Starting an Adarsh Gram (Model Village) for Specially Abled People and Senior Citizens under Model village project of Members of Parliament

- **Why do we need to include Specially Abled People in the model village project?**

Persons with disabilities (Specially Abled People) are most disadvantaged group of people in a community. Though they have immense talent like any other person unless there is a positive attitude to include them in the mainstream development they would remain poor, illiterate, unemployed and dependent in their life. But if we include them in the development programme with a positive attitude they can contribute to the community building –nation building. Come let us include the excluded in model gram Panchayath project initiated by the government of India.

- **How many Specially Abled People are there in a Village panchayath?**

At present only sample survey data, estimates are available. Panchayath Raj institution at village level is facing difficulty to plan and allocate resources based on the estimates and sample survey information at Gram Panchayth level. Without basic data and decentralization of services, the rehabilitation services cannot be taken to the needy persons. Resulting in lack of clarity-on concept of disability, accessible environment, simple registration system, and rehabilitation needs, eligibility to access social services etc. As per 2011 census data 2.20% of people have some type of disability. But we need data, which gives socio-economic profiles, literacy rate, unemployment, incomes and jobs, benefits availed so far in order to develop services in the community. We can get the above data by introducing Village disability register with OMR interface and smart cards. This data gives complete profile of individual with disability, their actual needs, family information and panchayth profiles in a digital accessible database, which is useful in developing services and other social security benefits in an Adarsh gram project.

You can get more information about VDR in the following website-Indian Accessible disability Data. net. It cost only Rs 97 per person to develop comprehensive database on disability and senior citizens with the needs assessment.

http://www.i-add.net/

- **How do identify them and there needs?**

In Village disability registers there are 5 forms. In form C data on needs –educational, economic, social, housing, assistive devices, employment, social security benefits availed data is collected.

- **What are there needs?**

The needs of persons with disabilities are by and large same as the needs of other persons in the community.
In India we need to focus on Community Based Rehabilitation, which aims to build rehabilitation services using potential inherent in the families and communities without disintegrating people with disabilities away from their communities.

We have list some of the key article of United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006), specifically to include in Adarsh Inclusive village for Specially Abled People:

Article 6 - Women with disabilities
Article 7 - Children with disabilities
Article 9 - Accessibility

Article 24 - Inclusive Education
Article 19 - Living independently and being included in the community
Article 21 - Freedom of expression and opinion, and access to information
Article 27 – Work and employment
Article 28 - Adequate standard of living and social protection
Article 31 - Statistics and data collection

- **Who are the most vulnerable groups among persons with disabilities?**

Persons with disabilities are the poorest of the poor in any community. Among this group children, women/girls and senior citizens with disabilities are most vulnerable groups. We need focus on girls/women with disabilities as we see inherent negative attitude towards women with disabilities.

- **How can we meet their needs using 3% of development budget and existing schemes?**

Disability is a state subject listed in the state list in Indian constitution. It is also a Panchayath raj subject as per PRI ACT.
In the year 1995 a comprehensive legislation for protection and equal opportunities for persons with disabilities was passed by the Indian parliament. As per this act 3% of poverty alleviation budget must be spent for persons with disabilities. This is in addition to 4% reservation in jobs.

Panchayath Raj at district. Tehsil and village level can plan rehabilitation and other services if they have accurate data and needs of person with disabilities. Under the Adarsh village project MPs can develop need-based support in each gram panchayth to utilize 3% of development funds, 4% reservation and various benefits available under state and central government schemes. NGOs/SHGs/CBOs working at district level can provide support in developing CBR services and inclusion in the mainstream development programmes

- **What is Community Based rehabilitation?**

Community-Based Rehabilitation (CBR) focuses on enhancing the quality of life for people with disabilities and their families, meeting basic needs and ensuring inclusion and participation. It was initiated in the mid-1980s but has evolved to become a multi-sectorial strategy that empowers Person with Disability to access and benefit from education, employment, health, education, vocational, social and other services. But it is noticed that, lack of accurate database about children with disability is a major problem for panchayath's and community to plan community based rehabilitation services, inclusive education, early interventions, and medical support

- **How to train local volunteers in CBR?**

Local volunteers can be trained by approaching Bangalore University, which offers diploma in CBR and PG diploma in CBR on distance education mode, which uses the local PRI system for skill training.

- **How to train local PHC doctors in medical certification? What are the needs of senior citizens in a village?**

Aging and Disability go hand in hand. We see many villages where people who stay back in the villages are senior citizens. When old age become unbearable with disability and poverty once can imagine plight of older citizens. Old citizens have wealth of knowledge and skills.

If we start Senior citizen forums / groups in village level we can utilize their skills and also give support to them in their old age.

- **How to meet the needs of senior citizens using the existing schemes and community support?**

There are many state and central schemes, which is listed in this document at the end.

- **Which are the agencies, which can help MPs in developing model village for persons with disabilities and senior citizens?**

Voice of SAP, CBR NETWORK, Seva In Action, KPMRC, Spastics society of Karnataka, Association of people with disabilities are some of the NGOs who are keen to help MPs in developing Adarsh Inclusive Gram.

CBR unit for fieldwork of students

Most people with disabilities live in rural areas, whereas a majority of the services are available only in urban areas. In order provide community based rehabilitation services to all persons with disabilities, there is a need for trained personnel who can start CBR units in rural areas. In order to take rehabilitation services to every nook and corner in our country, there is a need to review the existing strategies in CBR service delivery and explore new approaches. CBR Unit is one new approach to reach the persons with disabilities in rural areas. UNCRPD emphasis the need to reach the unreached persons with disability with community based services.

In the Article 19 titled Living independently and being included in the community it states:

A. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
B. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs

A. What is a CBR unit?

In a majority of rural areas there is no community based rehabilitation services. Families travel long distance to the district or even to state capital to receive rehabilitation services. Under CBR more 80% of rehabilitation services can be delivered at community level and working in close collaboration with the existing programmes such as ICDS (integrated child development scheme), Primary health care, Primary education and other rural development programme and other poverty alleviation programmes.

In order to scale up the basic rehabilitation services CBR units are highly effective. These units are established in each block's (100,000 population) centre and sub units are established one in each gram panchayath (5000 population). CBR units work like self-help mutual aid groups, which are very successful in states such as Karnataka, Kerala and Andhra Pradesh in India and in many countries in south Asia.

Disability is a subject that is included at micro policy level. For example under constitution of India it comes under the state list. Therefore CBR units must get integrated fully in PRI system within a span of 10 years.

In Uttar Pradesh 10 villages in a village panchayth will be selected closer to the university.

B. Nature of services offered in CBR Units:

CBR services

I. Pre Vocational Training
II. Micro credit
III. Inclusive and Special education
IV. Self help mutual aid groups for families
V. Pre-School and Early Intervention
VI. Home based Rehabilitation Program / Home Management Programme

VII. Rehabilitation services for Leprosy Cured Persons (LCPs)
VIII. Survey, Identification, Awareness and Sensitization
IX. Rural Camps for medical support and assistive devises
X. Advocacy, Disability rights citizen charters, Legal Literacy, Including Legal Counseling, Legal Aid and Analysis and Evaluation of Existing Laws and UNCRPD

C. Eligibility

1. Coordinator of CBR units must have completed PG Diploma in CBR recognized by Rehabilitation Council of Karnataka /or any other state in India
2. Assistant coordinator of CBR units must have completed Diploma in CBR or MRW recognized by Rehabilitation Council of India

Duration: Ten years .The CBR units can be sustained by Panchayath raj budget.

Sustainability: CBR UNITS can be easily sustained by including the budget into existing Zilla panchayath budgets. Disability is a PRI subject and many states have pro-active orders for facilitating such inclusion.

D. Who can apply?

Under panchayath raj institution tehsil level panchayath (middle level PRI institutions), registered charitable trusts, District CBR society, DRC and charitable societies and not for profit companies, national institutes; Self-help groups can apply for grants.

Duplication of CBR units not allowed under this scheme in a single tehsil /Taluk/block.

E. Budget

I. Grant for Purchase of Vehicle
II. Construction of Building
III. Grant for Computer
IV. Projects for Low Vision Centers
V. Half Way Home for Psychosocial Rehabilitation of Treated and Controlled Mentally Ill Persons
VI. District Disability Rehabilitation Centers (DDRCs)

F. Cost per unit-Should not exceed Rs 2 lakh per tehsil/Taluk/block as defined in PRI.

(All figures are in Indian rupees -1 lakh=100,000)

S. No.	**Item of Expenditure**	**Budget**
1.	**Recurring**	
(i)	Honorarium for coordinator main CBR unit (1 post)	15,000 per month consolidated with 10 % increase each year or on par with the guidelines in CBR scheme
(ii)	Honorarium for assistant coordinator (1 post for each gram panchayath. 50% reserved for women 25% reserved for persons with disability	10,000 per month consolidated with 10 % increase each year or on par with the guidelines in CBR scheme

	15% reserved for SC/ST 10% general category	
(iii)	Other recurring items Same as in other schemes	
(iv)	CBR services (refer sector B)	50000 per gram panchayath per year (In many states orders are passed by the government for allocation 3% of rural development programmes for disability services)
(v)	Travel	1500 per month x 12
2.	**Non-recurring**	
(I)	PC (Data base management, Tele rehabilitation services and monitoring of CBR units)	30,000
(II)	Two wheeler 1. Motor Bike (1) 2. Mopeds (one for each gram panchayath)	50% of cost of the vehicle will provided

Schemes for persons with disabilities

Rehabilitation Activities

TOP-DOWN OR BOTTOM-UP?

Around the world today there are many examples of what have sometimes been called 'community-based rehabilitation programs'. Some of these programs are 'top down'; others are 'bottom up'.

Top-down: Chain of command
Top-down programs or activities are mostly planned, started, organized, and controlled from outside the community: by government, by an international organization, or by distant 'experts'. And the local leaders are usually persons in positions of authority, influence, or power.

Bottom-up: Equality in decision-making
Bottom-up programs or activities are those that are largely started, planned, organized, and controlled locally by members of the community. Much of the leadership and direction comes from those who need and benefit most from the program's activities. In brief, the program is **small, local,** and **'user-organized'.**

Community participation is important to both top-down and bottom-up programs. But it means something different to each: In top-down programs, people are asked to participate only in ways that have already been decided from above. For example, a team of foreign specialists that certain persons in each community be selected as ‘local supervisors’ might make a decision. The local supervisors are taught several pre-decided 'packages' of cookbook-like information. Each supervisor then instructs a given number of 'local trainers' (family members of the disabled) how they 'must train' each particular disabled person. Thus 'community participation', from the viewpoint of the experts, means 'getting people to do what we decide is good for them'.

In bottom-up programs, 'community participation' means something else. The program develops within a village or neighborhood, according to the needs and wishes of its members. It may take an outsider with some knowledge in rehabilitation and skill in organizing people to help get things started. But it is the people themselves, especially disabled persons and their families, who make the decisions about their own program. They can learn from other programs and from the experts. But they do not simply copy or follow others. They pick and choose from whatever advice and information they can get in order to plan activities that fit the needs and possibilities of their particular village, and their particular children.

There are advantages and disadvantages to top-down and bottom-up. For a central government, a standardized, top-down approach is easier to introduce, administer, and evaluate in many communities at the same time. But in primary health care, it has become clear that top-down programs frequently fail or have serious weaknesses, mainly because they do not have enough popular leadership, understanding, and personal commitment. These are especially important for rehabilitation. Every disabled child is different and has her

unique combination of needs. An imaginative, problem-solving approach is essential. If decisions and plans come pre-packaged from above, rehabilitation measures often do limited good and sometimes even harm.
In a bottom-up approach there is a greater sense of equality, and of arriving at decisions together. People do not just follow instructions. They consider suggestions. They want to know ***why.*** This greatly increases the chances that exercise, aids, and activities will really fit the individual needs of the child. It also makes rehabilitation more interesting, meaningful, and valuable for all concerned. It helps both parents and children become more independent.

A bottom-up approach to rehabilitation has the advantage of flexibility and adaptability that comes from being organized and controlled locally. **Planning is a continuous learning process** that responds to the changing needs, difficulties, and possibilities within the community. Especially when disabled persons and family members play a leading role, participants at every level are likely to develop a spirit of respect, friendliness, and equality that keeps a program human and worthwhile.
Above all, a bottom-up program organized by those it serves, decentralizes and redistributes power: people who have been powerless begin to find strength through unity. You can never be sure where things may lead, how far people may go in terms of taking charge of their own lives or in demanding their rights.

On the following pages we look at community rehabilitation activities and programs from a 'bottom-up' approach in a village situation. This is where our own experience lies. For a different approach with more of the planning from above, we suggest you see the World Health Organization's ***Training Disabled Persons In the Community*** along with the supplementary materials. For a sharp analysis of different approaches, read Mike Miles' ***Where There Is No Rehab Plan***.

STARTING IN A VILLAGE -WHERE TO BEGIN?

Rehabilitation of disabled persons within a village or neighborhood usually has two major goals:

1. To create a situation that allows each disabled person to live as fulfilling, self-reliant, and whole a life as possible, in close relation with other people.
2. To help other people-family, neighbors, school children, members of the community-to accept, respect, feel comfortable with, assist (only where necessary), welcome into their lives, provide equal opportunities for, and appreciate the abilities and possibilities of disabled people.

One of the best ways to bring about better understanding and acceptance of disabled people is to involve both disabled and non-disabled persons in shared activities. The next few chapters discuss selected community activities that can help improve people's understanding and respect for the disabled. These can be introduced either as part of a rehabilitation program, or independently by concerned persons such as parents, schoolteachers, or religious leaders. Some of these activities, in fact, have proved to be good ways to create interest and open discussion with local people about starting a small community-based program.

There are many possibilities for getting people in a village or neighborhood more actively involved. Often a good way to start is to **call a meeting to bring together disabled persons and family members of the disabled.** Sometimes one or more leaders in the community happen to have a child or close relative that is

disabled. These persons, with a little encouragement, may take the lead in organizing other families with disabled children, or in starting a local rehabilitation program.

It makes sense to **start where people express their biggest concern.** For example, in Peshawar, Pakistan, a community program for *retarded* children was started because families of these children expressed a strong need. In Nicaragua, a group of disabled revolutionaries with *spinal cord injuries* started a program to produce low-cost wheelchairs to meet their particular needs. In Mexico, *physically disabled* village health workers started a community program for disabled children and their families. Today, these 3 programs have all expanded their coverage to include a far wider range of disabilities than they started with.

In a community program everyone helps out. Here the mother of a boy with polio sews cloth to form 'stockings' for use under plaster casts.

Some children have several disabilities, so it is hard to limit attention only to certain ones. We must try to meet the needs of the whole child, within the family and within the community. However, it often works best to start in **a small and fairly limited way, wherever people are ready.** Let things grow and branch out from there, as new concerns arise and new people become involved.

- **Who gets things started?**

Within a community or neighborhood there will often be persons eager to become involved in starting rehabilitation activities or even a program. All it may take is something to 'spark the idea'. This spark can be in the form of a person, a pamphlet, or even a radio program that triggers people's imaginations with ideas or basic information.

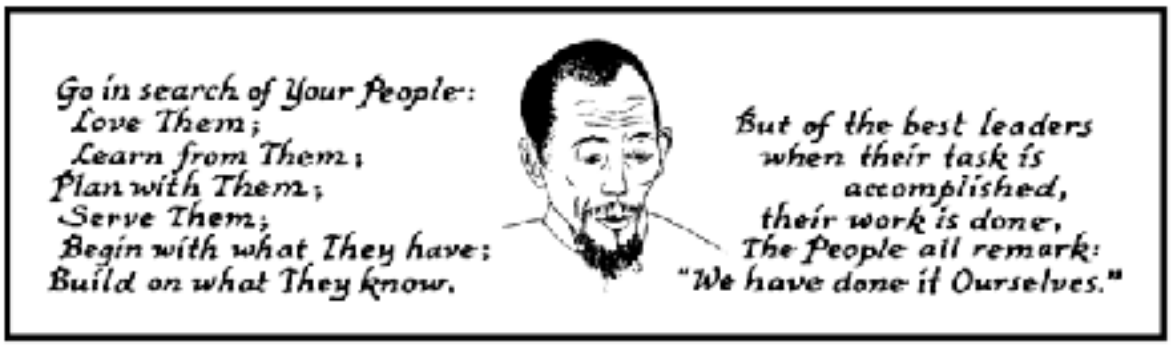
For example, we know of one village medic, herself disabled by polio, who received a WHO magazine with an article on "Rehabilitation for All." As a result, she began to organize the villagers to build a simple rehabilitation playground. In a similar fashion, CHILD-to-child activity sheets have sometimes inspired teachers to conduct activities that help school children to prevent certain disabilities or to behave toward disabled children in a friendlier, welcoming way.

Often, to get things started, it takes a person with some background in rehabilitation and in community work, to stay for a while in a village or neighborhood. Her role is to bring together people with similar needs, helping them to form a plan of action and to obtain the information and special resources they need.

Such a 'resource person' is sometimes called an **'agent of change'.** She need not be a highly trained professional in rehabilitation or social work. In fact, persons who have professional degrees often have the hardest time accepting that parents and disabled persons can and should be the primary workers and decision makers in a community rehabilitation program.

- **What is necessary is that the agent of change be someone who respects ordinary people, and is committed to helping them joins together to meet their needs and defend their rights.**

The agent of change should be a counselor, not a boss; a provider of information and choices, not orders or decisions. Especially when such a person comes from outside the community, her role is to stay in the background, to help the people make their own decisions and run their own program. At all costs she avoids taking charge.
Staying in the background, however, is easier said than done, especially for an agent of change who is deeply committed. To make sure that a program is run by the people, not by outsiders, it is often a good idea that agents of change and any visiting professionals not be present all the time. Instead, they should encourage the program to continue without them. Perhaps the final test of an agent of change's success is to leave the community forever, without her absence being much noticed. These ideas are said beautifully in this old Chinese verse:



To help start a program for the disabled, it often works out better if the agent of change is also disabled. This helps make the *outsider* an *insider.*

- **Disabled persons as leaders and workers in rehabilitation activities**

Some of the most exciting and meaningful community rehabilitation activities in various parts of the world are those that are **led and staffed by disabled persons themselves.** When the leaders and workers in a program are disabled, they can be excellent role models for disabled children and their parents. When they see a team of disabled persons working together productively, doing more to help other people than most able-bodied persons do, and enjoying themselves in the process, it often gives both family and child a new vision and hope for the future. This alone is a big first step toward rehabilitation.

Disabled workers give an example to disabled children that they can lead a helpful, full life. Polo Leyva, severely disabled by polio, has become a skilled welder and wheelchair maker.

Another reason for recruiting leaders and workers who are mostly disabled persons (or their relatives) is that they are more likely to work with commitment, to give of themselves. From their own experience, they understand the problems, needs, and possibilities of disabled persons. Because they, too, have often suffered rejection, misunderstanding, and unfair treatment by society, they are more likely to become leaders in the struggle for a fairer, more fully human community. Their weakness contributes to their strength.

- **Kinds and levels of village-based activities**

There is no formula or blueprint for starting a village rehabilitation program. How things get started will depend on various factors: the size of the village, the number and nature of disabled children, the interests and talents of parents and other persons, the resources available, the distance and difficulties for getting specific rehabilitation services elsewhere. Also consider the possibilities for getting assistance (voluntary, if possible) from *physical therapists* and other rehabilitation professionals, craftsperson's, health workers, schoolteachers, and others with skills that could be helpful.

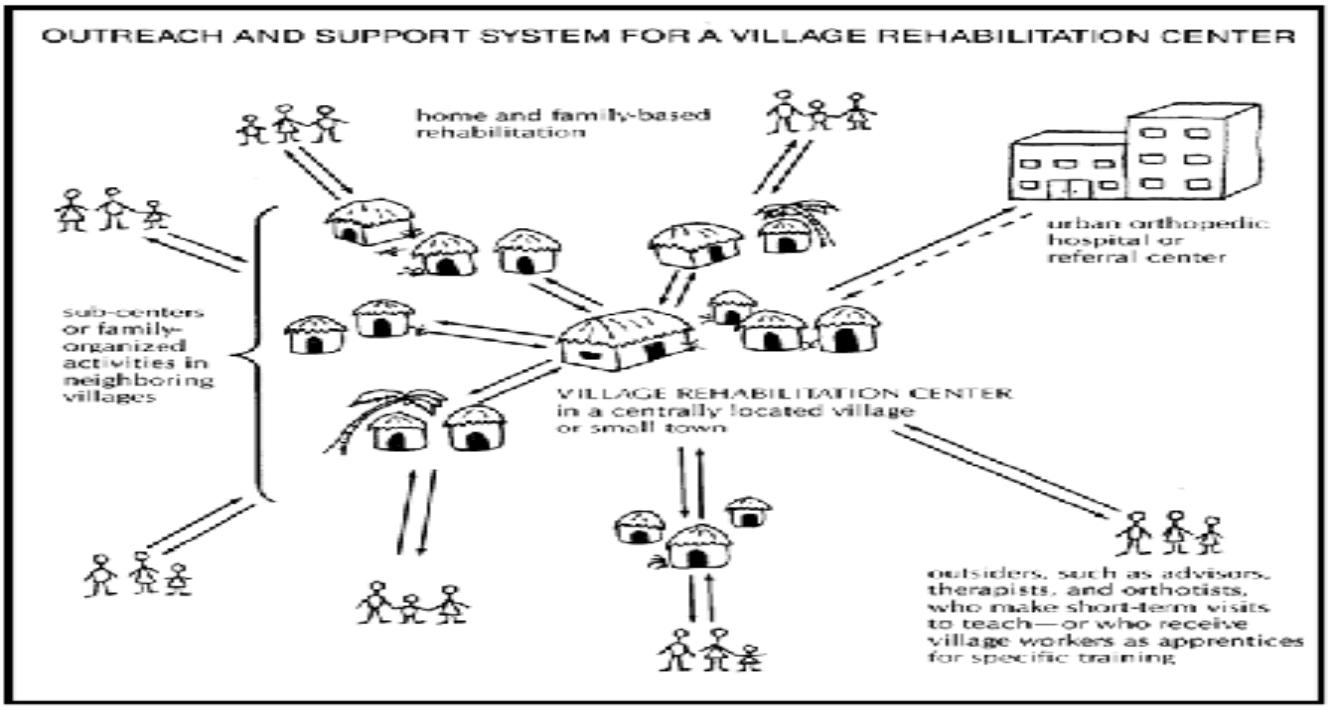
If rehabilitation is ever to reach most of the children who need it, **most rehabilitation activities must take place in the home** with the family members as the primary rehabilitation workers. And even where plenty of money and professional services are available, the home and community are still the most appropriate place for most of the rehabilitation of most disabled children.

For home-based rehabilitation to be effective, however, parents need carefully prepared and selected information, friendly encouragement, and assistance. And at times they will need back-up services of rehabilitation and medical workers with different ki nds and amounts of skills.

A good arrangement, perhaps, is a **referral chain,** starting with rehabilitation in the home with guidance from a small community center run by local, modestly trained workers. If possible, the center has close links with the nearest low-cost or free *orthopedic* hospital and professionally run rehabilitation center, to which the relatively few children with disabilities requiring surgery or complex *therapy* can be referred. Outside professionals (*orthotics, therapists,* and others) can help by making periodic teaching visits to village rehabilitation centers. They can also invite village workers to visit and apprentice with them in their city shops and clinics. (*Apprentice* means to learn by helping someone more skilled.)

Some villages will be too small or lack the resources to start their own community rehabilitation center. However, it has been found in several countries that once a modest center in one village opens, the word spreads. Disabled children with family members soon begin arriving from surrounding villages. In time the

rehabilitation team may be able to help disabled persons and their families in neighboring villages to organize their own sub-centers. Disabled workers from these sub-centers can learn by 'apprenticing' at the original center.



The above 'ideal' is more or less the way Project PROJIMO in Mexico works, although with certain difficulties and obstacles.

- **The role of a villager-run rehabilitation center**

Some of the most important rehabilitation activities take place with the family in the home. Others take place in the school, the marketplace, the village square, and, when necessary, in the nearest orthopedic hospital. **The key to helping all this happen can be the village rehabilitation center.**

A village rehabilitation center run by modestly trained disabled workers, together with the families of disabled children, can provide a wide range of services. These may include training and support of families, community activities, non-surgical orthopedic procedures, and making orthopedic and rehabilitation aids.

The program need not try to do everything at first, but can start with what seems most important and gradually add new skills and activities as needs and opportunities arise.

Eventually, a community team can gain considerable skill in many areas. For example, the village team of PROJIMO is able to adequately attend the needs of about 90% of the disabled children it sees (except for blind or deaf children for whom its services are still not adequate). Only about 10% need referral to orthopedic hospitals or larger rehabilitation centers. Visiting experts have found that at times the therapy or aids provided by PROJIMO are more helpful than those previously provided to the same children by Professionals in the cities.

The chart on the following page gives an idea of possible activities and functions of a village rehabilitation center. It also lists activities of possible 'sub-centers' in neighboring villages, as well as referral and support services needed from urban orthopedic and rehabilitation centers, and outside specialists.

Organizing the community to build a 'playground for all children' is one of the best ways to increase participation and to integrate disabled and non-disabled children in a way that everyone enjoys.

- **POSSIBLE ACTIVITIES AND FUNCTIONS OF REHABILITATION CENTERS AT DIFFERENT LEVELS**

Sub-centers in neighboring villages

- Parent meetings, mutual assistance and shared child care between families of disabled
- Playground for all children (disabled and non-disabled)
- Group action to get disabled children into school
- Special group activities for children who cannot attend normal school

Community awareness raising activities:
-Skills
-CHILD-to-child
-Involving school-children and villagers in building playground, improving accessibility, making toys and equipment

- Organized (group) visits to the village rehabilitation center in the neighboring village
- Educational and preventive activities
- Perhaps one or more 'village rehabilitation assistants' to help with basic therapy and rehabilita tion, under guidance from rehabilitation workers from the village rehabilitation center

VILLAGE REHABILITATION CENTER (serving children and their families from a gr oup of villages)

All of the activities listed for the sub-centers. And also:

- Family and small group training in basic care, therapy, and development of disabled childre n (guidelines and advice)
- Workshop for making and repairing (and teaching families how to make and repair) orthop edic and rehabilitation aids including:

- Braces	- Wheelchairs
- Crutches	- Artificial limbs
- Walkers	- Special footwear
- Special seating	- Therapy aids

- Non-surgical orthopedic procedures (straightening joints with series of casts, etc.)
- Arrangements within village to provide room and board for visiting disabled children and f amily members from neighboring villages

This May include:

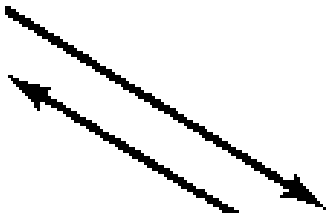
- Village families who are willing to take in visiting families at low cost
- A 'model home' where visiting families can stay, equipped with low-cost adaptations and equipment for better function and self-care by the disabled
- coordination, informal training, visits and advice to parent groups or sub-programs in neighboring villages

- Workshops and/or agricultural projects where disabled youth can learn income-producing skills to bring in some income to the program or family

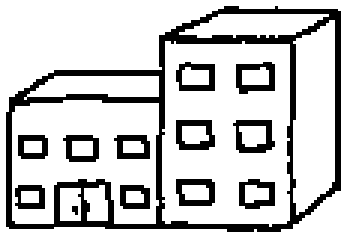
Prevention campaigns, for example:
vaccination against polio and childhood diseases, with special focus on underserved families and communities education campaign against overuse and misuse of injections

Activities to involve and include as much of the community as possible (adults and children) in the program; possibly,
-help with therapy
-help with play and entertainment
-accompany disabled children on outings, help them get to school, etc.
-village support committee
-A toy-making workshop where village children make toys for disabled children and also for their little brothers and sisters

- 'Outreach' to help start neighboring sub-centers, with provision of training, backup referral services, and regular visits



Urban orthopedic and rehabilitation referral centers, and **outside specialists**



- **Referral services for:** orthopedic evaluation, advice and surgery as needed (at low or no c ost)
- Orthopedic and rehabilitation equipment too complicated to be made at village level
- Periodic visits by orthopedic surgeons to village rehabilitation center to evaluate possible s urgical needs of selected children
- **Short teaching visits** (3 days to 1 month) by visiting specialists (physical therapists, occup ational therapists, special teachers, brace makers, limb makers, rehabilitation engineers, et c.) to **teach and advise the village team** (it is important that such visitors play a secondar y, background role and not be present all the time, nor take charge or work independently with children.)
- **Apprenticeship opportunities:** learning for village workers in the centers of the different s pecialists

- **The importance of community-run rehabilitation centers**

In an attempt to get the focus of rehabilitation out of big institutions and into the home, some community-based rehabilitation programs have tried to manage without any kind of local rehabilitation centers. 'Local supervisors' make home visits and work directly with the families of the disabled. However, when additional assistance or aids are needed, the local supervisor often has nowhere to turn. She has to send the disabled person to professionals in the city. For reasons of distance, cost, fear, or failure of the support system, these referrals too often do not work out. As a result, rehabilitation is often incomplete, and people get discouraged.

Of course, referral to large city hospitals or centers will still be important for selected individuals. However, there are several **strong arguments in favor of setting up a small village or community-based rehabilitation center run by local concerned persons:**

1. It is a visible, practical, low-cost base for coordinating rehabilitation activities in the home, and for providing back-up services outside the home
2. It can produce a wide range of rehabilitation equipment and aids quickly and cheaply, using local resources, with participation of families, schoolchildren, and local craftsperson’s, when possible.
3. It can include a 'playground for all children' and organize activities to encourage understanding and interaction with the disabled.
4. It can provide meaningful work and training experience for local, otherwise often untrained and unemployed disabled persons. It gives the families of disabled children and other villagers the chance to see what a useful, helpful, and rewarding role disabled persons can have in a community.
5. Although the best place for day-to-day rehabilitation is often the home, there are families for whom this may be very difficult. These include families in which one or both parents have left or are dead, or have drinking problems, or where step-parents or other family members are cruel to the child, neglect her, or abuse her sexually (a fairly common problem). In many homes, the family does the best it can. But the extra work of trying to care for a *severely disabled* child may simply be too much for the family that has to work long hours just to survive. Under any of these circumstances, special care at a community center may be of enormous benefit to both the child and the family.

6. If many small community centers join to form a 'network', they can exchange ideas and learn from each other. Or different centers can 'specialize' in producing different supplies or equipment. For example, one village center might make wheelchairs, another toys, and another low-cost plaster bandage for casting. Then different centers or programs can supply each other at low cost.

- **How small, local programs spread to new villages and areas**

Bottom-up programs tend to spread through popular demand. As the news of the program travels from family to family and town-to-town, even a small program based in a single village can reach far in its impact. For example, Project PROJIMO is based in a village of less than 1000 and has a staff of a dozen disabled villagers. In its first 4 years, PROJIMO has attended to the needs of over 1,000 disabled children from over 100 towns and villages and the slums of several large cities. (Since roughly one child in every 100 people is moderately to severely disabled, PROJIMO is in effect serving a population of over 100,000.)

There are various ways that bottom-up or 'people-centered' programs tend to spread. We speak of their growth as 'organic' because they grow and spread in a living, whole sort of way, like seeds into trees.

In Project PROJIMO, some of the young people from neighboring communities, who first come for rehabilitation, decide to stay and to work for a while in the program. In the process they learn skills, which they can use to help in the rehabilitation of other persons when they return to their own communities. In some cases, other villages and village-based health programs have sent young disabled persons to apprentice with PROJIMO for several months, in order to help start similar activities on return to their communities.

Another people-centered program that started small and has spread to many other towns is the Community Rehabilitation Development Program in Peshawar, Pakistan.

- **ACTIVITIES IN THE COMMUNITY TO WIN INTEREST AND UNDERSTANDING**

Group activities in a village or neighborhood can help improve understanding of and interaction with the disabled children. Four types of activities that have proved especially useful are discussed:

Playground for all children — PROJIMO

- **A 'Playground for all children'**
- **CHILD-to-child activities**
- **Popular theater**
- **A children's workshop for making toys**

Any of these activities may be used to gain people's interest and involvement when starting a community rehabilitation program. Or they can be used to increase understanding even where no special program is planned. For example, the workers in a village with a rehabilitation center can visit neighboring villages and put on skits or puppet shows about disability prevention. They might also talk with schoolteachers, local health workers or concerned parents about developing CHILD-to-child activities, or organize local children to build a 'playground for all children'. Project PROJIMO took a truckload of school children to a neighboring village to help the children there build their own playground. Nearly 100 children and adults built the playground in one day. After this information, we will explore other aspects of social integration and opportunities for the disabled.

Disabled Village Children
A guide for community health workers,
rehabilitation workers, and families
by David Werner

Inclusive Education for Disabled at Secondary Stage (IEDSS)

- **Overview**

The Scheme of Inclusive Education for Disabled at Secondary Stage (IEDSS) has been launched from the year 2009-10. This Scheme replaces the earlier scheme of Integrated Education for Disabled Children (IEDC) and provides assistance for the inclusive education of the disabled children in classes IX-XII. This scheme now subsumed under Rashtriya Madhyamik Shiksha Abhiyan (RMSA) from 2013. The States/UTs are also in the process of subsuming under RMSA as RMSA subsumed Scheme.

- **Aims**

To enabled all students with disabilities, to pursue further four years of secondary schooling after completing eight years of elementary schooling in an inclusive and enabling environment.

- **Objectives**

The scheme covers all children studying at the 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 class IX to XII, namely blindness, low vision, leprosy cured, hearing impairment, locomotors disabilities, mental retardation, mental illness, autism, and cerebral palsy and may eventually cover speech impairment, learning disabilities, etc. Girls with the disabilities receive special focus to help them gain access to secondary schools, as also to information and guidance for developing their potential. Setting up of Model inclusive schools in every State is envisaged under the scheme.

- **Components**

Student-oriented components, such as medical and educational assessment, books and stationary, uniforms, transport allowance, reader allowance, stipend for girls, support services, assistive devices, boarding the lodging facility, facility, therapeutic services, teaching learning materials etc.

Other components include appointment of special education teachers, allowances for general teachers for teaching such children, teacher training, orientation of school administrators, establishment of resource room, providing barrier free environment etc.

- **Implementing Agency**

The School Education Department of the State Governments/Union Territory (UT) Administrations are the implementing agencies. They may involve NGOs having experience in the field of education of the disabled in the implementation of the scheme.

- **Financial Assistance**

Central assistance for all items covered in the scheme is on 100 percent basis. The State governments are only required to make provisions for scholarship of Rs. 600/- per disabled child per annum.

State-wise details of CWSN approved to be covered under IEDSS scheme from 2009-10 to 2014-15

Slno.	State	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
1	Andhra Pradesh		699	7379		-	-
2	Arunachal Pradesh	-	-	-	-	-	598
3	Assam		586	849		4088	4806
4	Bihar	10231	11000			9601	9001
5	Chhattisgarh					5755	5922
6	Goa					255	100
7	Gujarat		9541	10768		4389	4389
8	Haryana		4771	5834		6074	5212
9	Himachal Pradesh			4001		2772	2683
10	J&K				3806	1403	2039
11	Jharkhand					2535	2311
12	Karnataka	1110		7606		10175	10158
13	Kerala	27361	28639	29657	31447	28010	33032
14	Madhya Pradesh	14287	20387	20764		14166	12913
15	Maharashtra	2085		281		9069	40619
16	Manipur			334	430	530	530
17	Meghalaya		238			252	-
18	Mizoram	582	667	717	895	825	-
19	Nagaland		4126	3695		-	-
20	Orissa	1369	2074	3956		6305	8557
21	Punjab	12290	12936			6994	10125
22	Rajasthan	300	4798	6273		5642	7537
23	Sikkim	62	184		174	143	68
24	Tamil Nadu	1027	8748	15265		8736	7965
25	Tripura			491		699	696
26	Uttar Pradesh		11528		21139	8472	8472
27	Uttrakhand		1041	1774	1843	1569	1579
28	West Bengal		18419	11653	21473	24001	24001
29	A&N Island	137	156			199	223
30	Chandigarh			202		346	500

31	Dadar & Nagar Haveli					38	40
32	Delhi	4885	5275	7127		6861	6855
33	Daman & Diu		14			9	8
34	Puducherry	516	465			436	356
35	Lakshadweep	-	-	-	-	-	98
	Total	**76242**	**146292**	**138626**	**81207**	**170349**	**211393**