dignity. Some of the best practices these states have initiated including disability assessment, access to requisite national id cards, aids and appliances, medical care, vocational skill training, individual assistance for livelihoods, economic activity groups, old age pension, insurance scheme etc.

Bihar, Odisha and Maharashtra have initiated field trial pilots on working with persons with disabilities with technical assistance from senior disability rights consultants. These states are working on a plan to be rolled out. All the 3 states have already formed a few SHGs of persons with disabilities.

In Bihar, the Bihar Rural Livelihood Promotion Society (BRLPS), which began the work since May 2013 has undertaken the following steps towards the inclusion of persons with disabilities in the pilot blocks – Disability orientation to the district team and relevant block officials, focus group discussions, survey of disabled people in 3 blocks, one in each of the districts of Gaya, Madhubani and Muzaffarpur through the existing SHGs, block planning workshops and identification and training of master trainers.

Odisha Livelihood Mission (OLM) has begun the work since June 2013, and has undertaken the following in the chosen one block each of Ganjam, Khorda and Jagatsingpur - Disability orientation to the team and relevant block officials, focus group discussions and identification of master trainers. A District Livelihoods Planning for persons with disabilities will also be done.

Maharashtra State Rural Livelihood Mission (MSRLM) began the work since March 2013 and has been able to undertake activities in two districts namely Ratnagiri and Yavatmal such as disability orientation to the team and relevant block officials, focus group discussions, survey of disabled people in the given area through existing SHGs, district livelihood plan for persons with disabilities and leadership training workshop for selected DPOs. Keeping in view the NRLM guidelines, that the existing SHGs need be strengthened wherever possible, MSRLM is working with DPOs established by different NGOs in the Yavatmal district to strengthen them.

Missing Links

Persons with disabilities are covered specifically under NRLM. The pilot programs are underway in 3 states to include persons with disabilities in livelihood programs. It is too early to comment on the achievements and benefits. Formation of category and gender wise groups of persons with disabilities is already begun working towards the goal. The convergence with NHFDC, Social Welfare, Education, Health, ICDS and employment departments is already under planning process. Along with appropriate training and capacity building; it is expected that persons with disabilities would be able to access gainful self-employment and skilled wage employment opportunities resulting in appreciable improvement in their livelihoods on a sustainable basis.

RECOMMENDATIONS

- Persons with Disabilities require special attention; dedicated structure for training and capacity building at districts and State level involving professionals recommended
- Special attention to augmenting the training and long term handholding of persons with disabilities including skill up-gradation and entrepreneurial guidance
- Enabling persons with disabilities from rural areas, and matching their skills with skill requirements of job providers to maximize employment opportunities
- Emphasis on convergence with various schemes of Rural Development along with other line departments/ministries to strengthen the exiting occupations of the persons with disabilities, ensure their participation as beneficiary of emerging opportunities as a result of various schemes for sustainable livelihood, and also introducing newer technologies in their enterprises
- Concurrent evaluation to assess the performance of the activities involving persons with disabilities and other special groups

References

http://aajeevika.gov.in/nrlm/NRLM-Mission-Document.pdf

MAHATMA GANDHI NATIONAL RURAL EMPLOYMENT GUARANTEE ACT (MGNREGA)

Introduction

The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) was passed by the parliament in September 2005 to provide for the enhancement of livelihood security to the households in rural areas. MGNREGA provides at least one hundred days of guaranteed wage employment in every financial year to every household whose adult members volunteer to do unskilled manual work and for matters connected therewith or incidental thereto. It aims to guarantee the Right to Work. The major responsibility of implementation has been gradually transferred to the Panchayat Raj Institutions. The MGNREGA guarantees employment as a legal right.

Objectives

- Augmenting wage employment for the poorest of the poor
- Strengthen natural resource management through works that address causes of chronic poverty, like drought, and thus encourage sustainable development.

Key Features

- Guaranteed Employment: Any adult member of a rural household applying for work under the Act is entitled to employment. Every rural household is entitled to not more than 100 days of employment.
- Guaranteed Wages: Wages are to be paid on a weekly basis and not beyond a fortnight. Wages are to be paid on the basis of: Centre-notified, state-specific MGNREGA wage list, Time rates and Piece rates as per state-specific Schedule of Rates (SoRs). In any case, the wage cannot be at a rate less than Rs. 100 per day.
- Unemployment Allowance: If work is not provided within 15 days of applying, the state is expected to pay an unemployment allowance which is one-fourth of the wage rate
- Provision of Work: Work is to be provided within a 5km radius of the applicant's village, else compensation of 10 per cent extra wage is to be provided to meet expenses of travel.
- Gender Equity: Men and women are entitled to equal payment of wages. One-third of the beneficiaries are supposed to be women. Worksite facilities like crèches are to be provided at all worksites.
- Financial Inclusion: Since 2008, all wage payments have had to be transferred to bank or post office accounts of beneficiaries.
- Social Security Measures: In 2008, a provision was created which made it possible to cover beneficiaries under either the Janashree Bima Yojana (JBY) or the Rashtriya Swasthya Bima Yojana (RSBY).
- Transparency and Accountability: All MGNREGA-related accounts and records documents have to be available for public scrutiny. Contractors and use of machinery is prohibited.
- Rights-based, demand-driven approach: Estimation and planning of work is conducted on the basis of the demand for work. Hence, beneficiaries of the scheme are enabled to decide the point in time at which they want to work.

MGNREGA & Persons with Disabilities

MGNREGA separate earmarking of unemployment/resources has not been provided for persons with disabilities. Persons who have 40% and above severity of disability, are considered as special category of vulnerable persons under MGNREGA.

According to the operational guidelines of the Act, State Governments have to identify specific works, which can be done by the disabled and vulnerable persons. In a village, different categories of persons with disabilities are to be organized to come together as a fixed group to accomplish the works proposed for them under the Scheme, in a way that makes it possible for them to exercise their choice. The efforts are made to ensure that the special category persons are given work close to their place of residence so that they need not travel long distances for MGNREGA works. Persons with disabilities are to be given preference for appointment as mates for MGNREGA works and as workers for providing drinking water, to manage crèches etc. at the work sites. They are paid wages equal to nondisabled persons employed in MGNREGA works.

The Guidelines of the Act stipulates that the persons with disabilities, at work-sites, shall be called by their own names alone and their name as well as their surnames shall be properly registered in the job cards. It seeks to ensure a stigma free environment at the work place so that the workers with disabilities are not ill treated/looked down upon or face any form of discrimination (using abusive language, calling them with their disability name, use of denigrating language, insulting them or hurting their feelings in any form).

It is also important to note, that on 24th October 2008 under Bihar Viklang Kalyan Parishad, a Muzaffarpur based network organization of persons with disabilities convened a meeting simultaneously at Muzaffarpur and Samastipur which was attended by various organizations from 11 districts of Bihar. All the participants were persons with disabilities of different categories from the villages. This meeting discussed on the various possibilities of work under MGNREGA and came out with a list of 19 different work areas that could be considered for persons with disabilities. Subsequent to this meeting, a letter was sent on 12th November 2008 to the Principal Secretary, Social Welfare and Principal Secretary, Rural Department, Government of Bihar for consideration.

Missing Links/Gaps

- As there is no specific mention of persons with disabilities so they do not seem to benefiting properly from MGNEREGA.
- There is no data available on the basis of gender. Hence no separate data is available about girls/women with disabilities benefitted under MGNREGA.
- The persons with disabilities remain ignored by the family as they are considered as unproductive members.
- All types of disability are not considered for jobs.
- At village level also, the society does not consider them as productive and contributing members and hence neglect them when it comes to economic contributions which is their right.

RECOMMENDATIONS

- Mention of persons with disabilities in the multiple disadvantaged category than as a beneficiary group.
- Persons with disabilities must be specifically mentioned then there would be accountability in implementation.
- Classification must be gender and disability category wise. Appropriate changes in job card are needed based on these two criteria.
- Safety aspects in all jobs need to be considered.
- Emphasis on Disabled Peoples Organisations (DPOs) and Community Based Organisations (CBOs) need to be involved in the planning for implementation.
- Many persons with disabilities have job cards, but no jobs. Many do not receive timely payment. Therefore effective implementations of the programme with fool-proof system for making payments need to be considered.
- Implementation of MNREGA through the Grama Sabah will be more efficient. Decisions of the Grama Sabah for identification of the beneficiary and remuneration paid through the same body will increase ownership and efficacy of the programme in every village and panchayat.

NATIONAL RURAL HEALTH MISSION (NRHM)

Introduction

The National Rural Health mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The key features in order to achieve the goals of the Mission include, making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators.

Objectives

- To provide effective health care to the rural population throughout the country with special focus on 18 states which included 8 NE states, 8 Empowered Action states, and the hilly states of H.P. and Jammu and Kashmir.
- To increase public spending on health from 0.9% of GDP to 2-3% of GDP.
- To undertake architectural correction of the health system to enable it to effectively handle allocations as promised under National Common Minimum Program.
- To strengthen health care delivery at the village level by provision of female health activist in each village; a village health plan; strengthening of the rural hospital for effective curative care and measurable outputs at community level through Indian Public Health Standards; and integration of vertical Health and Family Welfare programs and funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- To integrate health concerns with determinants of health like sanitation & hygiene, nutrition and safe drinking water through a District Plan for health.
- Decentralization of programs for district management of health.
- To address the inter-state and inter-district disparities especially among the 18 high focus states.
- To define time bound goals and report publicly on their progress.
- To improve access of rural people to equitable, affordable, accountable and effective primary health care.

Strategies

Core Strategies:

- Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services
- Promote access to improved healthcare at household level through the Accredited Social Health Activist (ASHA).
- Health plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub centers through untied fund to enable local planning and action and train more Multi Purpose Workers (MPW).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard.

- Preparation and implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene and nutrition.
- Integrating vertical health and family welfare programs at National, State, Block and District levels.
- Technical support to National, State and District health missions for public health management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of Human resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy lifestyles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in under-served areas.

Supplementary Strategies:

- Regulation of private sector including rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnerships for achieving public health goals.
- Mainstreaming AYUSH- revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
- Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible affordable, accountable and good quality hospital care.

NRHM & Persons with Disabilities

The 'Child Health Screening and Early Intervention Services' Programme under National Rural Health Mission initiated by the Ministry of Health and Family Welfare in Feb, 2013, aims at early detection and management of the 4Ds prevalent in children. These are Defects at birth, Diseases in children, Deficiency conditions and Developmental Delays including Disabilities. School health programme also involves screening, healthcare and referral of children with heart defects, physical disabilities, learning disorders and behavioural problems. Under the National Programme for Health care of Elderly (NPHCE), it is envisaged to arrange for suitable callipers and supportive devices from the PHC to SC for the elderly persons with disabilities to make them ambulatory. Under NRHM, untied funds are available which can be utilized for disability prevention and medical rehabilitation of leprosy patients.

Missing Links/Gaps

- Most of the initiatives pertaining to disability prevention and control have been conceptualized very recently and are still in nascent phase of implementation.
- PRIs and local bodies have not been sensitized to issues of disabled persons.
- ASHA modules do not cover the issues related to disability.
- Health plan beginning from the village level does not include the needs of people with disability.
- Stakeholders have not been sensitized to issues concerning people with disability.

- Capacities for data collection, assessment and review of evidence pertaining to disability have not been developed.
- Public-private partnerships in context of disability are lacking as success stories are there in private sector which can be taken into cognizance
- Inter-sectoral coordination missing
- Lack of trained human resources and capacity with respect to disability issues.
- The initiatives currently undertaken are covering only few age groups and not covering other vulnerable populations like women.
- Lack of specific operational guidelines and even where available, are only on paper.
- Medical curriculum also does not cover the topic of disability in detail.
- Citizen Charter also lacking on information on the services available for persons with disabilities.

RECOMMENDATIONS

- Gap analysis of existing infrastructure to be done in context of persons with disabilities, with special reference to women.
- Capacity building of human resources at all levels of health functionaries and ASHAs & AWWs should be done.
- Health plan should incorporate the needs of people with disabilities in the community.
- Public-private partnerships need to be strengthened and successful models need to be adapted and replicated by the government.
- Operational guidelines under NPHCE & School health programme to be formulated specifically catering to needs of persons with disabilities under NRHM, with inputs from Ministry of Social Justice and Empowerment.
- Gender sensitivity to be incorporated into the newly launched and existing initiatives by GoI.
- Sensitization of stakeholders should be done.
- Medical Curriculum should include disability and gender in detail and it should be both didactic and practical.
- Citizen charter should include and display the services available to people with disability.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

Introduction

With the launching of the National Programme for Trachoma Control in 1963, the first organised effort to control blindness at the national level commenced. In 1973, the ICMR did a survey and detected a prevalence of blindness of 1.38% in the general population and found that cataract was the major cause (55%) of blindness. Hence in 1976, the National Program for Control of Blindness and Prevention of Visual Impairment (NPCB & PVI) was launched as a 100% centrally sponsored programme. It was included as one of the priority programs under the Prime Minister's 20 point program. An evaluation of the national program was undertaken through a nationwide survey over the period 1986-1989. This survey showed that the proportion of blindness due to cataract had increased to 80%. This resulted in the Govt. of India redoubling efforts to control cataract blindness. The Govt. of India took a soft term loan from the World Bank and initiated the World Bank supported Cataract Blindness Control Program under the NPCB in 1994 in the 7 States which had a prevalence of blindness higher than the national average. The project was completed over a 7 year period and envisaged strengthening infrastructure and enhancing capacity of surgeons.

Goal: Initially it was to reduce the prevalence of blindness from 1.4% to 0.3% by 2000, presently revised to achieve it by 2020.

Objectives

- To reduce the backlog of blindness through identification and providing treatment to the affected
- To develop comprehensive eye care facilities in every district
- To develop human resources for providing eye care services
- To improve the quality of service delivery
- To secure participation of voluntary organisations and private practitioners in eye care
- To enhance community awareness on eye care

Key Activities

- Cataract surgery by intraocular lens implantation
- School eye screening
- Eye banking
- Eye care education

Success/Impact

- Cataract operations have substantially increased from 16 lakh in 1992-93 to 59.1 lakh in 2009-10.
- During 2009 -10, over 5 lakh school children have been provided free spectacles under the school eye screening programme.
- Training has been imparted to eye surgeons in IOL surgery and to nurses in ophthalmic techniques
- IEC activities are taken up at various levels and special campaigns are launched during eye donation fortnight (25th August to 8th September)

- Support to voluntary organisations, especially for expansion or up-gradation of eye care units in tribal and backward rural areas
- Decentralisation of project implementation to district level

Missing Links/Gaps

- Lack of data about prevalence of eye problems among persons with disabilities
- No data about treatment seeking behavior among persons with disabilities
- Gender based stigma and discrimination due to disability in persons with disabilities and inequities not addressed .
- Lack of disabled friendly services in health centers
- Lack of networking among health care providers with organizations working for persons with disabilities

RECOMMENDATIONS

- Creation of a body of evidence by conducting epidemiological research to collect accurate information regarding eye problems in people with disabilities and benefits of eye care programs for them.
- All service providers should collect data on persons with blindness among those accessing cataract surgery; persons with incurable blindness and low vision among those screened.
- Low vision and rehabilitation services and referrals systems should be established in district hospitals.
- Access to health services should be improved for all persons with disabilities. (health-care needs at centers / environmental: which includes infrastructure, communication, reasonable accommodation and transportation).
- Healthcare personnel should be trained to be "disabled-friendly". Organizations should make training on Disability and inclusive development a mandate.
- Special provisions should be made for treatment of persons with disabilities with preventable blindness under NPCB.
- Health promotion and awareness activities should be conducted with special focus to persons with disabilities.
- Inter-sectoral coordination should be established between Ministries of Health, Social Justice and Empowerment and Women and Child Development with specific reference to persons with disabilities.
- Public private partnerships should be established by linking with NGOs dealing with persons with disabilities.
- Standard Operating Procedures (SOPs) should be prepared for persons with disabilities in collaboration with Vision 2020. All standard operating procedures concerning eye care – should have inclusive aspects – which could be coordinated by Vision 2020 along with inclusive experts.
- Inclusion of disability and inclusive development aspects in all health care academic curriculum.
- Representation of persons with disabilities in NPCB /Vision 2020 administrative hierarchy.

NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

Introduction

The National Leprosy Eradication Programme (NLEP) under the Ministry of Health and Family Welfare, Govt. of India is headed by the Deputy Director General of Health Services (Leprosy) under the administrative control of the Directorate General Health Services Govt. of India. While the NLEP strategies and plans are formulated centrally, the programme is implemented by the States/Union Territories. The Programme is also supported by Partners such as the World Health Organization, The International Federation of Anti-leprosy Associations (ILEP) and few other Non-Govt. Organizations.

Objectives

- Elimination of leprosy i.e. prevalence of less than 1 case/10,000 population in all districts of the country
- Strengthen Disability Prevention and Medical Rehabilitation for persons affected by leprosy
- Reduction in the level of stigma associated with leprosy

Program Strategies

- Decentralized integrated leprosy services through General Health Care system
- Early detection & complete treatment of new leprosy cases
- Carrying out house hold contact survey in early detection of cases
- Involvement of Accredited Social Health Activists (ASHAs) in the detection and complete treatment of Leprosy cases for leprosy work
- Strengthening of Disability Prevention & Medical Rehabilitation (DPMR) services
- Information, Education & Communication (IEC) activities in the community to improve self-reporting to Primary Health Centre and reduction of stigma
- Intensive monitoring and supervision at Primary Health Centre/Community Health centre

Key Principles

- Reduction of stigma and discrimination
- Behaviour Change Communication
- Disability Prevention and Rehabilitation

Success/Impact

India has achieved the goal of elimination of leprosy (prevalence rate of 1 per 10,000 population) at the National level in December 2005. It has been estimated that India is home to around 58% of the global leprosy load. Till date, 33 out of 35 States /Union Territories have attained leprosy elimination at the state level. Chhattisgarh and Dadra and Nagar Haveli are yet to achieve elimination. As per data of 2012-13, approximately 1.35 lakh new leprosy cases have been detected, with an annual new case detection rate of 10.78, 4650 grade 2 disability cases and a prevalence of 0.73 at the national level.

Maharashtra has integrated the leprosy services into the General Health Care system to a greater extent and also empowered the GHC staff in handling leprosy at primary and secondary levels, has introduced the “On line” monitoring system for NLEP which helps trace every case of leprosy registered in the government health system.

Through the NLEP, few NGOs are able to build awareness in the community on leprosy and ways of tackling them. They are also able to train ASHAs on leprosy and encourage early reporting, referral, ensuring regular supply of MDT and on self-care. However, need to ensure that the programme is rigorously followed.

In Thiruvannamalai District of Tamil Nadu, old leprosy cured cases in need of MCR Protective Footwear had to depend on the availability of their footwear on the GHCs. The MCR Protective Footwear was not being recognised as a special aid for people affected by leprosy. Individuals with other disabilities obtain their aids and appliances from the office of the District Rural Development Agency (DRDA) or the District Differently Abled Welfare Office. The Leprosy Mission Trust India's 'Advocacy Project' in the district filed a petition at the Chief Ministers cell highlighting their challenges in receiving regular supply of MCR Protective Footwear and also requesting it to be recognised as an aid for people affected by leprosy. A government order has been passed which recognizes MCR Protective Footwear as an aid for people affected by leprosy. The order further directs the distribution of 3 MCR Protective Footwear per individual affected by leprosy in a year through the DRDA or District Welfare Office.

Missing Links/Gaps

- Delay/prevention in medical treatment due to socio cultural factors.
- General communities as well as people affected by leprosy are unaware about NLEP and their right to free leprosy treatment and management under the General Health Care (GHC).
- In many of the GHCs, staffs lack the requisite skills and knowledge in the detection, treatment and management of leprosy resulting in poor quality through integrated service delivery.
- Involvement of ASHAs in NLEP and providing incentives to them for supporting treatment of people affected by leprosy is an innovative step. However, the long duration of treatment and the other tasks assigned to ASHAs results in them losing focus on leprosy.
- The PWD Act 1995 considers only “leprosy cured” as disabled, persons suffering from leprosy are not considered as disabled.
- Instances of government functionaries not assessing the percentage of disability of persons affected by leprosy are noted, resulting in classifying a person affected by leprosy as “Hansen's Disease”. This results in non-issuance of the Disability Certificate and inability to access the disability benefits.
- Most people are unaware about the benefits that people affected with leprosy can avail due to the Act.
- Whatever benefits they do receive (monetary incentives for reconstructive surgeries, Micro Cellular Rubber Footwear) are through the Health department and not through the Social Welfare Department.

  Even within the disability sector, people affected by leprosy remain alienated from individuals with other disabilities. Thus within the sector too, their problems and challenges do not get highlighted.

  Other operational aspects need to be strengthened such as drug logistics and availability at the primary health centres, prevention of impairment and disability, unavailability of ulcer management within the different tiers of the general health care system and availability of customised footwear for people affected by leprosy with deformed feet.

RECOMMENDATIONS

- It is imperative to consider leprosy as a medico-socio-economic condition, as not only the medical, but also the socio and economic challenges faced by people affected by leprosy needs to be addressed.
- Special emphasis needs to be given to change mind-set of the communities and people affected by leprosy so as to promote inclusion of people affected by leprosy in society to live their lives with dignity. Information, Education & Communication (IEC) Campaigns under NLEP for increasing awareness on leprosy and creating a positive image about people affected by leprosy necessitate special attention.
- Training of GHC staff for the treatment and management of leprosy solicit close planning and monitoring.
- NLEP as a programme needs to be prioritised at state level and calls for joint reviews between the Central Leprosy Division, National Rural Health Mission and their counterparts at the state and district level for execution of planned activities.
- NGOs associated with NLEP can work closely with ASHAs and PRIs to support health-related interventions by:
  a) Ensuring people affected by leprosy and their family members are aware of the health services available in their communities and are able to access them;
  b) Supporting the development of self-care groups where people affected by leprosy can meet regularly to share experiences and learn about self-management/self-care activities to prevent and manage their impairments;
  c) Facilitating access to assistive devices where required, e.g. special shoes, and ensuring their repair and maintenance
- Appropriate mechanism at field level to be worked out for convergence with various schemes available under various Ministries/Departments to ensure that people affected by leprosy can access mainstream development programmes and activities.

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

Introduction

In 1993, a revised strategy called Directly Observed Treatment Short-Course (DOTS) to control tuberculosis (TB) was pilot tested. As a result of tremendous success in the pilot projects, REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP) was launched in the country in 1997 with WHO recommended DOTS strategy. The programme was expanded in a phased manner and by March 2006, the entire country was covered under the programme.

Objectives

- To cure at least 85% of all newly detected infectious cases of pulmonary tuberculosis
- To detect at least 70% of estimated new smear positive pulmonary tuberculosis cases

Components of Dots

DOTS is a systematic strategy having five components:

- Political and administrative commitment
- Good quality diagnosis, primarily by sputum smear microscopy
- Uninterrupted supply of good quality drugs
- Directly Observed Treatment (DOT)
- Systematic monitoring and accountability

Key Features

- Creation of sub-district unit for every 500,000 population (TU-Tuberculosis Unit)
- Supervisory staff at sub-district level
- Modular participatory training for staff at all levels
- Establishing microscopy centres for every 100,000 population (DMC-Designated Microscopy Centre)
- Establishment of Quality Assurance system (sputum microscopy and drugs)
- TB register at the TU level
- Uniform recording and reporting system
- Decentralised service delivery with community participation
- Patient-wise drug boxes
- Regular monitoring of patient with DOT and smear microscopy

Success/Impact

- TB mortality in the country has reduced from >42/lakh population in 1990 to 23 in 2009
- TB prevalence has also reduced from 338/lakh population in 1990 to 249 in 2010
- It has been estimated in 2006 that RNTCP has also led to a gain of $19.7 billion per annum in economic wellbeing

Missing Links/Gaps

- Lack of data about prevalence of TB among persons with disabilities
- No data about treatment seeking behavior or cure rates among persons with disabilities
- Gender based stigma and discrimination due to tuberculosis in persons with disabilities
- Lack of disabled friendly services in health centers under the ambit of RNTCP
- No special provisions or strategy planned for reaching out to persons with disabilities suffering with tuberculosis and ensuring their compliance during treatment process

RECOMMENDATIONS

- Access to diagnostic and treatment services should be improved for persons with disabilities. Periodic surveys should be done to assess the prevalence of TB among persons with disabilities. Healthcare personnel should be trained to counsel persons with disabilities and include them in the mainstream.
- Special provisions should be made for initiating treatment and ensuring the compliance of persons with disabilities suffering with tuberculosis in the RNTCP program.
- Health promotion and awareness activities should be conducted with special focus to persons with disabilities.
- Inter-sectoral coordination should be established between Ministries of Health, Social Justice and Empowerment and Women and Child Development.
- Public private partnerships should be established by linking with NGOs dealing with persons with disabilities.

JAWAHARLAL NEHRU NATIONAL URBAN RENEWAL MISSION (JNURM)

Introduction

Introduced in 2005 by Ministry of Urban Development, Government of India, the Jawaharlal Nehru National Urban Renewal Mission (JnNURM) is focused to the primary development of Indian urban cities. The aim is to encourage reforms and fast track planned development of identified cities on urban infrastructure and service delivery mechanisms, community participation, and accountability of Urban Local Bodies (ULBs)/ Parastatal agencies towards citizens.

Salient Features

- Focused attention to integrated development of infrastructure services in cities covered under the Mission
- Establishment of linkages between asset-creation and asset-management through a slew of reforms for long-term project sustainability
- Ensuring adequate funds to meet the deficiencies in urban infrastructural services
- Planned development of identified cities including peri-urban areas, outgrowths and urban corridors leading to dispersed urbanization
- Scale-up delivery of civic amenities and provision of utilities with emphasis on universal access to the urban poor
- Special focus on urban renewal programme for the old city areas to reduce congestion
- Provision of basic services to the urban poor including security of tenure at affordable prices, improved housing, water supply and sanitation, and ensuring delivery of other existing universal services of the government for education, health and social security.

Objectives

This program is mainly to cater to the improvements on quality of life and infrastructure in various cities across the country. It is designed to support:

- Water supply including setting up of desalination plants
- Sewerage and sanitation
- Solid waste management including hospital waste management
- Construction and improvement of drains and storm-water drainage system
- Road network; urban transport; construction and development of bus and truck terminals
- Renewal and re-development of inner city areas
- Development of heritage areas;
- Preservation of water bodies
- Integrated development of slums, i.e. housing and development of infrastructure in slum settlements
- Provision of basic services to the urban poor
- Street lighting

Key Principles

JnNURM funds can be accessed by eligible urban local bodies and parastatal organizations by application, to the Ministry of Urban Development, comprising:

- A City Development Plan (CDP) ;
- Detailed Project Report (DPR) ; and
- Timeline for implementation of the urban reform agenda.

A CDP provides both a perspective and a vision for the development of a city. DPRs are specific proposals in areas that are to be supported under the JnNURM, with details of the project's feasibility and compatibility with other norms and standards. The Timeline shows the schedule for the implementation of the urban reform agenda.

The Government of India will provide toolkits to enable the urban local bodies and other parastate organizations to formulate CDPs, DPRs, and Timeline for implementation of urban reform agenda.

Missing Links/Gaps

- Ministry of Urban Development has developed an Action Plan for implementation of Barrier free Environment (BFE) in the country. JnNURM has no clause / code on universal accessibility, hence the funding for the urban reforms and public transport systems such as buses/ Mass Raid Transit/ Bus Rapid transit may/may not comply with the Action Plan on BFE.
- City Development Plan's and Detailed Project Report have no criteria for implementation of universal accessibility standards.
- Urban Bus Specifications as given in the National Urban Transport Policy do not have condition for funding for accessible low floor buses for persons with disabilities and reduced mobility.
- Scale-up delivery of civic amenities and provision of utilities with emphasis on universal access to the urban poor do not mention access needs of persons with disabilities.
- Provision of basic services to the urban poor including security of tenure at affordable prices, improved housing, water supply and sanitation, do not cover requirements of persons with disabilities.

RECOMMENDATIONS

- Capacity building of ULBs on access standards and implementation of universal access features in all urban infrastructure, transit system and spaces.
- Allocation of funds to states and ULBs only when the CDPs and DPRS comply with the MoUD action plan on BFE and adhere to CPWD Guidelines “Space Standards for Barrier Free Environment for the Disabled and Elderly”, 1998 (revised edition 2013).
- The standard on mobility improvement shall be applied when a facility is newly constructed or remodeled on a large scale, and efforts shall be made to do so for existing facilities and rolling stock.
- Public Transport System should cover all modes of transport such as pedestrian, paratransit, waterways, railways, non-motorised transport (NMT), etc.
- Funds under JnNURM should be allocated for 50% of the vehicles/ rolling stock should be accessible for persons with disabilities and remaining 50% vehicles should be replaced by accessible vehicles in phased manner.

TOTAL SANITATION CAMPAIGN (TSC)

Introduction

Total Sanitation Campaign (TSC) is a flagship scheme of the Ministry of Rural Development. Launched in 1999 it advocates a shift from high subsidy to a low subsidy regime, greater household involvement, demand responsiveness, and providing for the promotion of a range of toilet options to promote increased affordability. It also gives strong emphasis on Information, Education and Communication (IEC) and social marketing for demand generation for sanitation facilities, to set up a delivery system through Rural Sanitary Marts (RSMs) and Production Centers (PC) and a thrust on school sanitation. TSC is implemented in a campaign mode-taking district as a unit so that 100 percent sanitation coverage in terms of households, Anganwadi and school toilets can be attained which would result in significant health benefits.

Objectives

- Bring about an improvement in the general quality of life in rural areas
- Accelerate sanitation coverage in the rural areas
- Generate demand for sanitary facilities through awareness and health education
- Cover all schools and Anganwadis in rural areas with sanitation facilities and promote hygiene behaviour among students and teachers
- Encourage cost effective and appropriate technology development and application
- Endeavour to reduce water and sanitation related diseases.
- Eliminate the practice of manual scavenging and convert all dry latrines into sanitary pour flush latrines.

Principles

To make the programme 'community led' and 'people centered' with increased stress on awareness creation and demand generation from the people for sanitary facilities in houses, schools and Anganwadis.

- Low to no subsidy: Recent studies show that subsidy is not a motivating factor for owning sanitary facilities. If awareness is created, people are ready to pay for acquiring such facilities.
- Focus on awareness generation (IEC): An informed and sensitized effort ensures the acceptability of sanitation facilities. The creative and extensive use of IEC has been taken as the key to mobilize community and create awareness on sanitation issues as well as generate demand for sanitation facilities under TSC.
- Community centered approach: Acceptability and community participation are related. TSC lays heavy emphasis on community participation for greater ownership of the programme. TSC ensures community participation at all levels of planning, management and maintenance.
- Demand responsive approach: TSC emphasizes on demand generation through social mobilization for sanitary facilities in houses & schools.
- Supply chain: TSC intends to develop alternate delivery mechanisms to meet community needs by providing for stronger backup systems such as trained masons and building materials through rural sanitary marts and production centers. The RSMs are serving as outreach institutions to disseminate information, stimulate demand through motivators, solicit “orders” from households for sanitary toilets.

- School Sanitation and Hygiene Education: Rural School Sanitation has been conceptualized as an entry point for wider acceptance of sanitation by the rural people by providing water and sanitation facilities in the schools/Aganwadis and, promoting the desired behavioural changes by imparting hygiene education, linking the same to home & community.
- Individual Household Latrines (IHHL): TSC aims to cover both BPL and APL families. But BPL families are eligible for subsidies (incentives), which are available for low cost basic unit and shared between Government of India, State Governments and beneficiary.
- Community Sanitary Complex: Community Sanitary Complex is an important component of the TSC. These Complexes can be set up in a place in the village acceptable to people and accessible to them so as to cover the uncovered population.
- School Sanitation: Children are more receptive to new ideas and school is an appropriate institution for changing the behaviour, mindset and habits of children from open defecation to the use of lavatory through motivation and education. School Sanitation, and Hygiene Education, therefore, forms an integral part of every TSC Project. Toilets in all types of Government Schools i.e. Primary, Upper Primary, Secondary and Higher Secondary and Anganwadis are planned to be constructed.

Missing Links/Gaps

- Accessible toilets in schools and IHHL are not prioritised. There is no allocation of funds for either making existing toilets accessible or for the accessories (grab bars, wash basin and European WC) in new toilets.
- No emphasis is laid on separate toilets for girls in the schools or the access needs of girls with disabilities.
- Menstruation Hygiene Management (MHM) for girls and girls with disabilities in schools is not given any emphasis and there is no mention of availability of running (pipe) water for the girls' toilets in schools. Disposal mechanism of sanitary napkins is an integral part of the girls toilets but it is missing in schools.

RECOMMENDATIONS

- Accessible toilets need to be provided for girls and boys. Separate cubicles are required near the general toilets and within 30 meters of the school premises.
- Allocation of funds and capacity building of the contractors, communities, School Management Committees (SMC) are required to provide accessible and functional toilets.
- All toilets which are constructed should also be maintained and be functional for optimum usage.
- All Girls toilets should have MHM facilities with running water.
- Individual Household Latrines with accessible features should be provided for persons with disabilities. Household surveys should be conducted by local NGOs, Block Development Officers, etc. to identify people with disabilities and provide adaptations in the toilets to suit individual needs.
- Community Sanitary Complex should have accessible bathroom cum toilets for persons with disabilities - separate cubicle, one each for male and female blocks. Planning, design, tenders and implementation should be carried out accordingly.
- Good practice models of low-cost, low maintenance and accessible bathrooms and toilets which cater to needs of people with disabilities are in need for replication.
- IEC materials used for sensitisation of people in the community need to be innovative to cause a demand responsive approach from people and improve their health seeking behaviour in the community.

THE PERSONS WITH DISABILITES ACT (PWD ACT)

Introduction

The Persons with Disabilities Full Participation, Equal Opportunities, Protection of Rights Act, 1995 (PERSONS WITH DISABILITIES Act, 1995) has been promulgated to give effect to the Proclamation on the Full Participation and Equality of the People with Disabilities in the Asian and Pacific Region.

The meeting to launch the Asian and Pacific Decade of Disabled Persons 1993-2002 convened by the Economic and Social Commission for Asia and Pacific held at Beijing from 1st to 5th December 1992, adopted the Proclamation on the Full Participation and Equality of People with Disabilities in the Asian and Pacific Region. The Government of India is a signatory to the said Proclamation. The Government considered it necessary to implement the Proclamation aforesaid and thus Parliament of India enacted this in the Forty-sixth Year of the Republic of India.

Objectives

- To ensure protection of rights, promote equal participation and take measure to ensure participation.
- To ensure free and compulsory education of all persons with disabilities till they attain age of 18 years
- To create public awareness about various health related aspects, measure of prevention and cure of disabilities and sharing information about various national programs in the field of cure of disabilities and health related aspects.
- To promote appropriate employment of persons with disabilities through reservation in the identified posts.
- To provide equal opportunities in all poverty alleviation and other development programs
- To promote accessibility and access of all persons with disabilities and ensure Barrier Free Environment through various measures
- To monitor quality of disability development organizations through the appointment of Competent Authorities at the State and National level
- To promote research and development in the areas of assistive devices, newer approaches and comprehensive rehabilitation for persons with disabilities
- To establish State level and National level mechanism to ensure protection of rights and to promote effective implementation of the Act.

Services

The above objectives are sought to be achieved through a package of services comprising

- Establishing Central Coordinating Committee, Central Executive Committee, State Coordinating Committee and State Executive Committee
- Establishing State and District level Medical Boards who would be empowered to issue disability certificates
- Initiating projects on inclusive education, special schools, all other modes of education with the support of the Government and Local Authorities

- Establishing teacher training institutes, research institutes, centers for production of assistive devices and provision of support services for persons with disabilities.
- Identification of posts suitable for different categories of disabilities and ensuring 3 percent reservation in such identified posts.
- Issuing guidelines for the coverage of persons with disabilities under all poverty alleviation programs
- Taking appropriate measures for the prevention of occurrence of disabilities and creating public awareness in respect of these measures.
- Preparing comprehensive education scheme providing for transport facilities, supply books and arrange writers for persons with disabilities
- Establishing Special Employment Exchanges and monitoring performance of the same.
- Evolving Schemes for providing incentive to employers in the private sectors for promoting employment of persons with disabilities.
- Providing preferential allotment of land to persons with disabilities and organizations promoting services for such persons.
- Promoting various schemes for ensuring access, accessibility and Barrier Free Environment to persons with disabilities.
- Providing continuity in employment to persons with disabilities who acquire disability or impairment while in employment.
- Developing and implementing guidelines and procedure for registration of organizations working for persons with disabilities.
- Establishing the National Institute for Empowerment of Persons with Multiple Disabilities
- Evolving and implementing various schemes for rehabilitation, support to NGOs and providing insurance to persons with disabilities.
- Appointing Chief Commissioner (Persons with disabilities) at National level and Commissioners (Persons with disabilities) at the State level.

Key Features

- It provides legal definition of 7 disabilities and establishes statutory authority for protection of rights
- It enlists procedure for issuing of disability certificates
- It mandates prevention of occurrence of disabilities
- It reiterates provision of free and compulsory education
- It recognizes all modes of education of persons with disabilities
- It provides reservation in employment to such persons
- It provides reservation in all educational institutions established or supported by Government
- It refers to affirmative action, research and development
- It ensure barrier free environment, access and accessibility
- It recognizes developing of rehabilitation schemes and providing support to NGOs.

Missing Links/Gaps

- It covers only 7 disabilities and does not refer to other disabilities
- Definitions of low vision, leprosy cured and mental illness are vague and subjective
- There is no provision of any penalty in case Central and State Coordination or Executive Committees have either not been established or are dysfunctional.
- Reservation of posts is only in the identified posts. There is not provision for ensuring that such posts are identified during a given time frame
- The scheme on providing incentive to employers in the private sector is not effective
- Provisions under Affirmative Action are very weak and thus have not been implemented
- The Statutory Authority established under the Act has no judicial power and hence has no power to get the orders implemented
- There is no specific judicial authority under the Act
- There no provision for any penal action in case of default, non-implementation or any violation of provision of the Act.
- Disability being a State subject, Central Government is not in a position to ensure implementation of the Act at State Government level
- The act contravenes the right to life, purpose, spirit and objectives of UNCRPD due to the chapter on preventions
- It is completely silent about the civil and political rights such as article 5, 10-18, 21, 22, 29 and 30 of UNCRPD
- It does not mandate the country to make adequate resource allocation for the purpose of the implementation of this act, any legislation without resource back up will not be very effective
- It does not explicitly state to include persons with disabilities as members of either coordination committee nor executive committee both at central or state levels
- Reservation is limited to identified posts and only for the direct employment but not in promotion
- Job identification gives the impression that persons with disabilities can be engaged only in few jobs but not in all the jobs, it is true that one cannot do all the jobs which is applicable to persons without disabilities also!
- There is no specific timeframe to create accessible and barrier free environment
- The definition of disabilities is only enumerative but not inclusive, which is a disadvantage for those certified with 40% and less degree of disability, to combat discrimination on the basis of disability.

RECOMMENDATIONS

- There is urgent need to enact a New Disability Law which should be in consonance with various provisions of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which has been ratified by Union of India.
- The judgment of the Supreme Court on identification of posts under Section 33 of the Persons with Disabilities Act must be implemented at the earliest.
- The State Governments should appoint full time Commissioners (Persons with disabilities), preferably people with disabilities or those having adequate understanding of disability related aspects.
- When the implementation of various provisions is not effective at the level of State Government – efforts should be made to ensure such implementation effectively.
- Adequate resource allocation for the purpose of implementing this Act is necessary
- Explicit mention of recruitment of persons with disabilities into the committees is required
- Reservation is needed in both 'direct employment' and 'promotion' too
- More powers/authorization to be considered for efficacy of chief commissioner and state commissioners
- Health promotion is required in order to prevent secondary complications and this is to be mentioned in the revised Act rather than only mentioning about the prevention of disabilities
- Definition of disability should be both inclusive to fight discrimination on the basis of disability and enumerative to avail various entitlements set aside for persons with disabilities.

Action Group on Persons with Disabilities

A knowledge based initiative of Solution Exchange for Gender Community and CBM India

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CBM is the leading disability and development organisation in India committed to improving the quality of life of people with disabilities. The vision of CBM is to have an inclusive world in which all people with disabilities enjoy their human rights and achieve their full potential.

CBM addresses disability as a cause and consequence of poverty in the most disadvantaged communities of the country, irrespective of race, gender, religion, age and HIV status. One of its key approaches is to generate knowledge, learn and share with others interventions / initiatives that concern persons with disabilities and bring to light the fundamental issues for policy considerations.

Within its projects, CBM uses comprehensive, sustainable, and community-focused approaches within the framework of the UN Convention on the Rights of Persons with Disabilities (UN CRPD) and core components of WHO Community Based Rehabilitation Matrix, which contribute to poverty alleviation and self-reliance. CBM also works with mainstream development organizations to include the issues of persons with disabilities in their area of work through initiatives such as disability inclusive development programme, capacity building, facilitating barrier free environment, integrating gender and disability in project cycle management and child protection.

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