THE UNIVERSITY OF MELBOURNE

सत्यमेव जयते

भारतीय पुनर्वास परिषद्

Certificate in Community Based Inclusive Development (CBID)

Explanatory Notes for Trainers

Rehabilitation Council of India

Department of Empowerment for Persons with Disabilities (Divyangjan)
Ministry of Social Justice and Empowerment
Government of India

सत्यमेव जयते

Certificate in Community Based Inclusive Development (CBID)

Explanatory Notes for Trainers

भारतीय पुनर्वास परिषद्

Rehabilitation Council of India
Department of Empowerment for Persons with Disabilities (Divyangjan)
Ministry of Social Justice and Empowerment
Government of India

Table of Contents

Intended Use for Explanatory Notes

To retain the competency-based nature of learning in this course, Self-Learning Materials (SLMs) are not given to trainees but are provided to trainers/ placement supervisors as *Explanatory Notes (ENs)* to help them design and check the Short Answer Written Responses section of the Portfolio project – Part D). ***Trainers must take the time to go through the Explanatory Notes and devise a set of practice-relevant questions covering the most important topics. A suggestion is 1-2 questions per subject per week.*** An example question, taken from ICD 1.1.1.2 – Diversity in Community is:

> *"Not all members of the community come from the same culture or language background. Their 'setbacks' and 'ways of coping' may differ. a) Identify two different 'set- backs' that people with disability in your community likely face, based on cultural, ethnic or language difference; b) Describe a different 'way of coping' with each setback; c) Discuss two ways that you might need to adapt yourself to meet the specific cultural needs of people and families living with disability in your community."*

Assessment and Intervention

Topic 1: Understanding Disability[1]

Introduction

What is the difference in the following three pictures?

Picture 1 is the example of fracture of the leg. This is called *impairment*.

Picture 2 shows the boy is not able to walk on his own and needs a walker. Impairment in the leg has caused a *disability* of movement.

Picture 3 shows a person is on wheelchair and cannot climb up the staircase, so he is *handicapped.*

Disability is limitation or function loss deriving from impairment.

Picture 1

Picture 2

Picture 3

Impairment may be missing or defective body part, an amputated limb, paralysis after polio, restricted pulmonary capacity, diabetes, near sightedness, mental retardation, limited hearing capacity, facial disfigurement or other abnormal condition.

As a result of impairment, disability may involve difficulties in walking, seeing, speaking, hearing, reading, writing, counting, lifting, or taking interest in and making one's surrounding. A disability becomes a handicap when it interferes with doing what is expected at a particular time in one's life.

[1]Content of this topic authored by Dr. Sujata Bhan, Professor and Head, Dept. of Special Education SNDT Women's University

According to Rights of Persons with Disabilities Act 2009, 21 types of disabilities have been covered. Benchmark disability refers to having at least 40% disability of any type recognized under the RPWD Act 2016. The new Act recognizes 21 types of disabilities.

The 21 disabilities are given below:-

Source: https://wecapable.com/disabilities-list-rpwd-act-2016/

Let us understand what each one of them means.

1. Blindness

Blindness is the state of being totally sightless in both eyes.

Blindness is defined by national programme for control of blindness (NPCB) as:

- Inability of a person to count fingers from a distance of 6 meters or 20 feet
- Vision 6/60 or less with the best possible spectacle correction
- Field of vision 20 degrees or less in better eye

2. Low vision

Low-vision means a condition where a person has any of the following conditions, namely:

- visual acuity not exceeding 6/18 or less than 20/60 up to 3/60 or up to 10/200 (Snellen) in the better eye with best possible corrections
- limitation of the field of vision subtending an angle of less than 40 degrees up to 10 degrees

A person with low vision uses or is potentially capable of using vision for doing a task with appropriate assistive device.

3. Cerebral Palsy

A group of non - progressive conditions characterized by abnormal motor control posture resulting from brain injuries occurring in the peri - natal, neo - natal or infant period of development.

4. Hearing Impairment

Hearing impairment is a partial or total inability to hear. It means a loss of sixty decibels or more in the better ear in the conversational range of frequencies.

5. Leprosy Cured Person

Leprosy cured person is any person who has been cured of leprosy but is suffering from - loss of sensation in hands or feet as well as loss of sensation and paralysis in the eye-lid but with no manifest deformity; manifest deformity and paralysis but having sufficient mobility in his hands and feet to enable him to engage in normal economic activity; extreme physical deformity as well as advanced age which prevents him from undertaking any gainful occupation.

6. Locomotor disability

It is a disability of the bones, joint or muscles leading to substantial restriction of the movement of the limbs or a usual form of cerebral palsy. Some common conditions giving raise to locomotor disability could be poliomyelitis, cerebral palsy, amputation, injuries of spine, head, soft tissues, fractures, muscular dystrophies etc.

7. Mental illness

Mental illness or mental disorder refers to a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life.

8. Intellectual Disability

A condition of arrested or incomplete development of mind of a person which is specially characterized by sub - normality of intelligence i.e. cognitive, language, motor and social abilities.

9. Autism Spectrum Disorder

A condition of uneven skill development primarily affecting the communication and social abilities of a person, marked by repetitive and ritualistic behaviour.

10. Multiple Disability including Deafblindness

Multiple Disabilities is the simultaneous occurrence of two or more disabling conditions that affect learning or other important life functions. These disabilities could be a combination of both motor and sensory nature.

11. Specific Learning Disability

Specific learning disability is a group of disabling conditions that hampers a person's ability to listen, think, speak, write, spell, or do mathematical calculations. One or more of these abilities may be hampered.

12. Speech and Language Disability

It means a permanent disability arising out of conditions such as laryngectomy or aphasia affecting one or more components of speech and language due to organic or neurological causes.

13. Muscular Dystrophy

Muscular Dystrophy is a group of neuromuscular genetic disorders that cause muscle weakness and overall loss of muscle mass. It is a progressive condition; meaning that it gets worse with the passage of time.

14. Chronic Neurological Conditions

Chronic neurological conditions, such as multiple sclerosis means an inflammatory, nervous system disease in which the myelin sheaths around the axons of nerve cells of the brain and spinal cord are damaged, leading to demyelination and affecting the ability of nerve cells in the brain and spinal cord to communicate with each other.

15. Dwarfism

Human beings with adult body height less than 4 feet 10 inches are considered to be affected with dwarfism.

16. Hemophilia

Hemophilia is a blood disorder characterized by the lack of blood clotting proteins. In the absence of these proteins, bleeding goes on for a longer time than normal.

17. Sickle Cell Disease

Sickle cell disease is a group of blood disorders that causes red blood cells to become sickle-shaped, misshapen and break down. The oxygen-carrying capacity of such misshapen red blood cells reduce significantly. It is a genetically transferred disease. Red blood cells contain a protein called hemoglobin. This is the protein that binds oxygen and carry it to all the parts of the body.

18. Thalassemia

Thalassemia is a genetically inherited blood disorder which is characterized by the production of less or abnormal hemoglobin.

19. Multiple Sclerosis

Multiple Sclerosis is a disabling disease that affects central nervous system. It inhibits the flow of information within the brain and between brain and various body parts.

20. Acid Attack Survivors

Acid attack survivors are the people (mostly women) who became the victim of the crime of acid throwing. These incidents often leave the victim with disfigured face and other body parts.

21. Parkinson's Disease

Parkinson's disease is Central Nervous System disorder which affects movement. Parkinson's disease is characterized by tremors and stiffness.

References

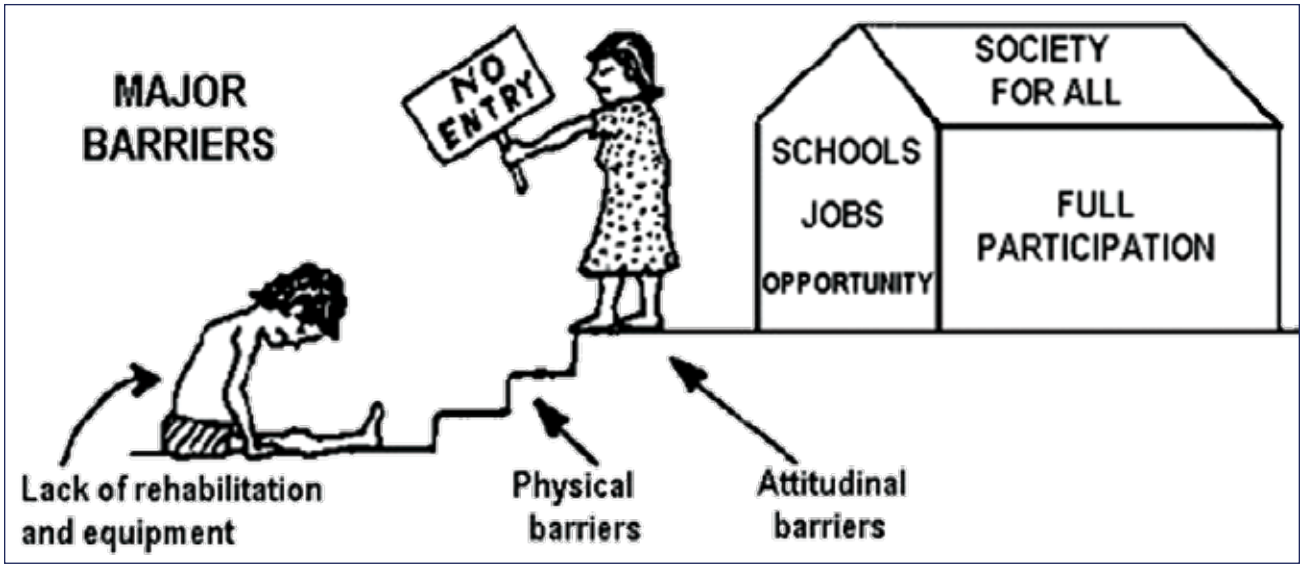
https://wecapable.com/rights-of-persons-with-disabilities-act-2016-india/

http://www.disabilityaffairs.gov.in/upload/uploadfiles/files/RPWD%20ACT%202016.pdf

Topic 2: Barriers to Disability[2]

Introduction

Do people with disabilities have the same opportunities on an equal basis with others?



Source: https://www.dinf.ne.jp/doc/english/global/david/dwe001/dwe00102.html

For centuries, society as a whole treated people with disabilities as objects of fear and pity. The prevailing attitude is that such individuals are incapable of participating in or contributing to society and that they must rely on welfare or charitable organizations. People with disabilities and their families face isolation and exclusion and remain on the fringes of the society. Persons with disabilities face barriers in society not because of their impairment but as a result of the different categories of barriers. These categories are: **attitudinal barriers; environmental barriers; and physical barriers.** Community people are mostly ignorant or merely not aware of the rights and individual needs of persons with disabilities. When persons with disabilities attempt to participate in any community programmes, they face these different barriers.

Let us examine these different barriers people with disabilities face.

2.1 Attitudinal Barriers

Attitudinal barriers are a result of how persons without disabilities perceive persons with disabilities. Persons with disabilities routinely face prejudice and discrimination. They are often assumed to be incapable and unintelligent. They are frequently treated with pity or fear, or avoided because persons without disabilities are unsure how to relate to them. It is common for persons with disabilities to be looked down on as inferior and to be labeled in negative ways. Myths, legends, scriptures and folklores are all part of the cultural belief system that shape such attitudes. Persons with disabilities frequently suffer more due to societal prejudices than due to their disabling conditions.

[2]Content of this topic authored by Dr. Sujata Bhan, Professor and Head, Dept. of Special Education SNDT Women's University

Disability is often seen as a curse, given as a result of previous wrongdoing by the individual or their parents. When a woman has a child with a disability it can in some contexts be assumed it is a punishment for something she or her husband did in a past life.

Many of these negative attitudes are also reflected in the media. At times, persons with disabilities may be labeled as heroes, brave, inspirational, or exceptional if they are able to live independent lives and achieve their goals. This can be patronizing and misleading.

2.2 Socio-emotional Barriers

When a child is born with a disability, the denial of the parents due to stigma attached with disability, is the beginning of socio-emotional barrier. As the child grows older, a general lack of acceptance in regular schools leads to social rejection, which is often characterised by: being feared, stared at, belittled, shouted at, degraded, teased, given labels, rude remarks, name calling, or such prejudiced reactions which show no tolerance of someone's company. All these, including the way one is greeted, may culminate to social barrier. As long as this child is restrained from socialization, especially because of his disability, it virtually is a social barrier. Such an attitude works against the child's quest to participate in different regular school activities. Such attitudes begin by the way children talk and feel for each other.

Social barriers are related to the conditions in which people are born, grow, live, learn, work and grow old, that can contribute to decreased functioning among people with disabilities. Social barriers prevent these people from participating in community and social life. Negative social attitudes exclude persons with disabilities from an equal share in their entitlements as citizens. Such attitudes also curtail the opportunities of people with disabilities from social contact and close personal relationships with others. People with disabilities are far less likely to be employed. Adults age 18 years and older with disabilities are less likely to have completed secondary school education compared to their peers without disabilities.

2.3 Physical and Environmental Barriers

There are physical barriers that exist in our environment. The physical environment is still designed without considering the special needs of persons with disabilities. There are many physical barriers that prevent persons with disabilities from participation. Public buildings, schools, shops, offices, health centres, markets, and places of worship are frequently inaccessible. Pavements generally lack ramps and public transport is inaccessible. There is lack of access to accessible or convenient transportation for people who are not able to drive because of vision or cognitive impairments. Communication, media and information presents barriers for persons with speech, hearing or visual impairments when the information is not presented in an accessible format, such as Braille and large-letter type or the use of sign language. Inaccessible communication systems prevent access to information, knowledge and opportunities to participate.

Environmental barriers may also include legislation that discriminates as well as inadequate employment laws. Policies can also be exclusive of persons with disabilities. For instance, a training institution whose policy on training states that the institution will enroll only candidates who are

mentally, intellectually and physically fit to work. This means that persons with disabilities are usually considered as being not fit to work. Such barriers can prevent persons with disabilities from participating in public and political life; education; health; sports and recreation; and business.

Source:https://blacktrianglecampaign.org/2012/08/02/bad-attitudes-do-not-cause-disability-any-more-than-good-attitudes-guarantee-health/

2.4 Initiatives in Removing Barriers

Today, society's understanding of disability is improving as we recognize "disability" as what occurs when a person's functional needs are not addressed in his or her physical and social environment. By not considering disability a personal deficit or shortcoming, and instead thinking of it as a social responsibility in which all people can be supported to live independent and full lives, it becomes easier to recognize and address challenges that all people including those with disabilities experience.

People with disabilities include people who have long-lasting physical, mental, intellectual or sensory impairments, and when these types of disabilities interact with other barriers, people with disabilities may not get a chance to participate in their community like they want to (UN Convention, 2006).

Some of the initiatives that can be taken by community rehabilitation workers are as below:

- **Simulations**

  Social barriers can also be minimized by providing the non-disabled individuals with practical personal experiences with those individuals with disabilities. This is where the non-disabled person is given an opportunity to simulate a particular physical disability, not in a derogatory

way, though. Simulating a disability makes the non-disabled peers directly experience what it is like to be disabled, thereby developing a better understanding of handicapping conditions and feelings one has. For example, some people in the community simulate wheel chair or crutch users, where they can take some time, practically using a wheel chair or crutch(es), as they move from one point to the other. It is hoped that such an activity makes those with no disabilities become empathic, and not sympathetic to those persons with physical disabilities. After some time in a wheel chair, or using any mobility assistive device, some people can better understand mobility rehabilitation needs for persons with disabilities.

- **Role-playing**

  Role-playing helps the non-disabled to experience feelings of being restrained and being incapacitated. As the amount of contact increases through play, children may become more positive towards their peers with disabilities, ultimately developing positive attitudes. If properly managed, such plays have been to help in eliminating prejudices. Once those with no disabilities develop positive attitudes towards those with disabilities, social barriers naturally fall off.

- **Sharing Information**

  Invite successful members of the community, preferably those with a similar disability, to give motivation speeches. This can be on open days, career days or parents' meetings. Contacts between prominent personalities with disabilities and non-disabled persons may help minimize or eliminate, social distances which commonly exist. Discuss the causes and implications of various disabilities so that the myths attached with the same are removed. Let persons with disabilities know about their rights and be their own advocates.

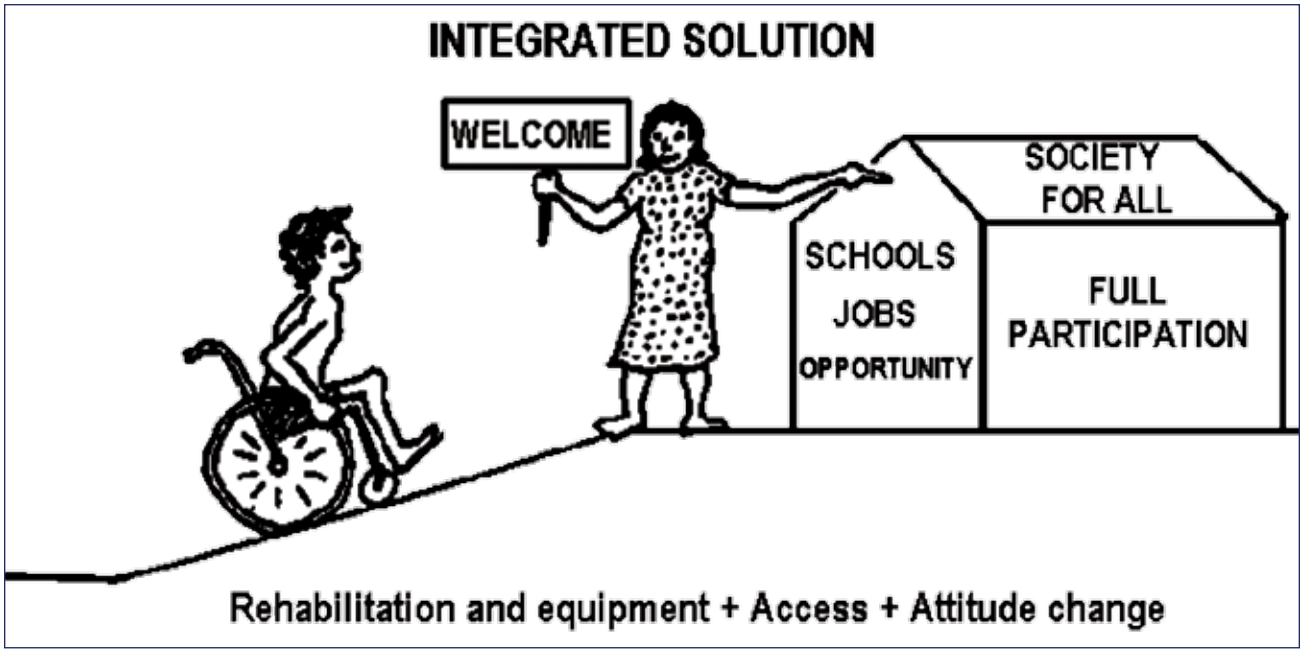
- **Involve the community**

  The experiences, ideas and information the community has are very important to making good action plans and strategies. Making sure the community is involved from the start is the best way. Following strategies can work:

  1. Be clear and tell the community what is going on – Regular reporting to the community builds trusting partnerships.
  2. Have a cross disability process – This means that people with any type of disability can participate in consultations.
  3. Consider rural/urban – Unique situations and issues of people who live in rural communities are part of the process.
  4. Consider gender – Any action plan to remove barriers needs to look at the particular barriers that women face.
  5. Produce practical outcomes – To make a real difference in people's lives.
  6. Keep privacy and confidentiality – It is important that when people want to give private and confidential information, confidentiality will be respected.

7. Make sure all government departments and agencies work together. When government departments work together, they can make sure the same policies about inclusion are in place and more positive changes can happen.

In conclusion we can say that we should aspire to work together with the community to remove all barriers for creating an inclusive society where people with disabilities participate and live a life of dignity.



Source: https://www.dinf.ne.jp/doc/english/global/david/dwe001/dwe00102.html

References

https://www.thebetterindia.com/140355/inclusion-people-with-disability-minority/

https://ipi.org.in/texts/ajit/dalal-disability-attitudes.pdf

World Health Organization; available at https://www.who.int/mediacentre/news/notes/2012/child_disabilities_violence_20120712/en/external icon

Topic 3 Disability & its Functional Impact[3]

Introduction

There are many implications of disability. They have both personal and general consequences. These implications have direct effect on the individual and their families.

The birth of a child is an exciting time for most parents with lot of dreams weaved around it. However, this excitement comes crashing down by the birth of an infant with any kind of disability. Life of the family changes if any member acquires any disability later in life.

Look at the picture below; what implications of disability can you see?

Source: http://marius.sucan.ro/media/gallery/discrimination-begins-in-family-wedding.jpg

Parents feel stigmatized because of their child's disability. Either they cut down on their own social life or do not involve their child with disability in social outings. The community learns a lot about disabilities and the more we separate people with disabilities from society the less people have contact with it and they don't know how to handle it or behave around it.

Disability places many challenges on the family. Many of these challenges cut across disability type, age of the person with the disability, and type of family in which the person lives.

Let us understand the various implications of disabilities on the families.

3.1 Physical Implications

The degree to which a person with disability is limited in doing activities of daily living like; walking, feeding oneself, and toileting will determine how much assistance he or she will need from other people. Providing this assistance can create a burden for family which may result in physical or psychological symptoms of poor health. The day-to-day strain of providing care and assistance leads to exhaustion and fatigue, taxing the physical and emotional energy of family members. Generally,

[3]Content of this topic authored by Dr. Sujata Bhan, Professor and Head, Dept. of Special Education SNDT Women's University

it's the mother who bears the maximum physical strain in a family as she has to look after the needs of the person with disability and also take care of the needs of other family members.

3.2 Psychological Implications

For families, caring for a disabled family member may increase stress. The birth of a special child may be associated with feelings of guilt, blame, anger, frustration or increased anxiety for the parents about the cause of the disability and about the future. Families are ashamed to share this with other members of the community due to negative attitude attached with disability. The responsibility of looking after the person with disability may affect decisions about work or having additional children. In these families, fathers often are under involved with the child and instead immerse themselves in work or leisure activities. This pattern usually is associated with more marital conflict. Some family members sometimes feel excluded and others being overly drawn in. For example, the primary caregiver may become overly involved with the person with disability. An older sibling may be expected to take more responsibilities to look after the disabled sibling. All of these potential effects could have repercussions for the quality of the relationship between family members, their living arrangements, and future relationships and family structure.

3.3 Emotional Implications

As stated earlier, giving birth to a special child can be devastating for the parents and the family. The emotional impact is enormous and may include-

Fear and worry about:

- The child's pain and suffering
- The child's future
- The question of whether one is doing enough or doing the right things to help the child

Guilt over:

- The limits of one's ability to protect the child
- The loss of attention toward other children, spouse and aging parents
- Jealousy and resentment of those with "normal" children

Feelings of isolation because one:

- Misses out on many family-oriented activities because child's disability prevents her/him from successfully participating
- Encounters criticism and judgment on parenting from others who don't understand the child's disability
- Feels like an outsider around parents of typically developing children

Grief over:

- The loss of hopes and dreams one had for the child
- Not having the parenting experience one would have imagined
- Recurrent reminders of what one's child misses out on leading to chronic sorrow

Families often report that the person with the disability is not a major burden for them. The burden comes from dealing with people in the community whose attitudes and behaviours are judgmental, stigmatizing, and rejecting of the disabled individual and his or her family.

3.5 Financial Implications

There is financial burden associated with disability. There may be sudden costs of medical care and other services. Assistive devices may be required to increase the functioning of the person with disability. A person on a wheelchair may require accommodations at home; transportation for carrying the person to school or for therapies; and medications and special food if required for the person with disability. This may lead to enormous financial burden on the family.

The disability can consume a disproportionate share of a family's resources of time, energy, and money, and at times other individual and family needs go unmet. The family's lifestyle and leisure activities change. A family's dreams and plans for the future may be given up. Social roles are disrupted because often there is not enough time, money, or energy to devote to them.

Factors affecting implications of Disabilities on the Family
• Type of disability (sensory, motor, or cognitive)
• Degree of severity of the disability
• Course of condition is constant or progressive
• Prognosis or life expectancy of the person
• Amount of care or treatment required
• The emotional status of the family
• The resources of the family

In conclusion one can say, having a family member with any disability can have an effect on the entire family; the parents, siblings, and extended family members. It is an **experience** for families and can affect all aspects of family functioning. Many families actually report that the presence of disability has strengthened them as a family. They become closer, more accepting of others, have deeper faith, discover new friends and develop greater respect for life.

References

https://family.jrank.org/pages/396/Disabilities-Impact-Disabilities-on-Families.html

https://steemit.com/steemiteducation/@mariaentela/the-reaction-of-the-family-to-disability-and-the-impact-of-disability-in-the-family-relations-mariaentela

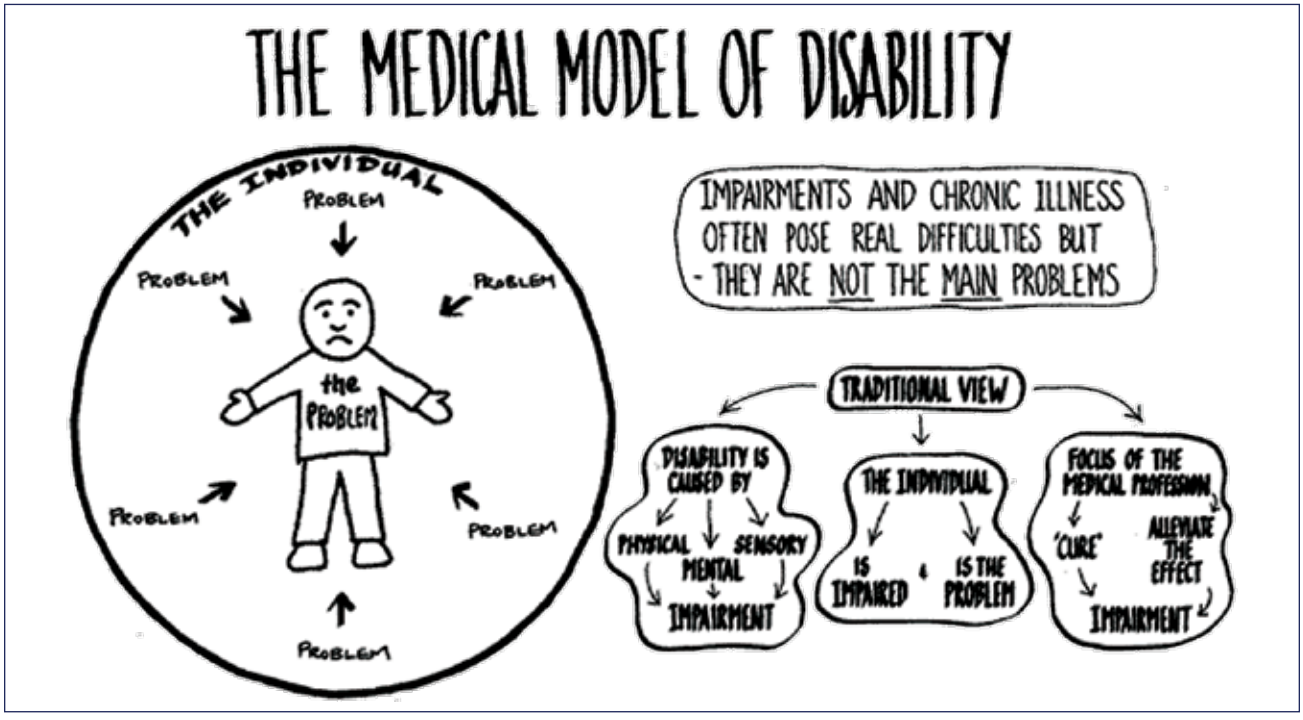
Topic 4 Models of Disability[4]

Introduction

There are several different models of disability that are important for rehabilitation professionals to understand in order to work with persons with disabilities. They provide an insight into the attitudes, conceptions and prejudices of the people and how they impact on people with disabilities. Models change as society changes. The change in models reflect the change in the social attitudes towards disability over time. Models also reveal the ways in which our society provides or limits access to work, educational and other services for people with disabilities.

Let us examine the various models of disability.

4.1 Medical Model of Disability



Source: https://in.pinterest.com/pin/108790147226829217/https://in.pinterest.com/pin/108790147226829217/

The medical model of disability is presented as viewing disability as a problem of the person, directly caused by disease or some health condition which requires medical care provided in the form of individual treatment by professionals.

According to the medical model of disability, a person with visual loss is considered disabled, just as a person with cancer is considered disabled. As per this model, the disability is viewed as a defect that a healthcare professional must find a solution for. This implies that disabilities can be "cured" by medicine. People are constantly looking for cure from their disabilities. But most of the times that is not the case in reality. This results in the stigmatization and institutionalization and isolation of many

[4]Content of this topic authored by Dr. Sujata Bhan, Professor and Head, Dept. of Special Education SNDT Women's University

individuals with disabilities. The solution is to provide the necessary care to support the "incurable" impaired person.

Medical model uses diagnosis to produce categories of disability, and assumes that people with the same impairment have identical needs and abilities. It ignores the contribution of social and other environmental factors to the limitations faced by people with disabilities.

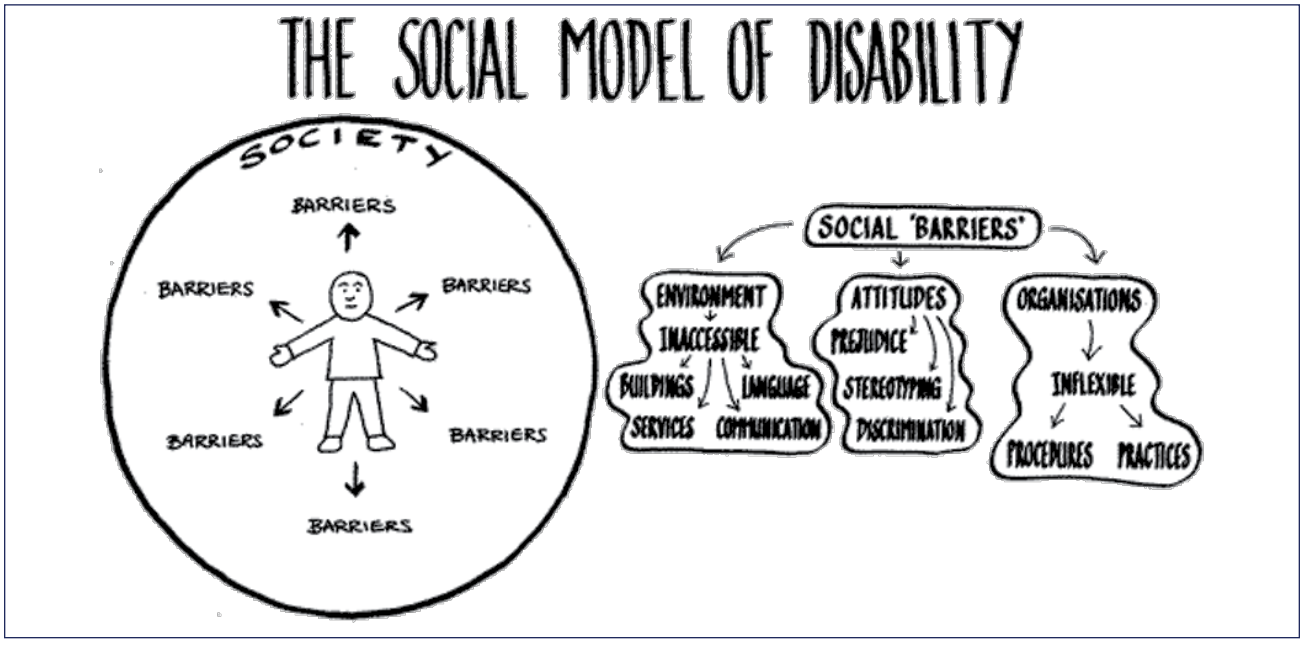
4.2 Charity Model of Disability

According to the charity model, a person who has a disability has a 'problem' in their body and good people should feel pity for the disabled person's tragedy, or be inspired by the disabled person's achievements. Disabled people's lives are rarely seen in a positive light. This model of disability depicts disabled people as victims of circumstance who are deserving of pity. It creates a view of disabled people's lives as tragic and pitiable. The disabled people are seen as needing help from the non-disabled people in order to live fulfilling lives, and ultimately to find cures to disability. The model isn't about supporting disabled people to live their lives on their own terms; it's not concerned with civil rights, independent living, meaningful employment or equal access to education.

The idea of being at the mercy of others lowers the self-esteem of people with disabilities. Employers also view disabled people as charitable cases. Rather than address the real issues of creating a workplace conducive to the employment of people with disabilities, employers may conclude that making charitable donations fulfils their social and economic obligations.

This does not mean that there should not be any charitable acts, but we do need to educate the donors the way they ensure that funds are channelled to promote the empowerment of disabled people and their full integration into the society as equal citizens, having our respect and not our pity.

4.3 Social Model of Disability



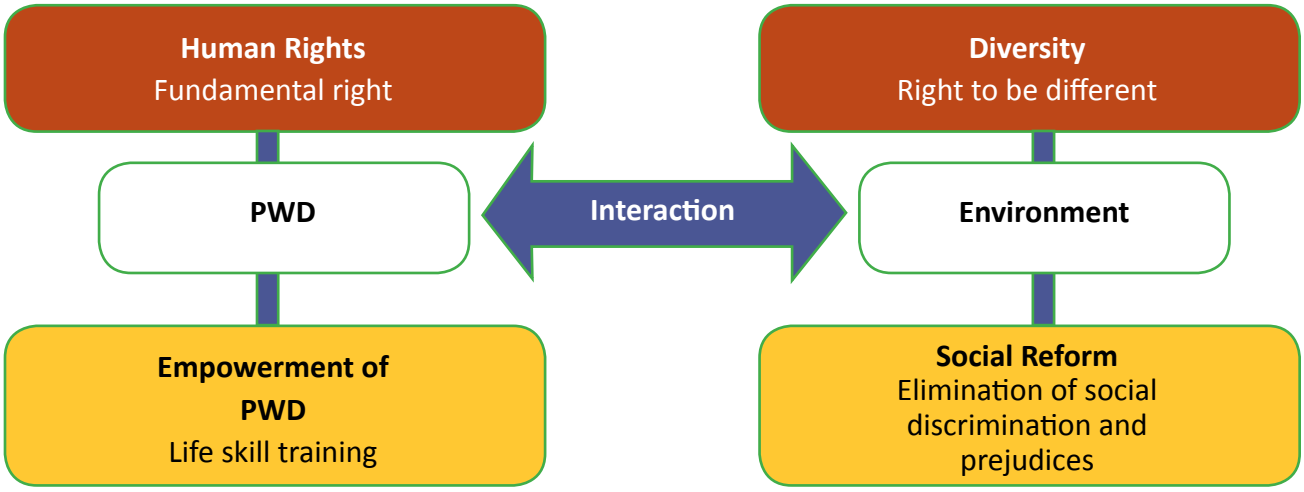
Source: http://cambridgeneurodiversityhub.co.uk/social-model-of-disability/

Social model of disability focuses on disability as a consequence of environmental, social and attitudinal barriers that prevent people with disabilities from maximum participation in society. For example, a person with visual loss is not disabled by the visual loss itself, but by the environment not providing the appropriate resources for that person. It is not individual limitations that are the cause of the problem. Rather, it is society's failure to provide appropriate services and adequately ensure that the needs of disabled people are taken into account by the society.

In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Society believes in one size fits all. That attitude needs to be changed and has to accommodate the diversity among persons with disability. Society believes in one size fits all. That attitude needs to be changed and society at large has to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life.

This model implies that the removal of attitudinal, physical and institutional barriers will improve the lives of disabled people, giving them the same opportunities as others on an equitable basis. The strength of this model lies in its placing the onus upon society and not the individual. At the same time, it focuses on the needs of the individual, for example, if a wheelchair user cannot use a bus, the bus must be redesigned.

4.4 Rights Based Model of Disability



Rights Based Model of Disability

The rights based model of disability focuses on the inherent dignity of the human being. It places the individual centre stage in all decisions affecting him/her and, most importantly, locates the main "problem" outside the person and in society. It's a right of every individual to get the same opportunities. It is also the right of person with disability to be different and get the accommodations done as per his/her need. Human rights model focuses on respect and recognition of the disabled individual by society. It clarifies that impairment does not lower human dignity nor does it lower the disabled person's status as rights-bearer. As per the rights model a person with disability has to be empowered with skills to live a life independently and even those who require high support services, it has to be a life with dignity. There has to be a social change wherein no stigma is attached,

no prejudices are there and a person with disability is participating meaningfully in all community activities.

> *If it is accepted that disability is located not solely within the mind or body of an individual, but rather in the relationship between people with disability and their social environment, then greater focus may be placed on amending disability through changes in social policy, culture and institutional practices.*

4.5 Policy and Legislative Measures

Since India became a signatory to United Nations Convention on Rights of Persons with Disabilities (UNCRPD) in 2007, a lot of significant measures have been taken to improve the quality of life of persons with disabilities. This was seen as a significant step in the paradigm shift in India from charity and welfare to rights and empowerment of people with disabilities.

4.5.1 *Inclusive Education of the Disabled at Secondary Stage (IEDSS 2009-10)*

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

4.5.2 *The Right of Children to Free and Compulsory Education Act or Right to Education Act (RTE 2012)*

An act of the Parliament of India enacted on 4 August 2009, which describes the modalities of the importance of free and compulsory education for children between 6 and 14 in India under Article 21a of the Indian Constitution. The amendment in the Act in 2012 included equal opportunities for children with disabilities stating same rights as non-disabled children for education.

4.5.3 *Rights of Persons with Disabilities Act (RPWD 2016)*

Significant features of this historic Act are:

- Every child with benchmark disability between the age group of 6 and 18 years shall have the right to free education
- Government funded educational institutions as well as the government recognized institutions will have to provide inclusive education to the children with disabilities
- The Act provides for penalties for offences committed against Persons with Disabilities
- Types of Disabilities have been increased from earlier 7 to 21 and Central Government will have power to add more types of Disabilities

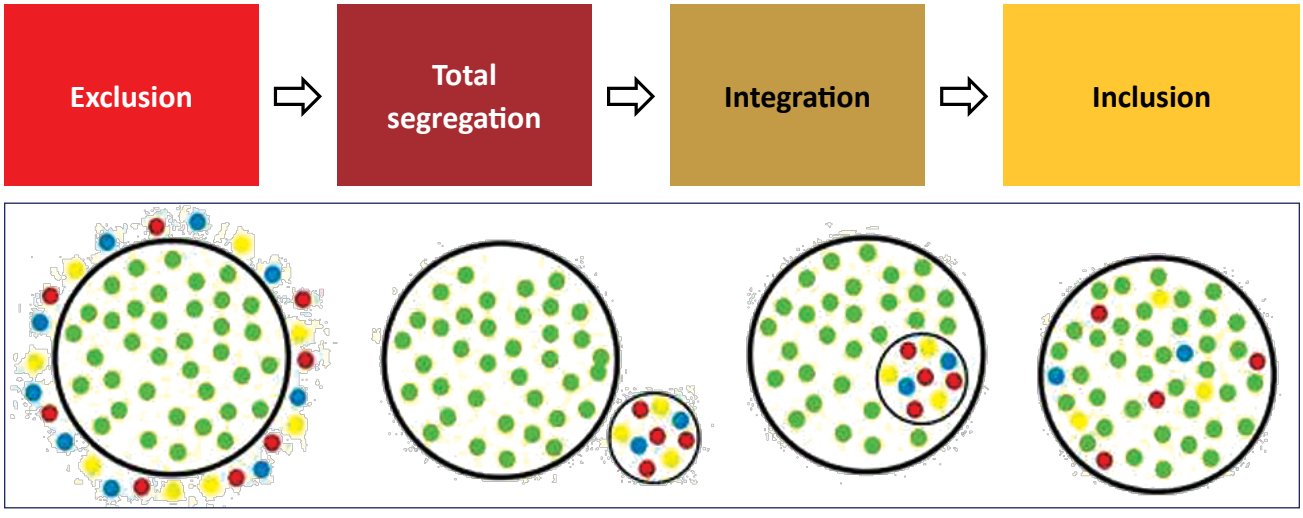
4.5.4 *Samagra Shiksha (2018)*

Samagra Shiksha is an integrated scheme for school education that includes three schemes of Sarva Shiksha Abhiyan (SSA), Rashtriya Madhyamik Shiksha Abhiyan (RMSA) and Teacher Education (TE).

The objective of this initiative is that school education should focus on holistic development of all children from pre-nursery to class 12. It highlights equal opportunities for schooling and equitable learning outcomes for all including children with disabilities.

4.5.5. *Paradigm Shift in Education*

We see a change in attitude towards education of children with disabilities from exclusion to inclusion. If we reflect on how did we think of moving from exclusion to inclusion. The answer is by moving from the Medical model of disability to the Right based model of disability.



Source: https://www.thinkinclusive.us/inclusion-exclusion-segregation-integration-different/

The diagrammatic depiction above explains this shift very well.

Exclusion	Children with disabilities are provided no education
Segregation	children with disabilities are provided education but in special schools separated from mainstream schools
Integration	Children with disabilities are present in mainstream schools but they have to fit in the existing system of the school. No accommodations are made for these children and even socially these children may cling to each other
Inclusion	All children with and without disabilities learn together and each child participates meaningfully in the classroom. Children with disabilities are also socially included in their class by their non-disabled peers

References

https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/33.pdf

https://mhrd.gov.in/sites/upload_files/mhrd/files/document-reports/Annexure-14%20%28SE%29%20%28IEDSS%20%29.pdf

http://samagra.mhrd.gov.in/

https://www.academia.edu/35204755/Models_of_Disability_ppt

https://madhavuniversity.edu.in/models-for-person-with-disability.html

Topic 5 Inclusive Development[5]

According to NSSO 2011 there are approximately 26.8 million people with disabilities in India. Majority of them (approximately 69%) are residing in rural area. They are caught in to vicious cycle of poverty and disability which means that disabled persons remain poor and that poverty causes disability. This is because poor people have poor access to health care, sanitation and hygiene so diseases are more to be seen in these houses and hence more disabling conditions. As they are poor they do not access assistive devices or therapy services which are expensive. The poor health and lack of mobility results in increase in disability. They do not go to school and get educated or proper skills and hence do not get good jobs. This results into further poverty…this is the vicious cycle. This can be broken by multi-sectoral approach in community based development program. It means we require comprehensive services to increase access to basic rights, health facilities and livelihood opportunities for reducing poverty to break the vicious cycle.

The WHO Community Based Guideline (2010) was developed after series of consultations with Disabled Peoples' Organizations, people with disabilities, their parents, Disability Organizations, Civil Society Organizations, experts and government agencies. They also advocated for creating inclusive society where people with disabilities can enjoy equal access to all developmental activities which are aligned with UNCRPD. This has resulted in to a Comprehensive CBR guideline focusing on inclusive development.

Inclusive development means:

- All people with disabilities are equally accepted in all development programs and given equal chances to participate and perform in various activities
- All people with disabilities shall have equitable access to benefits, fundamental rights, civil and political, socio-cultural activities without discrimination
- All people with disabilities shall have equal, safe and dignified access to built environment, information, technology and transportation for full participation

Therefore, instead of mere service delivery community based program, we need a comprehensive, right based community development program which is aligned with WHO guideline and UNCRPD. However, it has to be flexible, based on socio-cultural environment and contemporary program to meet the needs of people with disabilities. The ultimate goal of such programs is "Inclusive Society" where each person has equal access to rights and development activities.

It means, the community development programs shall be designed to-

- Include all people with disabilities in the program without any discrimination of age, cast, gender, religion and type of disability
- Enable and empower people with disabilities to reduce the multitude of barriers and increase access to housing, education, livelihood, medical and other poverty alleviation, schemes to break the vicious cycle

[5]Content of this topic authored by Ms. Kinnari Desai, Advocacy Manager, Blind People's Association

- Use the "Twin Track Approach" and create awareness in community, sensitize them about disability issue, hand hold to modify their existing environment and systems, and motivate them to promote participation of people with disabilities
- Equip people with disabilities to extend their services in helping other marginalized

This means that all the programmes and services and rights available and given to non-disabled people are made available to people with disabilities as a matter of right. All poverty alleviation programmes or scholarships or financial services to give an example shall be available to PwDs at par. Participation of PwDs in the electoral process, choice making in education, livelihoods, marriage and relationships is also as important.

In a CBID Project in Surendranagar, the women with disabilities and non- disabled women have formed Self Help Groups in various villages. These groups are democratic, based on equality of all. Some of the groups have become strong enough to get ranking by the Department of Agriculture, Government of Gujarat. One group has adopted an Aanganwadi which was discontinued by the government due to lack of funds. The SHG has taken up the total management and sustainability of this group.

In another Project in Dholka Taluka, the inclusive SHGs have collaborated with Usha Silai School, a vocational training initiative of Usha, manufacturer of Usha Sewing Machines. This group has been trained by Usha Trainers in making of fashionable apparel and they are commercially producing and selling the same now. This group has been covered and shown on national television by NDTV Network.

Blind people's Association has helped the Election Commission of India in making the Lok Sabha and other elections accessible to PwDs by helping to remove inaccessible features, printing of Braille Ballot Papers etc. The BPA has also developed a team for audit of public buildings for making them accessible.

Topic 6 Transition to a Rights-based approach[6]

Rehabilitation of persons with disabilities (PwDs) has been going on through the ages in different forms. Professionalization of services and special programmes for PwDs began around 300 years ago in Europe and the west. In India the first institutional programmes which segregated PwDs and taught them in a special school mode began around 150 years ago. The journey from Special care to rehabilitation in the homes in familiar surroundings is only around three decades old. The outreach model progressed to community-based rehabilitation and then on to Community based inclusive development which is based on the rights of PwDs to access services.

Before talking about the Right based model let's look at the brief overview of different models:

- **Charity Model**: People with disabilities are considered as vulnerable, burden and dependent on charity or support for living. The society assumes that PwDs have to be fed and cared for as they are not capable of being independent
- **Medical Model**: Person with disabilities are considered as having a defect which needs to be corrected and only then can they fit in to the society with medical intervention. For example, a person having polio needs a corrective surgery and orthotic aids for movement. The process after that of his integration into society or livelihood is not the concern of the medical team.
- **Social model**: Inaccessible environment and systems of the society are responsible for the problems faced by people with disabilities. For example, a person who is a wheelchair user is denied a job which is on the third floor in a building without a lift. The problem is not with the wheelchair user but with the building or societal systems which allow such buildings to be built.
- **Human Rights model**: People with disabilities are human first and they have equal rights as other human beings. The authorities are responsible to ensure their equal access to these rights. Hence all programmes have to include PwDs as a matter of right and not charity. For example, a PwD has the right to open a bank account, get access to financial assistance, cast vote, stand for election, right to speech and have meaningful interactions and relationships in society.

These models are evolved on the bases of various perceptions and approaches evolved in society to to view the situation of people with disabilities in communities. Therefore, these models have created strong impact in design and implementation of Community Development programs.

UNCRPD's focus of Human Rights and WHO CBR guideline has introduced the "Right Based Approach" in the community Development programs. It means instead of mere service delivery, the program shall ensure equal rights, dignity, and participation of people with disabilities at all the levels and enable them to exercise their right to choice. There is no strict guideline or fixed steps to implement Right Based Approach. However, the following action or activities of the program may help define "Right Based Approach":

[6]Content of this topic authored by Ms. Kinnari Desai, Advocacy Manager, Blind People's Association

Empowerment: Empowerment is the key component of right based program. It means training people with disabilities to fight collectively or individually against the discrimination or violence. Moreover, empowerment means holding hands and helping others to improve their quality of life. The following activities may help empower people with disabilities:

- Capacity building and training of people with disabilities to increase access to fundamental rights
- Awareness campaigns to build capacity of women with disabilities
- Increase access to education especially girl child with disabilities
- Introduce the concept of SHGs or DPOs to raise collective voices
- Provide need based legal counseling and link with advocates to fight against discrimination
- Train them to communicate smartly
- Enable people with disabilities to motivate and empower other individuals of their village/ community

Sustainability: The real achievement of any right based program is the presence of same synergy and action in the community even after withdrawing from a project. The sustainability component will help reduce gap between community and people with disabilities who will carry the same mission ahead even after completion of the project. The following activities may define the sustainability:

- Involve people with disabilities in designing and implementation of the program
- Ensure that all people with disabilities are aware about various entitlements, schemes, reservations available for them and the process to avail them
- Motivate people with disabilities to participate in socio-cultural, sports, civil and political, leisure and spiritual activities with equal enthusiasm
- Link people with disabilities with health, livelihood, finance agencies and local government leaders for self-employment and employment
- Ensure access to social security schemes and poverty elevation scheme e. g. Pradhanmantri Awas Yojana, NREGA, access to clean drinking water etc
- Equipped people with disabilities to participate in their community development activities
- Involve women with disabilities in mainstream activities of women's organization
- Sensitize Government machineries about their respective roles and educate them about rights of people with disabilities

Inclusion: Inclusion is the ultimate goal of any community development activities. To observe the long-term impact of a project, training and sensitization of various stakeholders is essential. The following activities may help promote inclusion through the project:

- Sensitize civil society organizations in disability issues
- Build capacity of mainstream organization to promote inclusive programs
- Build bridges between organizations to strengthen the referral services
- Create awareness in parents and in neighborhoods to increase acceptance
- Sensitization of various stakeholders in disability to break stereotyped image of people with disabilities
- Capacity building of regular schools to strengthen the inclusive education
- Extend support to make public places, information and technology accessible for people with disabilities

Topic 9 Family Structure[7]

Introduction

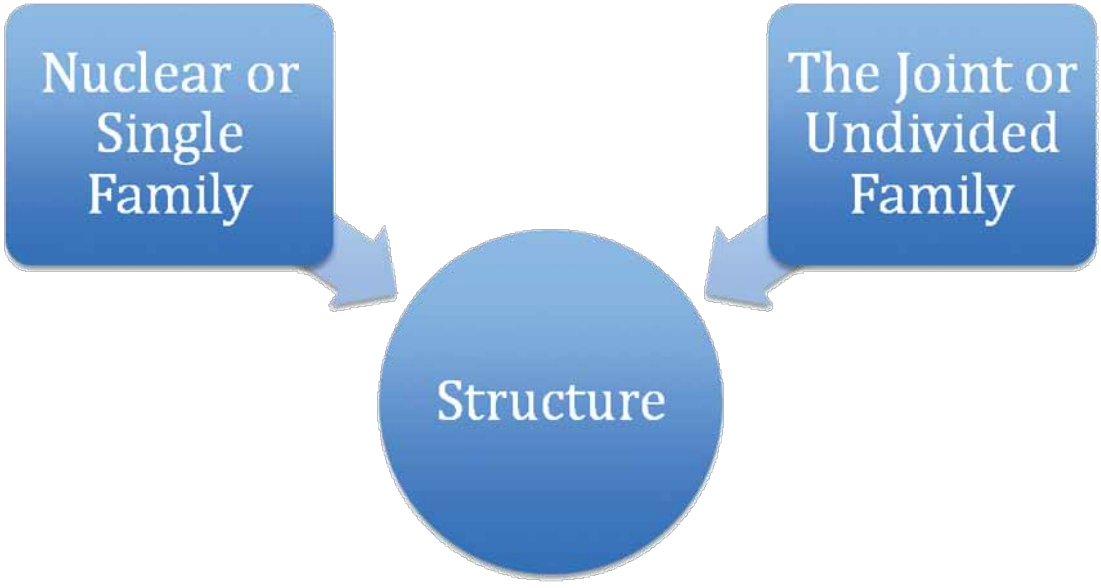
Family has a great influence on the life of a child from his birth to adulthood. Every individual with a disability would belong to a family. In order to work with a person with disability one would need to work along with his/her family. Therefore, how the family structure and the dynamics in a family affect the growing child with a disability is of important understanding for any rehabilitation worker.

Let us understand the context of Indian families and the family dynamics.

9.1 Family Structure

Family is a social group consisting of a father, mother, one or more children and may be grandparents and also extended family. It is the most immediate group a child is exposed to. It forms the basis of establishing trust and social relationships found in society. Society is a collection of families. No society or civilization ever exists without family. It plays a very important role in the development of personality of an individual and also in the process of socialization.

On the basis of size or structure, family can be classified into two main types:



Nuclear Family

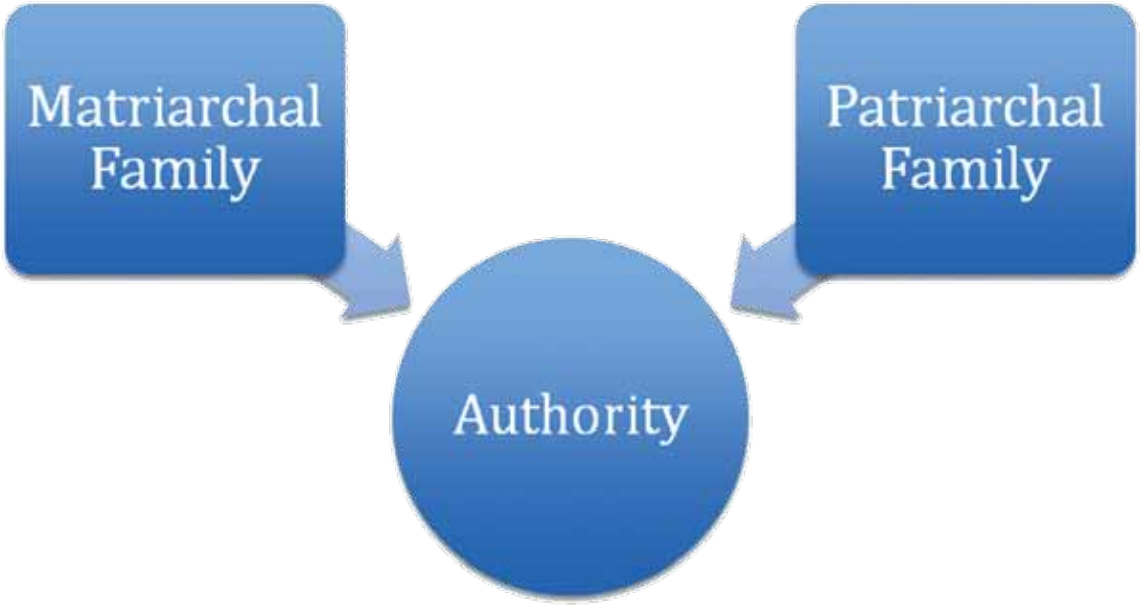
A nuclear family is a small group consisting of a husband, a wife and children. It is generally not under the control of adults or elders of the family. But in India, even a nuclear family may be remotely controlled by the in-laws. In all modern societies, nuclear family is the most common type of family.

[7]Content of this topic authored by Dr. Sujata Bhan, Professor and Head, Dept. of Special Education SNDT Women's University

Joint Family

A joint family consists of more than two generations living together. According to Iravati Karve, a joint family is 'a group of people, who generally live under the same roof, who eat food cooked in one kitchen, who hold property in common, and who participate in common family worship and are related to each other'. The head of the family controls all the decisions of the family.

On the basis of the nature of authority, family can be classified into two main types:



Matriarchal Family

The matriarchal family is a mother dominated family. The mother is the head of the family. She exercises authority and manages the property. Daughters inherit the property of the mother. The status of the children is decided by the status of the mother. After the marriage the wife stays back in her mother's home. The husband pays occasional visits to the wife's home. Sometimes, relatives of mother's family like her brother exercises authority in the family.

Patriarchal Family

The patriarchal family is also known as father dominated family. The father is the head of the family and exercises authority. He is the administrator of the family property. Only the male children inherit the property. Sons continue to live with the father in his own house even after their marriages. Only the wives come and join them. Women have secondary position in these families. Children are brought up in their father's family.

A family is guarded both by social taboos and by legal regulations. The society takes precaution to safeguard this organization from any possible breakdown. The structure and dynamics of a family varies whether it is a family in urban India or in rural India.

9.2 Characteristics of a Family

The major characteristics of a typical Indian family are as follows:

- **Clan domination**

  Rural family in the Indian context, for the most part, is clan dominated. Urban families may not be.

- **Joint family**

  The prevalence of the joint family system is an important feature of the rural family. Urban families are mostly nuclear.

- **Size**

  A rural family generally includes some distant relations besides the immediate members of the family. Hence in terms of size, the rural family is usually larger than the urban family.

- **Patriarchal and matriarchal families**

  In the patriarchal family the head is male. On the other hand, the head of the matriarchal family is female. The rural family system in several parts of South India and in Northeast is mostly matriarchal. The patriarchal rural family system is observable in North India.

- **Homogeneity**

  Homogeneity is another essential feature of the rural family. The bonds that bind the members of a rural family are stronger and last longer than those in the case of the urban family.

- **Economic unit**

  A rural family is a single economic unit with all its members co-operating with one another in the agricultural and other operations on the basis of simple division of labour by age and sex, under the management of a single head. In an urban family mostly all adult members contribute to family income.

- **Greater discipline and inter-dependence**

  There is greater discipline and inter-dependence among the members of the rural family in comparison to urban family.

- **Common lifestyle**

  All the activities of the rural families revolve round agricultural operations such as sowing and harvesting. Agriculture, being the common occupation of rural families it is instrumental in providing a common lifestyle to them. In urban family each member is individualistic and have less commonalities.

- **Hospitality**

  The members of the rural family are very much hospitable. They take all possible care to entertain the guests. Urban family is too busy to entertain guests most of the times.

- **Old customs and traditions**

  The rural family is very traditional. They are very particular about following old customs and traditions. Urban families are more practical and mechanical in their approach to life.

- **Marriage**

  In the rural family marriage is within one's own caste. The decision of the head of the family in matrimonial affairs is final. Any deviation from it is socially condemned. Inter caste marriages are more common in cities.

- **Socialization**

  Socialization refers to the process of the internalization of the social norms, customs and traditions prevalent in society. The norms of the family are followed by all family members without asking a question in rural family in comparison to urban family.

- **Family honour**

  Rural family is characterized by a feeling of family pride among its members. The members of the rural family leave no stone unturned to uphold family honour. This is prevalent less in urban family.

- **Religion**

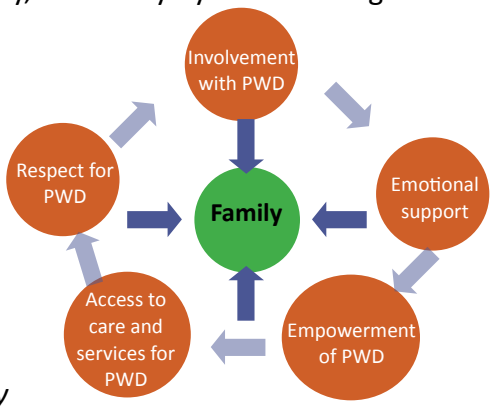
  Families in rural India are very God-fearing. They attach more importance to ritualistic activities in comparison to urban family.

- **Absolute authority of the family head**

  In the rural family, all the members are subordinated to the absolute authority of the family head. His word is final in almost all the affairs of the family. He manages the family property, distributes work, arranges marriages and settles disputes. In urban family there is more delegation of power and work.

9.3 Family Dynamics

Family dynamics is the pattern of relationships that exist in any family. The inter-personal and intrapersonal relationships within the family affect the family dynamics. With the presence of a person with disability in the family, the family dynamics changes all the more.



Family of a person with Disability

Family relationships affect the emotional, social, moral and cognitive development of a child in his/her entire lifespan. Parents, siblings, friends, in-laws, extended family influence each other's well-being and development.

9.3.1 *Factors that Influence Family Dynamics*

The influences of family dynamics will vary from family to family. Some common factors that may influence the development of family dynamics are:

- **Socio economic factors**

  Families with disability generally come from low economic strata and that adds up to the challenge of bringing up the child with disability. Access to services for the person with disability may not be easy.

- **Size of the family**

  A bigger family with more children can have a positive effect as there would be more family members to share the burden. The involvement of all family members with the person with disability may be divided. But at all point of time, there would be someone taking care of his/her needs.

- **Type of family**

  In nuclear family the support system expected from the family may not be available. Joint family provides emotional support to the parents and to each other.

- **Caste and cultural background**

  The attitude towards the disabled is also affected by caste and cultural background. In the lower castes the exclusion and discrimination of a person with disability may be observed more. Some consider disability as a matter of sin committed by the person himself or by their parents and one can do little about it other than pray. Culturally, some families attach more importance to male child and a female child with disability leads to double disadvantage.

- **Religion**

  Religion in the form of prayers and some ritualistic activities provides faith to the family to fight all the challenges they face. Sometimes the myths and prejudices towards persons with disability are also rooted in their religious practices.

- **Parent relationship**

  Parents may be having a constant arguments related to issues arising out of presence of the person with disability in the family related to financial matters or his/her care giving. Parents may blame each other for the child's disability. Mother's focus may shift to the child with disability and have little time and energy left to focus on her role as a wife. Parents may be overprotective and thus hindering the overall development of the child with disability. Some parents could also be neglectful of this child and focus all their resources on their atypical child.

- **Sibling relationship**

  Siblings could be jealous because all attention may be given to the sibling with disability. Siblings may be ashamed or excluded by their peers. The older sibling may be given the role of a caretaker to the sibling with disability, thus causing resentment. They may also worry that after parents are no more, they would have to take care of their sibling with disability. While some siblings may willingly assume the role of care taker in the absence of their parents. They may be involved in the life of their sibling with disability.

- **Joint family relationships**

  Parents may have little say in the upbringing of their child. Grandparents may be governed by religious or cultural norms followed by the family. Their word being the last word, many a parents cannot provide the right intervention to their child with disabilities. But at times good interpersonal relationships within a joint family may prove to be a huge support both physically and emotionally to the person with a disability as well as to his/her parents.

Despite the increased stresses of living with disability within a family, individuals and families are remarkably resilient to the challenges that disabilities present. The interdependent nature of individual, family, and community life cannot be emphasized less. A community rehabilitation worker's job is to help every family to adapt to the needs of the child/adult with disability and do what it takes to empower this person with necessary skills to make him/her an independent person who can live a meaningful life with dignity.

References

https://www.sociologygroup.com/kinship-india-iravati-karve/

https://www.sociologyguide.com/marriage-family-kinship/Types-of-the-family.php

https://culturalatlas.sbs.com.au/indian-culture/indian-culture-family

http://www.scielo.br/pdf/ptp/v17n2/7878.pdf

Topic 10 Factors to be Considered in Approaching a Family[8]

You will agree that no one plans to have a child with disabilities. First of all we need to realize that birth of child with disability is an unforeseen phenomenon. All families, where a child with disability is born, are unprepared and this incidence can be seen regardless of race, region, religion or economic status. The presence of a child with disability may impact the family as a social unit in variety of ways. Parents and siblings may react with shock, disappointment, anger, depression, guilt and confusion. Relationships between family members often change, in either a positive or a negative manner.

A child with disability presents unique and diverse challenges to the family. On one hand, the child may lead the family into crisis, resulting in major conflicts among its members. Family relationships may be weakened by the added and unexpected physical, emotional, and financial stress imposed on them. On the other hand, family members may see this child as a source of unity that bonds them and actually strengthens relationships. Many factors influence the reactions of family members: the emotional stability of each individual, religious values and beliefs, socioeconomic status, the severity of the child's disability, and the type of disability, to name a few.

In this module, we discuss how rearing children with disabilities affects parents and we will examine a broad range of family and parental issues related to rearing children with disabilities. We will review the family as a social system defined by a set of purposes, roles, and expectations. Each family member fulfils various roles that are consistent with expectations established by discussion, tradition, or other means. Each member functions in an interdependent manner with other members to pursue family goals. Using a social system framework, we can see how changes in one family member can have an effect on every other member and consequently the entire family system. If we accept the notions and concepts associated with this sociological view of a family, we can see how birth and presence of a child with disability can significantly affect the family over time.

Shock

The very first response to the birth of a child with disability is generally shock. Parents and family members are filled by feelings of anxiety, guilt, numbness, confusion, helplessness, anger, disbelief, denial, and despair. Sometimes, there are feelings of detachment, bewilderment, or bereavement. Unfortunately, at such a time, when many parents need assistance, very little useful information and help may be available. The length of time it takes parents to deal with these feelings or move through this period depends on their psychological makeup, the types of assistance received, and the seriousness of the disabling condition. During the initial shock period, most of the parents are unable to process or comprehend information provided by medical and other health-related or CBR personnel. For this reason information given to parents may need to be repeated on several occasions until they have fully understood the condition of their child. Also during this time, parents may be very low on their self-worth and value systems. They may blame themselves for the disabilities in their child and may seriously question their positive perceptions of themselves. Likewise, they may be forced to reassess the meaning of life and the reasons for their present challenges.

[8]Content authored by Mr Akhil Paul, Director, Sense International India

Realization

The stage of realization is characterized by several types of parental behaviour. Parents may be anxious or fearful about their ability to cope with the demands ci caring for a child with unique needs. They may be easily irritated or upset. Considerable time may be spent in self-accusation, self-pity, or self-hate. Information provided by health care/ CBR professionals during this period may still be rejected or denied. However, during this stage, parents come to understand the actual demands and constraints that will come with raising a child with disability. This realization frequently overwhelms couples, and as a result, they may remove themselves from family and social activities for a period of time.

Avoidance

This is the stage of defensive retreat, which parents attempt to avoid dealing with the anxiety-producing realities of their child's condition. They may try to solve their dilemma by seeking placement for the child in a hospital, institution, or special schools. Some parents respond by disappearing for a while or by retreating to a safer and less demanding environment.

Acknowledgement

This is the stage in which parents are able to mobilize their strengths to confront the conditions created by having a child with disability. At this stage, parents become capable of involving themselves in the intervention process. They are also better able to comprehend information or directions provided by a specialist concerning their child's condition. During this stage, parents begin to accept the child with the disability as well as others and even themselves. It is during this stage that parents become capable of directing their energies to tasks and problems outside of themselves.

We must remember, however, that patterns of parental response are highly variable. Parents and families respond to the birth and ongoing development of children and sibling with disabilities in common yet divergent ways. Furthermore, the time required for parents and others to make the various adjustments is extremely variable. Parents of children with disabilities have many other concerns. They especially want to know what their child's future educational and social needs will be. They want to know what their child will be capable of doing as he or she grows older and becomes an adult. They want to know how the presence of the child will affect other family members. Most importantly, they want to know how to maintain normal family functioning and manage the stress associated with having a child with disability.

Changes in Family Roles and Patterns

Presence of a child with disabilities strongly influence the manner in which family members respond to one another, particularly if the child is severely disabled or has multiple disabilities. It is often the mother who experiences the greatest amount of trauma and strain in responding to consequences of the birth and presence of a child with disability. Due to her involvement in caring for the child, she may no longer be able to handle the other tasks she once performed, such as preparing meals, doing laundry, doing grocery shopping, and assisting other household chorus. When the mother is

drawn away from the tasks she used to perform, other family members must often assume more responsibility. It may be difficult for family members to adjust to the new roles and routines that result from having a child with disability in the family. Each family member may need to alter his or her personal routine in order to assist the mother. Initially, the demands and needs of the child may be numerous and time consuming. For families that are already experiencing serious emotional, financial, or other problems, the addition of a child with disability may serve as the catalyst for many other problems.

Rapport Building and Communication

First of all, the CBID professionals need to establish strong relationships with families of children with disabilities by spending time to learn about their wishes and concerns for their children and to learn about the meaningful activities they participate in at home. Some of the things which can be said to family members are:

- It's not your fault. You are not powerful enough to have caused the kinds of problems your child has.
- What do you need for yourself?
- I think your son could be a success story for our agency.
- I value your input.
- Under the circumstances, you are doing the best you can do. Frankly, I don't know what I would do or how I would be able to carry on.
- I agree with you.
- Your child has made progress and I know he can do more, so we will continue to work with him.
- Why are you taking all of the blame? It takes two to make or break a relationship.
- I don't know. I can't tell what's wrong with your child or what caused the problem.
- Your child knows right from wrong. She knows most of society's values and that's because you taught them to her.
- There is a lot of love in your family.
- You know, it's okay to take care of yourself too.
- I believe in your instincts. You're the expert on your child.
- You're being too hard on yourself, please let go.

References:

https://gramvaani.org/

Innovative Approaches to family Support- 2007

Exceptional Parent-2004

https://www.ruralhealthcarefoundation.com/

Topic 11 Importance of Screening[9]

11.1 Need for screening:

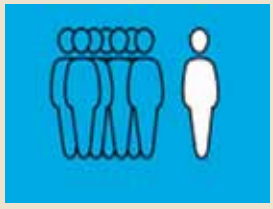
There is enough evidence to show that disability is a leading cause of marginalization in our society.

Marginalization leads to deprivation of basic necessities and affects the well-being of individuals.

In order to prevent marginalization of individuals their disability or the conditions that disable them must be identified. This is vital so that the productivity of individuals is not affected.

Marginalization

Treatment of a person or a group as insignificant for a productive activity.



Source: https://images.app.goo.gl/gygyyZHhTD6ZMm6L7
Source: https://images.app.goo.gl/47rBwiihW55mns1W7

Let us understand some important concepts in this regards.

The World Health Organization (WHO) in 1976 and thereafter in its' International classification of functioning, disability and health (ICF) (2001) document, provides a threefold linear distinction of three important terms.

Impairment	Disability	Handicap
		
Loss of an organ or a function for example damage to eyes and sight	A routine essential activity which is hindered or restricted due to impairment for example an individual not able to read or write due loss of sight	A condition arising out of impairment or disability which prevents a person to carry out functions such as getting education, doing a job.
Affecting body	**Affecting functioning**	**Affecting participation**

Source: https://www.slideserve.com/silas-cochran/clinical-aspects-of-meditouch-products

A CBID workers' role is important in the above context as he/she has the responsibility of preventing an individual from becoming a handicap person. This is vital as it will reduce social inequality, burden to the family and also avoid the individual from getting demoralized due to marginalisation. Hence, preventing impairment becoming a disabling or a handicapping condition is essential. How do you think this could be done?

[9]Content of the topic authored by Dr. Varsha Gathoo, AYJNISHD (Divyangjan), Mumbai

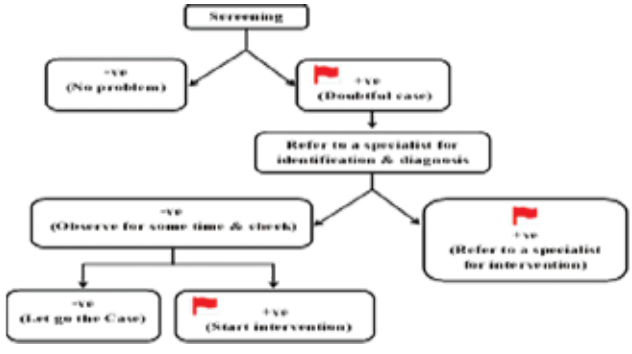
The proverb 'prevention is better than cure' is well known. It means that stopping something from occurring is easier than repairing the damage caused by it.

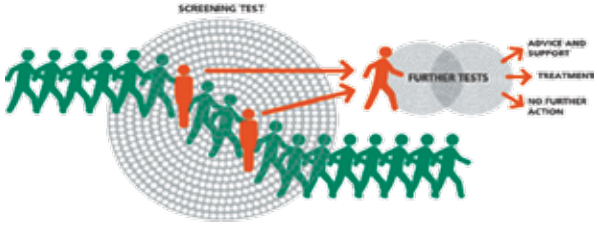
Q: Think about instances where this or such other proverbs are applicable. Also think for yourself whether there is only one stage or there could be multiple stages of prevention?

Ans: You are right if you thought that prevention can be done at different stages and levels. Screening of a problem or a condition is said to be the first stage or primary prevention.

11.2 Meaning and importance of screening:

Simple, basic or preliminary *test(s)* or *examination* to *discover* if there is anything *wrong* in an individual(s) is called screening. It is to be remembered that screening for a disability is not diagnosing a disability. It simply means eliminating doubt and determining whether an individual needs further referral to test for a disability. In case of a CBID worker it means ascertaining if there are any signs or symptoms in an individual for a disability. If an individual's screening test is showing an underlying cause of a disability then he/she needs to be referred immediately to the specialist. While doing so care must be taken to maintain confidentiality and also a caution that the screened individual must not be labeled as being disabled. It simply means clearing a doubt for further referral if needed.





Source: https://www.phpc.cam.ac.uk/pcu/spectrum-effect/

11.3 Method & Process of screening:

The need for screening for early identification and interventions of disabilities is evident. The CBID workers need to keep in mind that the screening methods and procedures will differ with respect to purpose across different age groups. The methods and procedure will also differ for different age groups.

Screening at birth: Ideally disability needs to be screened at birth itself. The screening of all new born babies is referred to as 'Universal new born screening'. This is to be undertaken by the medical and para-medical professionals before the mother and the baby are discharged from the maternity hospital. For example screening the hearing ability of a baby is done by the use of an instrument called Otoacoustic Emission Test (OAE). Some disabilities are screened through testing reflexes while some

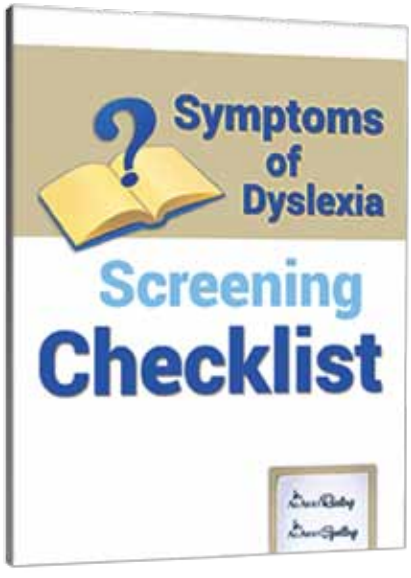
are done by blood tests e.g. for detecting blood disorders or disability such as Down's syndrome. Screenings is also done for developmental disabilities by specialists. The role of a CBID worker is to create awareness in the community about the need and importance of new born screening and ensuring that the hospitals have the facility for it.

Screening in children: Screening in children can be done individually or in group. Aganwadi and Asha workers can assist in screening young babies and infants if they are provided with checklists for ascertaining growth and developmental milestones of children. The checklist should be simple and easy to administer and should cover signs and symptoms of a disability and also the milestones of developmental domains such as (1) Motor and Physical (2) Communication and (3) Cognitive and (4) Socio-emotional. As children enter Balwadis and preschools the foundational literacy skills such as pre-reading, writing and numeracy skills could also be screened by the Balwadi teachers for ruling out learning difficulties and disabilities.

Screening in adults: Adults may be comparatively easy to screen as they can undertake self-screening. CBID workers can assist adults who have difficulty in reading and writing. Screening is easier to do with the help of technology. There are various apps which can be downloaded on the mobile phone for screening a disability besides online screening.

Source:https://researchforevidence.fhi360.org/what-disability-screening-tools-are-available-to-use-in-low-resource-schools

Source:https://www.starkey.com/online-hearing-test#!/HearingTestLandingPrimary#HearingTestApp



Source: https://info.allaboutlearningpress.com/symptoms-of-dyslexia-checklist

References

ICF(2001) https://apps.who.int/iris/bitstream/handle/10665/42407/9241545429.pdf;jsessionid=77F23DCA4C83629E49EC71A5A155B71E?sequence=1

Topic 12 Selection and Administration of Checklists[10]

12.1 What is a checklist of disability?

In our day-today household activities or at office we often make list(s) of items or tasks to verify. Even while planning a travel we make a list of items and later check whether we have done the work and packed the items for the travel. These are simple checkpoints which we make but we may or may not jot down these. But for purposes of administration in an office or an institution there are written lists of items or actions to be done which are to be verified for completion. These are the formal checklists.

For a CBID work in a community, a checklist is essential for many things. It could range from screening for a disability to assessing whether there are enough provisions in a community for providing a barrier free environment.

Source: https://images.app.goo.gl/nhNqUY7r3MCkUSKi7

The checks i.e. tick marks or the crosses can help a CBID worker to gather information about various aspects of disability in a particular community such as screening, referral, procurement of aids and appliances, profiling the persons with disabilities, arranging sensitization programs and ultimately for creating a good data base about the individuals with disability. These checklists usually may vary in their formats. Generally the checklists are in the form of questions or statements.

12.2 Content of a checklist

There are various types of checklists used in the social sector. Its' content differs according to its' purpose.

Table 2.1 Types of checklists

Sr. No.	Type of checklist	Purpose that it serves
1	Data gathering checklist	This is used to gather numbers. For example gathering number count of men vs. women vs. children with disabilities. It could be used to gather number of babies screened and number of babies referred.
2	Task or Standard operating check-list	These are used to clearly state the procedure or steps to be undertaken. For example for organizing a screening camp for adults to test vision or hearing such checklists would provide step wise expectations that needs to be checked.
3	Troubleshooting checklist	These are used to diagnose or solve a problem. Given the situation that individuals are in, such checklists provides stepwise instructions to do in a critical situation. For example if an electronic device of a person with disability gets wet by chance, or stops functioning, the trouble shooting checklist could be used to ascertain the precautions.
4	Coordination checklist	These checklists are for complex activities that requires synchronization of multiple people, teams and departments. For example in a disaster management operation for persons with disabilities, it would require cooperation of various agencies such as the family, the NGO associated, the state social welfare department and the disability commissioner

[10]Content of the topic authored by Dr. Varsha Gathoo, AYJNISHD (Divyangjan), Mumbai

12.3 Parameters for selecting a checklist

From the table 2.1 above it is understood that there are various checklists that a CBID worker could use. There are various parameters based on which a checklist could be selected for use. The most important being the 'purpose' for which the data is to be collected. The other parameters would include the demographic details such as age, gender, and the literacy levels of the respondents. An important parameter could also be the sensitivity of the data to be collected.

12.4 Contextualizing and administering a checklist

There are ready to use checklists for gathering data and information from the community. However not all items in it could be relevant. For example while collecting data for accessibility through a checklist of mobility in rural areas the items pertaining to mobility issues of urban areas such as using a metro or local train would be irrelevant. Hence it would be ideal to check the context in which the checklist is to be used. At times a CBID worker may have to adapt and contextualize the statements while using it. There are also some guidelines to be followed for using a checklist. The general tips for administration are provided in the box below:

- ✓ Explain the purpose of using the checklist to the respondents
- ✓ Obtain the permission from the individuals with disabilities if they are adults.
- ✓ In case of children parental consent may be obtained.
- ✓ The statements or the questions asked may be read out to the respondents to ensure that they understand the language and provide correct information
- ✓ Confidentiality of respondents may be maintained.

Topic 13 Interpretation of Results[11]

13.1 Scoring of a checklist:

The purpose of gathering data using a checklist could be for multi-fold. We have seen in the earlier topic that checklists could help in ascertaining a range of information. It can tell us about different age groups having different disabilities in a community to discovering and listing barriers or the infrastructure and resources available in a community. It can also include checking or ascertaining compliance of certain works. The main objective for using any type of checklist is thus to collect primary data i.e. information and arrive at a conclusion i.e. a result about the ground realities. Look at the checklists below:

Weekly checklist for community activities

CBID parameters	Monday	Tuesday	Wednesday	Thursday	Friday
Acceptability of disability in the community	Yes No	Yes No	Yes No	Yes No	Yes No
Social participation of PwDs in community meetings	Yes No	Yes No	Yes No	Yes No	Yes No
Barrier free environment in schools	Yes No	Yes No	Yes No	Yes No	Yes No
Assisting in getting UDID cards	Yes No	Yes No	Yes No	Yes No	Yes No
Information on aids and appliances	Yes No	Yes No	Yes No	Yes No	Yes No

Source:https://images.app.goo.gl/2bCXTQrwUDapF4r46

Pause and think….

Data i.e. responses obtained from both these checklists are in different forms. In the first one you get it in the form of number of check marks while as in the second one you will get Yes/No and the estimate of work from the number of happy faces or stars.

Q. How would you combine these responses to get your consolidated result?

Ans: The responses need to be converted into numbers. This is called developing a scoring key.

A scoring key is assigning marks to the responses. In the above checklists one will have to assign marks say 5 to Excellent and 1to poor. In the second checklist also 4 to 4 happy faces and 1 to one happy face and so on…Later count and aggregate the total to arrive at result.

13.2 Type of data:

There are 4 types of data or scales. The nominal, ordinal, interval and ratio. Only the first type of data *i.e.,* Nominal can be obtained from a checklist.

[11]Content of the topic authored by Dr. Varsha Gathoo, AYJNISHD (Divyangjan), Mumbai

Nominal Data: This type of data is tells us the category e.g. Male / Female / Children. For the sake of counting and aggregating the result, we may assign a score of '1' to male, a score of '2' to female and a score of '3' to children. However it is to be noted that the 1, 2 and 3 is not associated with any degree or order (e.g., category of 1 is not higher or lower than 2 or 3). It simply means separating information into different categories.

Ordinal Data: This type of data gives an order to the information. For example 4 happy faces means Excellent infrastructure, 3 happy faces means very good, 2 means good and one happy face means poor infrastructure. But the data may not tell us how much 'Excellent 'is better than 'good'. This type of data however helps to provide estimates.

Interval data: This type of data gives the exact differences between the values. The clock is an example of interval data. Test scores of different subjects in the school are example of this data.

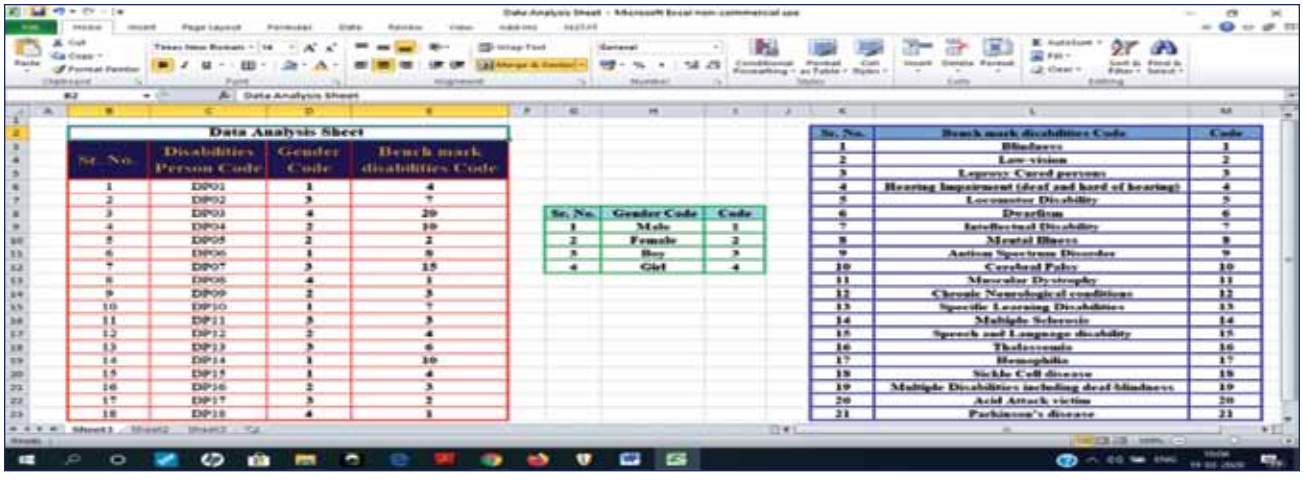
Ratio: This type of data also gives us difference between values, but additionally this type of data has an absolute zero. Weight of the children or the head circumference information collected by Aganwadi or Asha workers are the examples of ratio.

13.3 Interpreting data

Data needs to be understood. For doing so it is to be tabulated. An excel sheet is useful for tabulation of the data based on which analysis is done to draw the result. Let us see an example.

In a community of approximately 1000 people a CBID worker plans to map the disability. He/ she wants to find out the adult male & female and the children having 'Bench mark disabilities' in the community. A door to door survey was conducted using a checklist. The CBID worker has identified 35 cases which is to be reported.

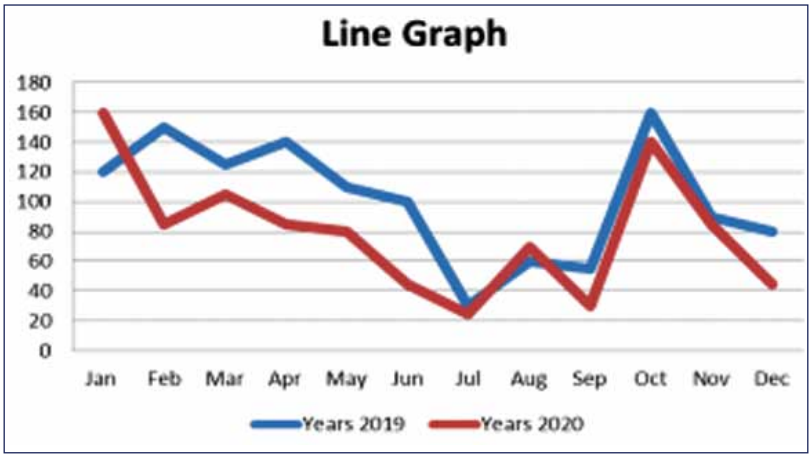
An excel sheet in the computer can be used to enter the raw data and obtain the results.



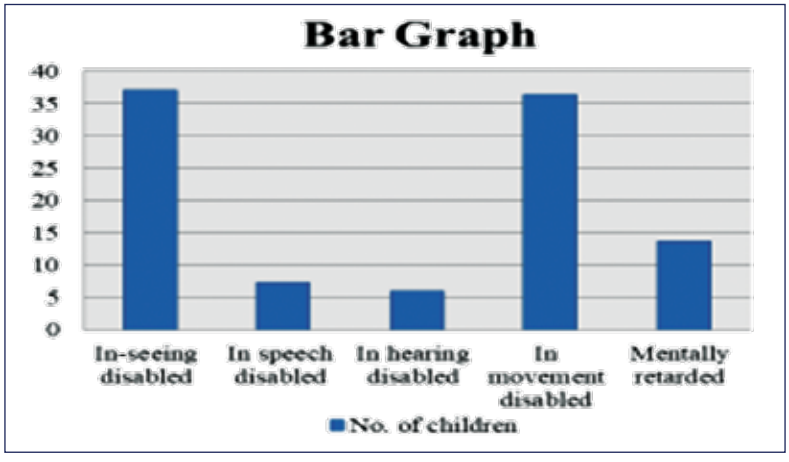
In the example above after entering the data one can prepare a graphical representation of the obtained result. Let us see the other forms of representing the data.

13.4 Graphical representation of data:

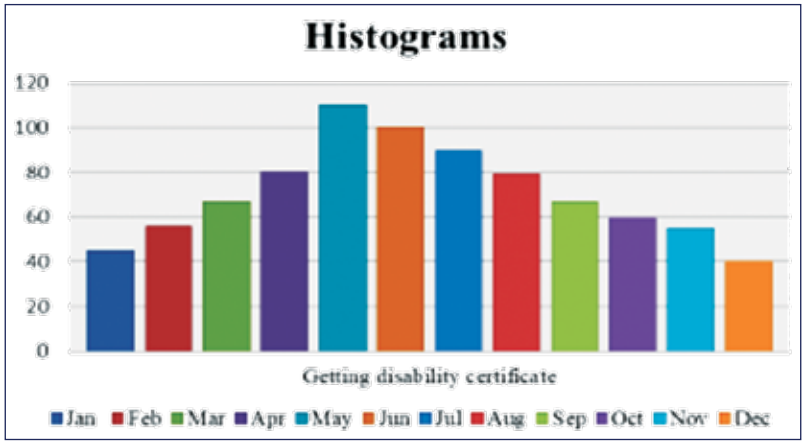
Line Graphs: This type of graph can be used to show continuous data of events over the time. For example month wise distributions of aids and appliances.



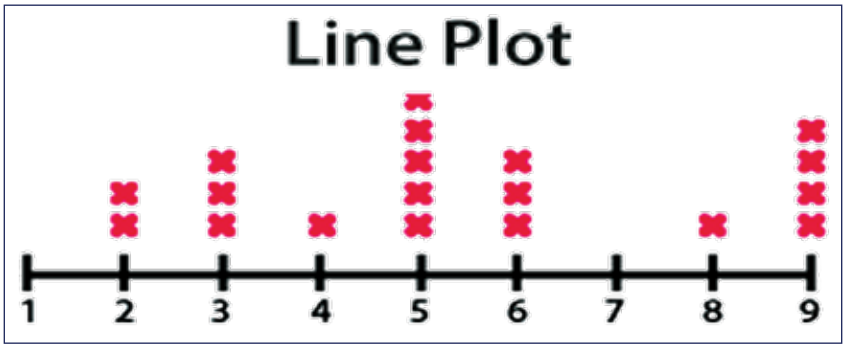
Bar Graphs: This is used to display the data in the form of categories. It can also be used to compares the data of categories e.g. no of children with various types of disabilities.



Histograms: These are bars which are used to represent the frequency of numerical data organized into intervals. As all the intervals are equal and continuous, all the bars are of the same width. For example number of adults getting disability certificates every month.



Line Plot: This has a number line and shows the frequency of data on it. A cross or a dot is placed above a number line to show each time when that data occurs again. For example in the 9 community meetings the number of PwDs attending meeting can be depicted as below:

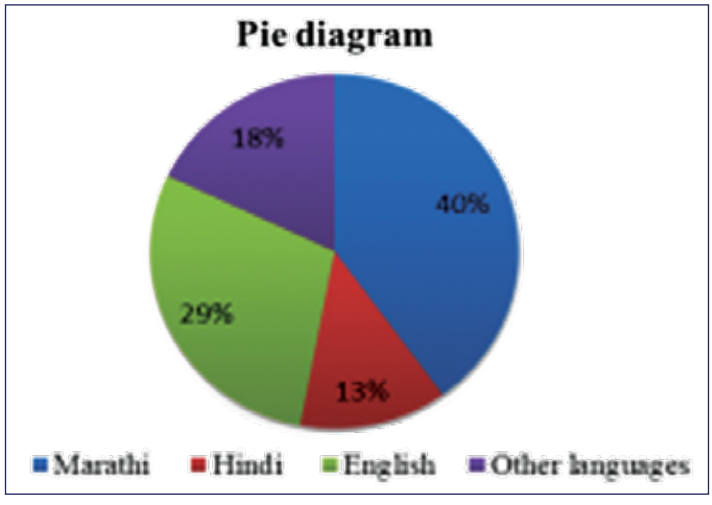


Frequency Table: This type of a table shows the tally e.g., number of PwDs within the age group.

Frequency Table

Rulers of France		
Reign (Years)	Tally	Frequency
1-15	𝍸 𝍸 𝍸 III	18
16-30	𝍸 𝍸 I	11
31-45	𝍸 I	6
46-60	IIII	4
61-75	I	1

Pie diagram: It shows the relationships of the parts of a whole. The circle is considered as 100% and is divided into the categories as per the percentage like 40%, 13% etc. For example depicting languages spoken by different PwDs.



Topic 14 Case Review with Health Specialists[12]

Outcome: *Understand the process of case review and facilitating family participation in rehabilitation process*

14.1 Importance of case review with a multi-disciplinary team

Case review means a consultation process. It includes thoroughly examining the condition of a person or of a situation. In case of an individual with disability it means carefully examining his/her situation and trying to find out solutions so as to solve an individual's problem. The word case can also be used for a group or a community and not just for individuals. Let us see examples of both of these:

Individual as a case: A child with a disability enrolled in a mainstream regular school refuses to go to school. This forms an individual child's case.

Community as a case: A community is desirous of creating a barrier free environment. This forms a community case.

In either of the case do you feel that a CBID worker alone can solve the problem? Certainly not! There are so many things associated with issues of both the cases. Let us take it one by one. In an individual child's case refusing to go to school there could be many different reasons.

Issues	Possible problem solvers
Not able to understand teaching of the regular class teacher	Special educator and regular school teacher
Bullying or teasing by classmates	School counsellor
Unwell	Doctor or a nurse
Home work	Parents

In the second case for creating a barrier free environment in a rural community there would be support of so many authorities required for example the panchayat, the significant adults, Block development officer, Tahsildar, Education officer, Engineer, the PwDs themselves or their parents, a Specialist in disability and so on.

The UNCRPD's Article 26 also directs that multidisciplinary assessment of an individual needs and strengths should begin at the earliest possible stage. This is essential so that all areas such as physical, mental, social and vocational aspects are assessed and appropriate measures for full inclusion and participation in all aspects of life is facilitated.

[12]Content of the topic authored by Dr. Varsha Gathoo, AYJNISHD (Divyangjan), Mumbai

So in both the cases we see that a team is required. It is hence beneficial that a multidisciplinary team is formed by a CBID worker for any community issues. Multidisciplinary team refers to the fact that many different authorities i.e. professionals or persons work together toward a common goal.

14.2 Steps for a case review

Step 1: Collect preliminary data: Using a proper instrument like a checklist collect the data and record relevant information about the case

Step 2: Identify the stakeholders: Depending upon the case requirement identify the relevant people i.e. the stakeholders who could provide inputs for the case.

Step 3: Share the case data and brainstorm: The data collected with respect to the case and the results needs to be openly shared with the stakeholders and a discussion i.e. brainstorming needs to be undertaken.

Step 4: Prepare an action plan with accountability: Based on the discussions an action plan could be drawn. It is essential that the plan should have timelines and responsibilities to the stakeholders

14.3 Essentials for a case review meetings

Each case is unique as individual is unique. For proper outcomes of the case review meeting it is very essential that certain essentials be followed. These would include the following checks:

- ✓ Collect the demographic details with respect to the case including the cultural aspects.
- ✓ Use respectable language so also correct terminologies while conveying conditions.
- ✓ Confidentiality of the data is essential. Utmost care should be taken during and after the case review.
- ✓ Report writing and periodical follow up of case review is a must.

References:

UNCRPD retrieved from https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-26-habilitation-and-rehabilitation.html

Topic 15 Acceptance of Family[13]

It is always shattering when a family get to hear the grave news about a child's health. Whether that happens in one day, or slowly over years, it begins a process in which most parents of children with disabilities grow into with jerks, not smoothly and not steadily. One mother of a child with disability says she resents her friends telling her that God gave her this burden because she's so strong but she doesn't agree.

In the past decade, the human society has seen many doors open for children with disabilities. Yet today's parents still know the exclusion of the special look, when people stare their child with the constant sight of pity, fear or curiosity in the eyes of others which gets in the way of helping their child.

Disability & Family

We all know and understand that disability places a set of extra demands or challenges on the family system, which last for a long time. Many of these challenges cut across disability type, age of the person with the disability, and type of family in which the person lives. There is the financial burden associated with getting health, education, and social services; buying or renting equipment and devices; making adaptations to the home; transportation; and medications and special food. For many of these items, the person or family may be eligible for financial support or reimbursement under a government/ voluntary scheme. However, many of the families/ parents are not aware about what services and support they are entitled for and then working with a system to certify eligibility is another major challenge faced by families. Another major challenge is coordination of services among different providers (such as doctor, physiotherapist, occupational therapist, special educator, and counsellor).

For parents whose children belong in the above statistical group, there can often be major barriers to entering the many circles of community life. Many a times it is seen that these families with children disabilities find it very difficult to participate in the community that the rest of us take for granted. Attending a wedding, grocery shopping, seeing a movie in a theatre may require a lot of extra work and planning.

The day-to-day strain of providing care and assistance leads to exhaustion and fatigue, taxing the physical and emotional energy of family members. There are a whole set of issues that create emotional strain, including worry, guilt, anxiety, anger, and uncertainty about the cause of the disability, about the future, about the needs of other family members, about whether one is providing enough assistance, and so on. Grieving over the loss of function of the person with the disability is experienced at the time of onset, and often repeatedly at other stages in the person's life.

[13]Content of this topic authored by Mr. Akhil Paul, Director, Sense International India, Ahmedabad

Family life

Family life is changed, often in major ways. Care-taking responsibilities may lead to changed or abandoned career plans. Female family members are more likely to take on caregiving roles and thus give up or change their work roles. This is also influenced by the fact that males are able to earn more money for work in society. When the added financial burden of disability is considered, this is the most efficient way for families to divide role responsibilities.

The disability can consume a disproportionate share of a family's resources of time, energy, and money, so that other individual and family needs go unmet. Families often talk about living "one day at a time." The family's lifestyle and leisure activities are altered. A family's dreams and plans for the future may be given up. Social roles are disrupted because often there is not enough time, money, or energy to devote to them (Singhi et al. 1990).

Social life

Friends, neighbours, and people in the community may react negatively to the disability by avoidance, disparaging remarks or looks, or overt efforts to exclude people with disabilities and their families. Despite the passage of the Americans with Disabilities Act in 1990, many communities still lack programs, facilities, and resources that allow for the full inclusion of persons with disabilities. Families often report that the person with the disability is not a major burden for them. The burden comes from dealing with people in the community whose attitudes and behaviours are judgmental, stigmatizing, and rejecting of the disabled individual and his or her family (Knoll 1992; Turnbull et al. 1993). Family members report that these negative attitudes and behaviours often are characteristic of their friends, relatives, and service providers as well as strangers (Patterson and Leonard 1994).

It is important for parents to join parents' networks/ self-help groups and they may discover that getting to know other parents with some of the same challenges can help them find a knowledgeable sympathetic ear. Families can find other people to talk to who understand the day-to-day challenges they face. Many choose to join email chat groups where they can be a part of a much larger circle of regional families.

Every family makes its own temporary peace with the social reality of their child's limitations and behaviour. Some families want to limit themselves to the safety of a very small circle that they draw around home, school and a few close friends. Other families seem confident navigating in bigger circle, and may even help lobby organizations to open centres that are accommodating to children with differences. It will be best if families resolve to think outside the circle and welcome someone new into their acquaintance, they will be widening their own social worlds. Here are some suggestions:

1. Listening makes a difference: It is not up to us to solve the problems or to know all the answers... just listen. An easy way to start is by simply asking, "How are things going?"
2. Throw assumptions out the window: Each family is in a different part of their long journey, which includes sadness, frustration, and joy so do not make assumptions.

3. Explore ways to help: Ask how you can help. Maybe it is assistance with laundry, grocery shopping, taking other children for an outing or giving couple of hours of respite/break to parents.

The birth of a disabled child requires parents to love a significant figure – their child, who is denied of the capacity to give a feeling of accomplishment. Families that acknowledge their child with Disability are characterized as being in a condition of harmony between recognition of the child's limitations and looking to make up for these limits.

References

1. https://www.parentmap.com/article/acceptance-for-children-with-disabilities

2. https://www.unicef.org/sowc2013/files/SWCR2013_ENG_Lo_res_24_Apr_2013.pdf

3. https://family.jrank.org/pages/396/Disabilities-Impact-Disabilities-on-Families.html

4.https://www.nwitimes.com/news/local/porter/valparaiso/effects-of-disability-on-the-family-as-a-whole/article_491a57ef-d3dd-5686-a3f5-c25336a4a063.html

Topic 16 Resource Mapping[14]

STRENGTHS BASED APPROACH AND METHODS 2 (RESOURCE MAPPING):

This is very fact, evident that all the communities have resources, even they are very poor. The CBID program team should have skill to understand the community resources, how to identify these resources, link with the CBID program activities, and most importantly they should be very skillful in mobilizing these community resources. The community resource identification or analysis is key activity of CBID project. The purpose of resource analysis or resource mapping is to identify current resources available in the community that could be used for CBID project activities. Before we proceed for various methods for resource mapping exercise, it is important to understand Resource Mapping from CBID project perspective.

Understanding of Resource Mapping:

Resource mapping is not a new strategy or process in community development program. This resource mapping exercise is also known by different names such as community resource mapping, participatory rural appraisal, natural resource mapping.

The resource mapping exercise helps the CBID project team to plan the project activities, and activities can be matched with the resources. Through this exercise, the CBID team able in the identification of resources available in a particular community; identification of new or additional resources to sustain existing specific CBID activities or initiatives within a community, and/or identification of resources to assist in creating and building capacity to support a more comprehensive community system for serving persons with disability.

Purpose of Resource Mapping in CBID.

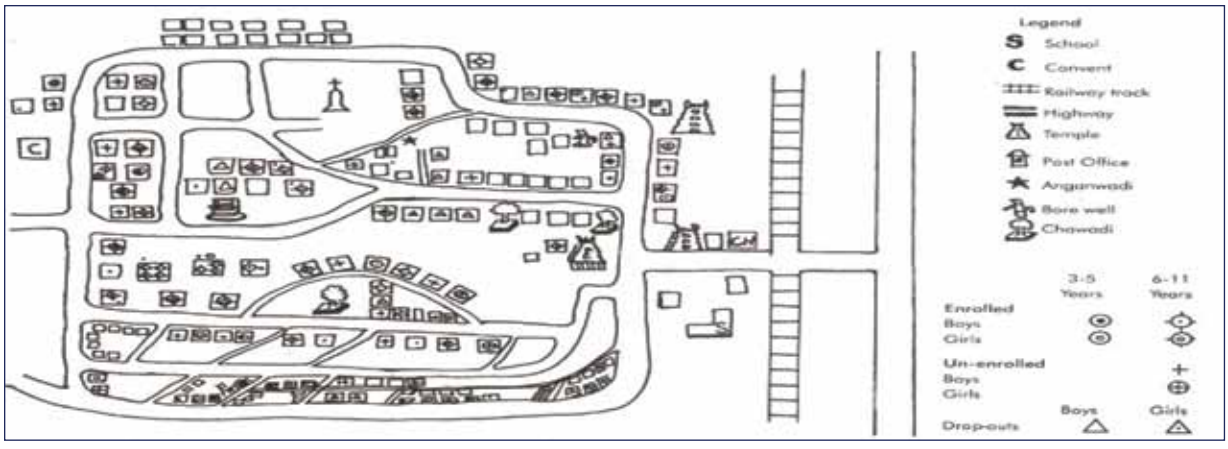
- To allow the persons with disability, the family members, community members identify, locate and classify past and present resources, how they are or were distributed, ownership of resources, reveal the significance of each resource for community inclusive development.
- Establishing relations with resources and existing issues related to persons with disability, and community at large.

Types of Community Resource Mapping Methods:

1. Social Map:

Social mapping is perhaps the most popular method in resource mapping. The social mapping focusing on habitation patterns and the nature of housing and social infrastructure: roads, drainage systems, schools, drinking water facilities, in the community. The social map is prepared by the local community not by the expert. It depicts what the local people believe to be relevant and important for them.

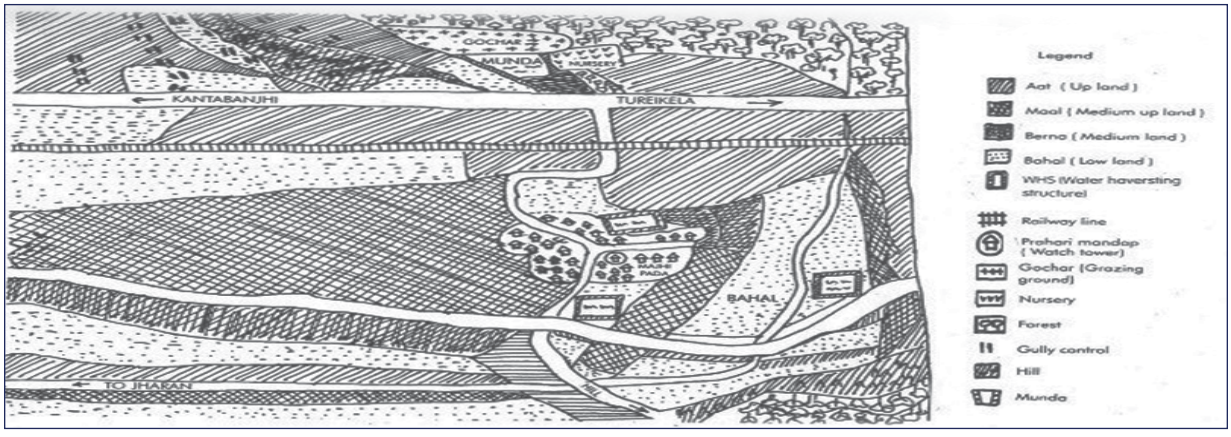
[14]Content of this topic authored by Mr. Bharat Joshi, Manager, Blind People's Association, Ahmedabad



The chief feature of a social map is that it is a big help in developing a broad understanding for the various facets of social reality, viz., social stratification, demographics, settlements patterns, social infrastructure.

2. Resource Map:

While the social map focuses on habitation, community facilities, roads, temples, etc., the resource map focuses on the natural resources in the locality and depicts land, hills, rivers, fields, vegetation etc. A resource map may cover habitation as well. At times, the distinction between the resource and social map may get blurred. Therefore, the CBID team has to be careful while preparing resource map. This map usually uses for natural resource management project.



3. Time Line:

Time line is an important method quite commonly used to explore the chronological dimensions from historical perspective. Time line captures the chronology of events as recalled by local people. It provides the historical landmarks of a community individual or institutions. The important point to note here is that it is not history as such but events of the past as perceived and recalled by the people themselves. The timeline method helps to generate discussions on changes with respect to issue you are interested in, e.g., education, health, food security, gender relations economic conditions, etc. It helps CBID team members to develop a rapport with the villagers, since a discussion about the past of the village can be a good non-threatening and enjoyable starting point.

4. Gender Mapping:

The gender mapping exercise is very important in community based inclusive development project. The CBID project ensures that women with disability, and without disability would participate equally, access the resources, and their voices can be heard. The gender mapping exercise highlights men and women access to, control over and thinking regarding the importance of certain resources. This exercise will help CBID team to understand status of women in the community, community perceptions to women, and specially women with disability.

Role of CBID Team in Resource Mapping:

As a Facilitator: The CBID team members play different role in resource mapping exercise. The first role is Facilitator. Being a facilitator, he/she introduces the resource mapping tool to the group, provides necessary materials for the resource mapping. He/she facilitates the exercise, and also moderate the process as and when requires, he/she intervenes. He/she finds ways of integrating dominant and quiet people and makes sure that all group members are able to express their opinions, and ensures that the group keeps to the topic. He/she ensures that the exercise should complete on given time.

Note-taker: It is very important to take notes of discussion being done by the community members, and collect the information through discussion and observation. He/she documents all the important information as per the topics discussed in the group. He/she also observes and notes that who is talking, whose participation is more, is there equal participation, do women participate. He/she sits together with facilitator and discusses the notes while filling the documentation sheet after the mapping exercises.

Team-leader: In every resource mapping exercise, the team leader plays very significant role. He/she is the responsible for entire resource mapping exercise at the community level. He organizes the training for CBID staff on resource mapping, and arrange the logistics for the resource mapping exercise. He/she introduces the team of resource mapping exercises and CBID to the local community. He/she facilitates the summarising and documentation process.

Conclusion:

Resource Mapping exercises along with other exercises such as Stake Holder Analysis, Objective Analysis, and Problem analysis will help CBID team to develop, design the Project Plan. The CBID team becomes an aware about the community resources, status of people with disability in the community, community perception. The community resources will be effectively utilized, and participation of community will be ensured.

References:

PRA Tool Box; of the Joint Back to Office Report Technical Backstopping to the Preparatory Phase of GCP/ETH/056/BEL http://www.fao.org/3/x5996e/x5996e06.htm

Giacomo Rambaldi, 1998; Participatory Methods in Community-based Coastal Resource Management; Participatory methods in community-based coastal resource management. 3 Vols. International Institute of Rural Reconstruction, Silang, Cavite, Philippines.

Topic 17 Participatory Planning[15]

Introduction

When a child is born with a disability many dreams associated with the child are shattered. But that's not the end of the world if early intervention is done. The child can be provided with all kinds of therapies to overcome the developmental delays, at least to some extent. The parents' role in early intervention is very crucial as they spend more time with the child than any therapist. They also know their child more than any professional. The child's well-being is of paramount importance to them more than anybody else in the world.

Therefore, involving parents in any programme for the young infant with a disability should be mandatory. Many professionals underestimate the contribution a parent or the family can make in the success of any intervention plan.

Each child is unique, with their unique disability and unique needs and their unique ways of learning. Same shoe does not fit all. Similarly, same teaching methodology does not help all children learn. Therefore, we prepare individualized education plan for each child when they enter school. Just the same way, before the child enters school, during their early intervention, we also have to understand the child's family context. Since no two families are alike, we prepare individualized family service plan (IFSP). This is not a very common practice in India, but very important nevertheless.

Let us understand the meaning and need and process of IFSP.

6.1 Individualized Family Service Plan (IFSP)

What is an IFSP?

The IFSP is a written document that maps out the early intervention services a child will receive. It also states how and when these services will be provided. It mentions a child's current levels of functioning, his/her specific needs and goals for treatment.

IFSP has a family based approach. All members of the family play a significant role. Their inputs are essential and the whole document highlights how the family would be involved.

Difference between IFSP and IEP

IFSP	IEP
0-3 years	3-18+
Focus on child's and family need	Focus on needs of the child
Therapies provided at clinics and home	Services provided at school
Families have a service coordinator	There is no service coordinator
Review after six months	Review after a year
IFSP team makes decisions	IEP team makes decisions

Source: https://www.peakparent.org/blog/transition-early-intervention-services-ifsp-preschool-services-iep

[15]Content of this topic authored by Dr. Sujata Bhan, Professor and Head, Dept. of Special Education SNDT Women's University

What services are provided under IFSP?

A child who qualifies for special services may receive one or more of the following services:

- Speech therapy
- Physio therapy
- Occupational therapy
- Psychological services
- Hearing (audiology) or vision services
- Social work services
- Assistive technology for activities of daily living

Who are involved in IFSP?

The team of people involved in IFSP could involve the following:

- Child with Disability
- Parents/Family members
- Medical doctor
- Early interventionist
- Speech therapist
- Physio therapist
- Occupational therapist
- Audiologist
- Vision specialist
- Psychologist
- Social worker

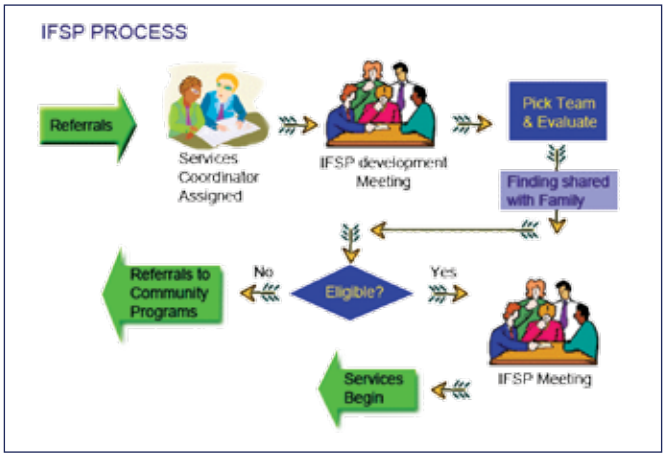
What is the format of IFSP?

The IFSP must include statement of

- Child's present level of physical, cognitive, social, emotional, communication, adaptive and self-help development
- Family's strengths and needs related to enhancing the child's development
- Major outcomes expected of the child and family
- The services that will be provided
- The frequency and the manner in which the services will be provided
- Projected dates and duration of the services provided
- The criteria, evaluation procedures and the timeline for measuring progress

- The service coordinator who would be managing or providing the services
- Steps that will be taken to support the child and the family for the transition from early intervention to a preschool program

What is the process of IFSP?



Source: https://www.speechbuddy.com/blog/legal-issues/writing-the-individualized-family-service-plan-ifsp/

- IFSP process begins with identification of a child with a disability
- A service coordinator is assigned to implement and co-ordinate the services planned in the IFSP
- A proper clinical assessment of the needs of the child including medical diagnosis
- Interaction with the family to understand their concerns related to the cause and prognosis of their child
- Understanding family's strengths and their expectations from the child
- Mapping of concerns, priorities and resources of the family by the service coordinator
- Assessing child's current level of functioning
- Based on information gathered about the child and the family planning the services required
- The IFSP team needs to meet at least once in 6 months to review and make necessary changes
- All stake holders work together in coordination with each other
- Family takes complete responsibility of working with the child along with other team members

To conclude a rehabilitation professional has to understand the ecology of the child with disability, work in unison with the family empathizing and supporting them and providing them the services which the child needs in a very structured manner. IFSP just helps all the stakeholders to define the needs, the outcomes and the manner in which they can be achieved.

References

https://www.specialeducationguide.com/early-intervention/the-who-what-why-of-an-individual-family-services-plan-ifsp/

https://edge.sagepub.com/sites/default/files/Sample%20Individualized%20Family%20Service%20Program_1.pdf

Topic 18 Family Capacity[16]

Aim of Session: To train the learners in supporting the family in developing and realizing realistic goals for the PWD

The family is the first unit in which the person with disability interacts. The mother is usually the first teacher and first caregiver.

The family goes through a process of shock, grieving and mourning when they are faced with the birth of a child with disability…Gradually this phase is then transferred to the phase of adjustment, acceptance and coping with the challenges of bringing up of this child.

It is when the family fully accepts that the child with disability is their responsibility, only then does the real rehabilitation of the child start

The rehabilitation of the person with disability has to follow the life cycle approach and the CBR / CBID worker must ensure that age- appropriate training is given to the person with the disability in the community surroundings and familiar surroundings.

The CBID worker must give training to the parents in the following aspects to help them to plan for the future of the PwD in their family.

- Cause and consequence of disability
- Assistive device and their use
- Accessing entitlements available from the Government and the community
- Awareness of laws applicable to disability

The worker would need to give age-wise training to the family. This would be as follows:

- 0 to 5 years early intervention training
- 5 to 15 years early childhood education and education
- 15 years and above vocational training and occupation based training.

They would also be needed to be trained in adjustment to disability, orientation and mobility, wheelchair training and use of assistive devices. Awareness will also be needed in extra and co-curricular activities like Braille, Sign Language.

It is very important for the Parents and family to understand the importance of goal setting. They have to be explained that goal setting can lead to greater success and performance. Setting goals not only motivates, but can also improve mental health and the level of personal and professional success.

Goal setting helps parents and the PwD to look forward to something to be gained in their lives and makes them positive about the future. It gives concrete shape to the dreams and aspirations.

[16]Content of this topic authored Ms Nandini Rawal, Executive Director, Blind People's Association, Ahmedabad

Goal setting helps to understand the current situation of the person and plan steps for bringing improvement in the current situation. This will involve also finding out current skills of the person, honing these or helping him or her to develop new and needed skills for stability and independence in the future.

The Goals set should be based on "SMART" categorization

- Specific:
- Measurable:
- Achievable:
- Realistic:
- Timely:

The family will be helped to set the goals for the PwD based on the following:

- Age
- Sex
- Type of disability
- Extent of disability
- Need of the person
- Choice of the person
- Assessment
- Functional ability
- Family condition
- Family trade

It is very important that the PwD is asked for his choice. Rehabilitation should not be thrust or imposed without her consent or choice.

Based on the above, the family will set goals for the PwD.

If he is a child, his education and socialization will be planned, his conceptual training will be needed as also use of assistive devices, expanded core curriculum etc.

If the PwD is in the adolescent group, goals will be set according to needs of puberty like body concept, understanding of body needs, sex education, socialization, pre-vocational training etc.

If the PwD is an adult, his goals would be related to relationships, gainful occupation, independence in living etc.

Goal setting will help the PwD to grasp new opportunities and have a better quality of life. It will also help the family to assess the progress the PwD has made over the years. Once the goals are achieved and new goals are set, the family can trace the actual progress made on different areas.

References:

https://www.uky.edu/~eushe2/Bandura/Bandura2011AP.pdf

http://www.puckett.org/presentations/FamCapacity_Build_I_2014_Adelaide.pdf

https://www.benefits.com/social-security-disability/goals-for-people-with-disabilities

Topic 19 Communication[17]

Communication is an essential component of basic life skill. It means expressing, conveying and understanding the information. It could be related to sending or receiving, verbal or non-verbal, or could be one to one or between groups. People with disabilities are deprived of a lot of information as it is not accessible. Signboards, advertisements with lots of audio, or those only with actions are not understood by people with different disabling conditions.

Generally, information could be conveyed through-

- Verbal communication through Voice, technology
- Written material such as books, magazines or digital information
- Non-verbal through body language, gestures, sign, objects or painting
- Or could be combination of two or more ways

Communication results in to empowerment if it is done through mutually understood language, sign or gestures. It means different modes, tools and need based technology can be used for effective communication. Let us discuss the above points in detail for better clarification:

***Verbal communication through voice and technology*:**

Verbal communication is the most common mode of communication. However, people having hearing impairment or people having multisensory impairment may not have effective verbal communication skill. Remember the following points while using this mode:

- Face the person while speaking
- Speak slowly so that everyone can follow
- Use pictures and images with the verbal information
- Get latest information and learn to use technology such as text to speech devices and speech to text devices etc
- Written communication through print material and digital information
- Subtitles in news, films and videos

Maximum information is available in the form of books, magazines, and digital information. People who have print disability may not have equal access to this information. The following points will help us design accessible information:

- Prepare E-books or Daisy books for easy navigation
- Include accessibility component from planning and developing material instead of reworking again on it at the later stage

[17]*Content of this topic authored by Ms. Kinnari Desai, Advocacy Manager, Blind People's Association*

- Do put captions under the picture or image for equal access to information
- Transcribe the material in Braille
- The websites should be made accessible which may provide various facilities such as change font size, its colour, and easy navigation to reach to the desired information
- Information could be prepared in simple language with pictures and examples to make it accessible for all
- Stay informed about latest technology, devices, and applications to access print materials
- Provide audio version of the text or information for easy access
- Information in terms of instruction or signage can be developed inclusive so that each one can access it with dignity
- Non-verbal through body language, gestures, sign, objects or painting

Your body language, gestures, sign or objects can communicate instead of uttering a single work. It is a strong medium of communication. However, people with visual impairment may not read the non-verbal gestures being conveyed but surely trained to use the non-verbal gestures and body language for effective communication. Do look at the below points before using the non-verbal mode:

- Try to learn recognized sign language of Deaf and Deaf-blind
- Use real objects as far as possible
- Create body awareness to use body language effectively
- Promote the effective usage of hand, eyes and lips while speaking
- Teach gestures with verbal information for cultivating habit to use them simultaneously
- Drawing or painting can be used as a metaphor to express thoughts, condition or dreams

Combination of 2 or more ways to communicate:

In some situation, 2 or more modes of communication are use together for effective communication. It is also known as “Total” communication. For example, a person with hearing impairment may use sign language, lip reading and the blur speech to send and receive the information. Similarly, a person with visual impairment may use Braille script, Daisy books and audio material to access the information. Some views on combination:

- Let people choose their most suitable combination
- Promote combination to reduce dependency on only one mode of communication
- Skill to communicate through various mode can help manage in diverse situation
- Combination may increase acceptance and social inclusion of people

Topic 20 Certificates & Procedures for Availing Them[18]

People with disabilities are entitled to various concessions and schemes run by Government and NGOs. To avail these benefits, each person with disability shall have recognized disability certificate and basic documents of citizenship. Basic documents of citizenship will ensure equal access of fundamental rights and disability certificate will help avail entitlements of reservations and concessions for bench mark disability.

Let us talk about the basic documents:

Each Person with disability shall have following basic documents of citizenship:

20.1. Adhar Card

Adhar Card has become an essential document which needs to be linked with the bank account and PAN Card. Sometimes, people with disabilities may face problem while scanning eyes or taking biometrics during the process. However, there is a guideline issued by the authority to take alternate measures to issue the card in such cases.

The following documents are required to avail the Adhar Card:

- Birth certificate or School Living certificate as an age proof
- Ration Card

Adhar Cards are being issued by Taluka Panchayat in case of rural area and Civic Centers in case of cities and towns. Generally, Adhar Card is being sent to home address through post once it is ready. Adhar Cards can be downloaded from the website www.uidai.gov.in.

20.2. Voter ID/ Election Card:

Election card is one of the important documents of citizenship. It also enables the person to exercise the right to vote. Moreover, it can be used as important photo identity card.

The following documents are required to get the voter ID:

- Electricity/Telephone/Ration card for the proof of residence
- Passport size 2 photos
- Adhar Card for age proof

Contact nearest primary school (polling station) in rural area and Collector office or nearest polling station in cities for the application of new ID or changes in the Election Card. Any person with disability above the age of 18 can apply for the Voter ID.

---

18 Content of this topic authored by Ms. Kinnari Desai, Advocacy Manager, Blind People's Association

20.3. PAN Card:

Permanent Account Number (PAN) is a unique number given to each tax payer in India. It is mandatory to link the bank account with the PAN card. Maximum people with disabilities receive their pension, scholarship or subsidy directly in their bank amount and hence, it is prerequisite to get the PAN card immediately.

The following documents are required for the PAN card:

- Adhar Cards
- Two latest passport size photos

Online application can be done or contact the agents to avail the Permanent Account Number.

Documents related to disability:

20.4. Disability Certificate:

The disability certificate is a "Passport" to avail all the benefits for bench mark disability. The certificate issued by District Civil Hospital is the only valid certificate. Any certificate issued by private doctors is invalid for any schemes or concessions.

The documents required to get the Disability Certificate:

- Adhar Cards /Ration Card/Election card
- Two latest passport size photos

A person with disability is required to approach the nearest respective District Civil Hospital for the disability certificate. Please laminate the certificate to prevent from damage. Do remember the validity of the certificate and renew it time to time as advised by the authorities.

20.5. Unique Disability Identity Card(UDID):

The Government of India has decided to issue a Unique Disability Identity Card (UDID) to each person with disability. The aim of this project is to collect the complete database of people with disabilities in India. Instead of carrying multiple disability identity cards, this card can be used as a single ID to avail all the benefits.

The documents required to get the UDID:

- Adhar Card
- Two passport size photos

There are two ways to apply for UDID; while issuing the disability certificate, or online application from the website *www.swavlamban.gov.in.* Once it is ready, UDID will be delivered to person with disabilities via post within 2 to 3 months.

20.6. Social Defense ID:

Social Defense Department (Gujarat) or Social Welfare Department or Department of Social Justice & Empowerment(the nomenclature will change form state to state in India) is issuing an Identity card to all persons with disabilities residing in the state. It also works as a travel concession for state transportation buses. Different states may have different eligibility criteria to avail this concession.

The documents required for this I Card:

- Disability Certificate
- Adhar Card
- Two latest passport size photos

The residents of Gujarat state can apply online for Social Defense I Card through "esamajkalyan.gujarat.gov.in" Moreover, the person can visit the office of respective District Social Defense/Kalyan Officer for the application. Different states have different eligibility criteria for the I Card. Government of Gujarat has following criteria for the ID:

- Visual impairment 80% and above with escort
- Hearing impairment 80% and above without escort
- Locomotor Disabilities 40% and above with escort
- Mental retardation/Intellectual disabilities 40% and above with escort
- Railway Certificate:

Railway certificate is required to avail concession tickets to travel in Indian Railways.

The documents required for this certificate:

- Disability Certificate
- Adhar Card
- Two latest passport size photos

This certificate can be availed along with the disability certificate from the district civil hospitals.

Topic 22 Referrals - Single Window Service Provision

Single Window Referral System:

The welfare state has responsibility and moral duty to look after their citizen, especially vulnerable community of the state. The welfare state undertakes various welfare measures either through long term welfare programs or welfare schemes. These various schemes and programs of social welfare are planned and implemented by the concerned department. For e.g. health department is responsible for the health programs, insurance programs, Education department is responsible for scholarship, free education program etc. The main objective of all these schemes, programs is to promote the welfare and development of the poor and underprivileged group of the society. Each department has its own specific procedure for implementation and also different criteria for deciding beneficiaries. In addition to this, for the application of these schemes, which has to be done from the office of that concerned department, and these offices are located at different places.

Whether it is a health program, livelihood or income generation, education program, rural development program, or other tribal development program, all these schemes should benefit the persons with disabilities equally. In the above situation, it is very difficult for the people with disabilities to avail the benefits of government development programs or schemes.

How people with disabilities can take advantage of these government schemes in this situation is a matter of concern. The CBR program needs to arrange how these government schemes can reach out to persons with disabilities. This is because extending the benefits of government schemes to persons with disabilities is also an important activity of the CBR program. Therefore, in the CBR program, it is necessary to create a system which will make the benefits of these government schemes available to persons with disabilities very easily and at low cost. This system can be developed as a single window referral service or system.

What is a Single Window Service System?

Single window service is a system at the village level where persons with disabilities and other backward classes can get information about government schemes, as well as necessary documents, and apply there and avail the benefits of government schemes. They also can get update about the status of application.

How to create a Single Window Service System in CBR?

The following steps can be taken to create this system through the CBR program.

1. Building close partnerships and relationships with government departments.
2. To sensitize government officials on disability and related issues.

3. To study various schemes of the government, to make a compilation booklet.

4. To select a place between 15 villages for single window system in consultation with government officials, community leaders, PWDs, and other backward class leaders. It is advisable to select three such places in a taluka.

5. After selecting the place, every three months to prepare an annual calendar of where, at what time, and on what date will be able to avail this referral service.

6. To make people with disabilities, family members aware about government schemes and how to take advantage of this single widow system. To train persons with disabilities to fill up the application form.

7. Promoting the single window system in the community, and trying to get more people to benefit.

8. To empower the community and persons with disabilities to manage this system properly and become self-reliant.

9. To collect and analyze the information of the beneficiaries through this system and report to the government.

10. Advocating for such a system to be run by a group of persons with disabilities elsewhere.

Case study Seva Setu Program: One Window Service launched by Govt. of Gujarat

This is an effective goal-oriented initiative by the Gujarat government, for speedy decision making for people living even in the remotest parts of Gujarat and to provide them with on-the-spot solutions to their queries. This is an effective goal-oriented initiative by the Gujarat government, for speedy decision making for people living even in the remotest parts of Gujarat and to provide them with on-the-spot solutions to their queries. The government has created a dedicated programme, wherein it will reach out to the citizen to meet their requirements, rather than people reaching out to the government. A multifaceted 'Seva Setu' programme is launched in 18,000 villages and all the Municipalities and Municipal Corporations of the state, by reaching out at their doorstep to provide various services.

At the Taluka level, Seva Setu camps are being organized in a village that is centrally located within a cluster of 8-10 villages. A committee of 13 officers led by the Prant Officer supervises the programme in each cluster of villages. In this goal oriented programme implemented to provide on the spot delivery of services, applications are registered between 9 am to 1 pm and are processed between 11 am to 2 pm. Services for the registered applications are provided on the same day between 3 pm to 5 pm.

Now, *Seva Setu* has become a bridge that ensures efficient delivery of services to the poor at their doorstep; and decisions are taken by facilitating citizens to ensure accrual of benefits to each and every citizen; this ensures on the spot solutions, on the same day, without delay.

A Seva Setu camp is organized among a cluster of 8-10 villages under the supervision of the Sub Divisional Officer and 12 other committee members that include

1. Prant Officer
2. Mamlatdar
3. Taluka Development Officer
4. Regional Forest Officer
5. PI/PSI of the concerned area
6. Extension Officer
7. Horticulture Officer
8. Veterinary officer
9. Supply Inspector
10. Social Welfare Inspector
11. Education Inspector
12. Mukhya Sevika
13. Gram Sevak

Conclusion:

The present demand in CBR program is partnership, networking and convergence with the existing government programs. This practice would help to address disability as a mainstream issue, include people with disability in mainstream programs, and very importantly sustain the CBR program activities. This is a big challenging task before CBR team to do convergence with the Government Department for existing and future Govt. schemes. One of the ways for the convergence is Single Window Service System, which is very cost effective, efficient in resolving issues related to implementation of Government schemes and benefiting to larger population in very short time span.

Topic 23 CBID Matrix[19]

DEVELOPMENT OF CBR

India and other developing countries have 80% of the population living s in villages. It therefore follows that persons with disabilities (PwDs) also reside in rural areas. Small percentage of PwDs can avail of services which are largely confined to cities. PwDs were given services of education and rehabilitation in IBR (institutions based rehabilitation). It was not possible and viable to cover all disabilities in IBR. Most of the urban rehabilitation centers have an age limit of up to 35 years and also capacity limit of a few hundred persons . Vocational training trades were not suited for rural areas. IBR was also very costly. India like other countries started looking for a strategy for reaching out to people with disabilities in rural areas.

CBR was developed in the 1980s, to give people with disabilities access to rehabilitation in their own communities using predominantly local resources .The WHO & UN promoted CBR as a means of delivering services at the community level through the primary health care system. CBR was conceptualized in 1974 and developed in the 1980s, to give people with disabilities access to rehabilitation in their own communities using predominantly local resources.

In 1979 the first edition of a Manual called “Training in the Community for People with Disabilities” (TCPD) was brought out. CBR became widely known and, on a mostly small scale, practiced almost everywhere and WHO has reported that programmes using the title of CBR exist in about 90 countries.

WHAT IS COMMUNITY BASED REHABILITATION (CBR)?

CBR is a strategy within general community development for the rehabilitation, equalization of opportunities, and social inclusion of all people with disabilities

CBR is carried out through the combined efforts of people with disabilities, their families, communities and the generic services of health, social welfare and employment

A 2004 joint ILO, UNESCO and WHO paper repositioned CBR as a strategy for rehabilitation, equalization of opportunity, poverty reduction and social inclusion of people with disabilities.

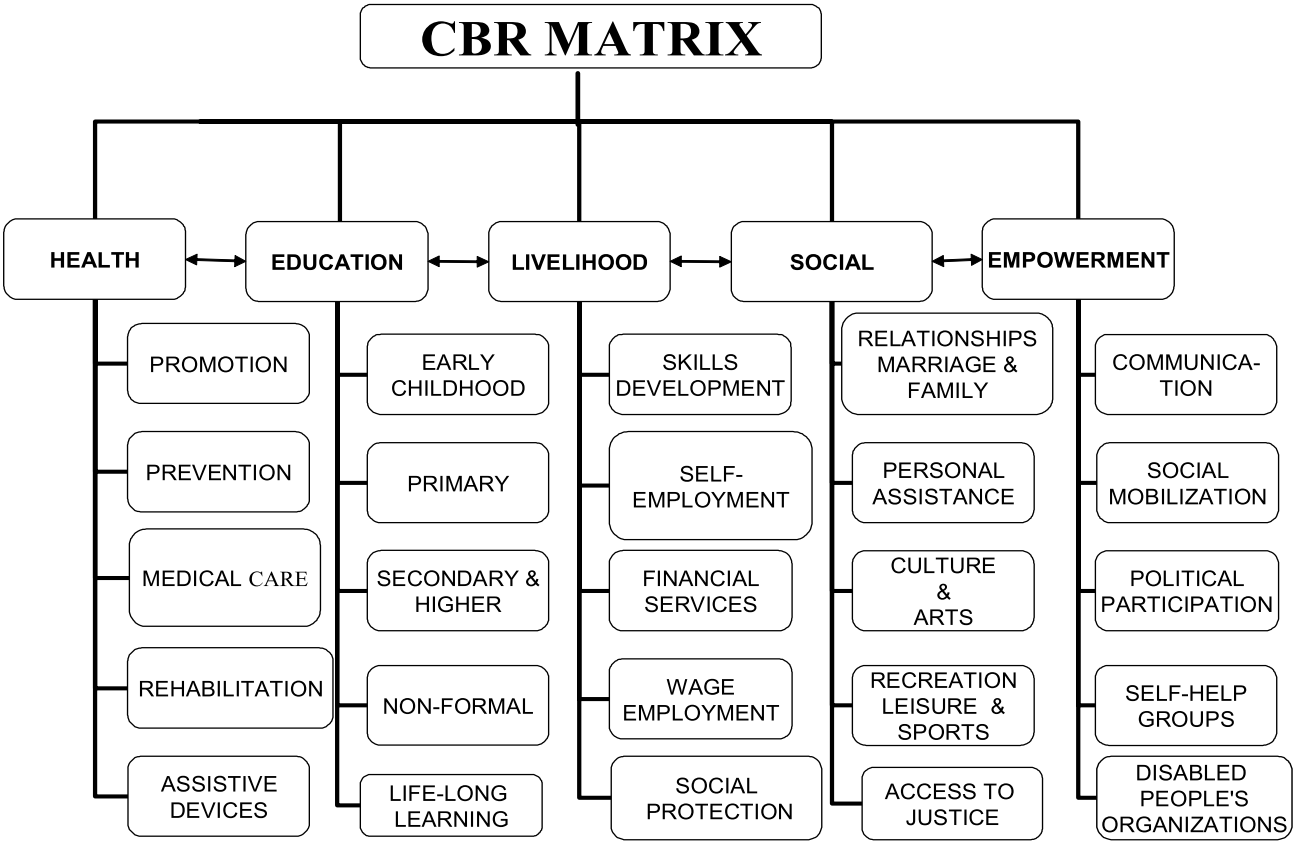
CBR as a strategy came about as a response to the needs and problems of the community such as the fact that disability is not known or understood, poverty is the main issue that affects the development of persons with disability, services of rehabilitation are not present in the community, people with disabilities are excluded, assistive devices are not available and people with disabilities are unaware of their rights and entitlements.

As the programmes were implemented and awareness was created, people with disabilities became aware of their rights and also became organized. The Charity approach led to the social model and ultimately the rights based model. CBR then was seen as an integral part of community development and also was perceived as being part of the entire scenario of community development.

[19]Content of this topic authored by Ms. Nandini Rawal, Executive Director, Blind People’s Association, Ahmedabad

Recommendations to develop guidelines on community-based rehabilitation (CBR) were made during the International Consultation to Review Community-based Rehabilitation which was held in Helsinki, Finland in 2003.

The CBR matrix gives an overall visual representation of CBR. The matrix illustrates the different sectors, which can make up a CBR strategy. CBR Matrix perceives CBR as a multi-sectoral approach and has 5 major components: health, education, livelihood, social and empowerment. The Matrix follows a Life Cycle approach and tries to touch all parts and aspects of human life.



It consists of five key components, each divided into five key elements. Each of these elements has a dedicated chapter in the guidelines. The elements are sub-divided into content headings. Each element has between four to nine key content headings.

GOAL: HUMAN RIGHTS ~ SOCIO-ECONOMIC DEVELOPEMNT ~ INCLUSIVE SOCIETY

HEALTH – ACTION POINTS

- Promotion,
- Prevention,
- Medical Care,
- Rehabilitation,
- Assistive Devices

The points mean that there should be publicity regarding disability - causes and mitigation, PwD's receive assessments, are referred to specialized rehabilitation services where necessary, and receive basis services at community level and have access to assistive devices

HEALTH – ACTION POINTS are that there is need to build Public Policy, create supportive environment, ensure that people with disabilities and their families are aware of the types of prevention activities available in their communities and ensure that health personnel are aware of needs of people with disabilities

EDUCATION – ACTION POINTS

- Early Childhood,
- Primary,
- Secondary and Higher Secondary,
- Non Formal,
- Life Long Learning

This means that education is a lifelong process and that PwDs have access to learning, local school are accessible and welcoming, there is age related training, formal and non- formal education is welcoming & inclusive, there is community mobilization & involvement, training in rights awareness, PwDs are able to access government & other funding support, there is parental involvement and use of community resources

LIVELIHOOD– ACTION POINTS

- Skills Development,
- Self-Employment,
- Wage Employment,
- Financial Services,
- Social Protection

This section deals with understanding of types of livelihood, helping PwDs to acquire skills, involving family members & community in livelihood for PwDs, identifying community resources for livelihood, creating awareness & publicity about importance of livelihood for PwDs.

LIVELIHOOD– ACTION POINTS

There is a need to create awareness about social protection and entitlements/concessions available and lobby for entitlements for PwDs if they do not exist. There is a need for inclusion of PwDs in poverty alleviation schemes like MGNREGA.

SOCIAL– ACTION POINTS

- Personal Assistance,
- Relationship,
- Marriage and Family,
- Culture & Arts,
- Recreation,
- Leisure & Sports,
- Justice

This section emphasizes the importance of increasing social participation of PwDs by community awareness and demonstration, removing physical and attitudinal barriers that exclude PwDs, develop personal assistance, working with media/religious leaders to promote positive

There is a need to promote arts & culture for social change, encourage disabled artists, increase accessibility of PwDs to cultural & religious programmes, adapt sporting activities for PwDs, encourage mainstream sports programmes to become inclusive, create awareness about rights and help PwDs to access justice and accessible information about rights & laws for PwDs and identify community resources for protecting rights of disabled people

EMPOWERMENT– ACTION POINTS

- Advocacy & Communication,
- Community Mobilization,
- Political Participation,
- Self-Help Groups,
- Disabled Peoples Organizations

This section emphasizes the need to empower PwDs so that they can speak up for themselves, share, information & creating awareness about different communication modes of PwDs, provide information to disabled people about rights and options so that they can make a choice, encourage communication friendly environment for PwDs and mobilise the community for creating positive images about disabled

The Matrix is a compilation of all the aspects that touch a human being's life and has been specially developed to enable CBR Planners to plan programmes which touch every aspect of the life of the persons with disability.

Reference:

https://www.who.int/publications-detail/community-based-rehabilitation-cbr-guidelines.

Topic 24 Interventions at Community Level[20]

Community Based Inclusive Development (CBID) is a process which allows community members including persons with disabilities to express their needs and to decide their own future with a view to their empowerment, ownership and sustainability. It recognizes the importance of the needs of persons with disabilities from the community perspectives. It seeks to understand the community's concerns and priorities, mobilizing persons with disabilities and other community members, and engaging them in activities and programming. In CBID, persons with disabilities and other community members define, plan and implement activities and programs related to their own future. They manage the resources available to them. Here, the focus is on helping persons with disabilities and other community members organize themselves to solve their own problems. All constituents of the community are part of this process, including persons with disabilities, women, the elderly and children. For NGOs, as an external facilitator, the role is to build, rebuild or strengthen the community's capacities to solve their own problems.

In developing countries in the Asia-Pacific region, CBID focuses on the basic needs and inter-dependence of persons with disabilities and their immediate families. Taking into consideration that the majority of persons with disabilities are in rural areas, stakeholders include neighbors, extended families, friends living nearby, Disabled People's Organizations (DPOs), NGOs, village and community leaders, personnel in health and education institutes (hospitals, schools), potential employers, and local, provincial and national governments, in addition to persons with disabilities and their immediate families

Inclusive Communities:

The term 'inclusive' is now commonly used with reference to educational provision that welcomes all children, including those with disabilities, to participate fully in regular community schools or centres of learning. The principle of 'inclusion' is also being applied to policies and services in health, skills training and employment and to community life in general.

The concept of an inclusive community means that communities adapt their structures and procedures to facilitate the inclusion of people with disabilities, rather than expecting them to change to fit in with existing arrangements. It places the focus on all citizens and their entitlement to equal treatment, again reinforcing the fact that the rights of all people, including those with disabilities, must be respected. The community looks at itself and considers how policies, laws, and common practices affect all community members.

The community takes responsibility for tackling barriers to the participation of girls, boys, women and men with disabilities. For example, many people in the community may have beliefs or attitudes that limit the kinds of opportunities that are open to people with disabilities. Policies or laws may contain provisions which work to exclude them. There may be physical barriers such as stairs rather than ramps or inaccessible public transport. Such barriers may also reduce access to work opportunities.

[20]Content of this topic authored by Mr. Akhil Paul, Director, Sense International India, Ahmedabad

CBID benefits all people in the community, not just those with disabilities. For example, when the community makes changes to increase access for people with disabilities, it makes life easier for everyone in the community too.

Community Involvement

If the community decides to address the needs of people with disabilities, the process of establishing a CBID programme can begin. One approach to implementing CBID is through the leadership of an existing community development committee or other structure headed by the chief of the village or the mayor of the town. This committee guides the development activities of the community. Such a committee is well suited to act as co-ordinator of the many sectors, governmental and non-governmental, that must collaborate to sustain a CBID programme. For example, the community development committee can collaborate with the educational sector to promote inclusive education, with the ministry of transport to develop a system of accessible transport for people with disabilities, and with voluntary organizations to form a group of volunteers willing to take care of children with disabilities so their parents can do errands outside the home.

Community action for equal participation of both children and adults with disabilities varies a great deal between countries and also within a single country. Even with the guidance of a national policy encouraging communities to take responsibility for the inclusion of their citizens with disabilities, some communities may not identify this as a priority. Or, the members of the community development committee may decide that CBID requires special attention and so may establish a separate CBID committee. Such a committee might comprise representatives of the community development committee, people with disabilities, family members of people with disabilities, teachers, health care workers and other interested members of the community.

CBID Committee

The CBID committee takes responsibility for responding to the needs identified by people with disabilities in the community: raising awareness of their needs in the community; obtaining and sharing information about support services for people with disabilities that are available outside the community; working with the sectors that provide support services to create, strengthen and co-ordinate the required services; working within the community to promote the inclusion of people with disabilities in schools, training centres, work places, leisure and social activities. In addition to these tasks, the committee mobilizes funds to support its activities.

The CBID committee members may know how to solve many of the problems in the community, but will sometimes require additional information from experts in the education, labour, health, social and other sectors. For example, family members may seek information about how to improve the activities of daily living of a disabled person in the home; volunteers and community workers may need training on assisting people with disabilities and their families; teachers and vocational instructors may need training on including children and youth with disabilities in their classes; and business people may need advice on how to adapt workplaces for people with disabilities.

Hence, information exchange is a key component of CBID. All sectors should support CBID by sharing information with the community, collaborating with each other, and strengthening the specific services they provide to people with disabilities.

Community Workers

Community workers form the core of CBID programme to carrying out activities that assist people with disabilities. People with disabilities and their family members can make significant contributions as CBID workers. Sometimes teachers, health care workers, or social workers donate their time to this role. Other interested members of the community can also be encouraged to give their time. CBID workers provide information to people with disabilities and their families, including advice on carrying out simple tasks of daily living or making simple assistive devices to improve independence, such as communicating in sign language or using a white cane to move around outdoors. The CBID worker also acts as an advocate for people with disabilities by making contacts with schools, training centres, work places and other organizations to promote accessibility and inclusion. In addition, the CBID worker provides information about services available outside the community, and acts as liaison between the families of people with disabilities and such services.

Based on the description of CBID worker responsibilities, it is clear that women and men with disabilities and their family members are excellent candidates for this role. As the participation of DPOs has increased within CBID programmes, the number of CBID workers with disabilities has also increased. Nonetheless, there is a need for many more people with disabilities to become involved as CBID workers. The recruitment and training of CBID workers, maintaining their motivation and coping with turnover are among the major challenges of community leaders and CBID programme managers. Some incentive, such as regular in-service training, an annual award for the best worker, certificates of appreciation, or the provision of uniforms, may be offered to CBID volunteers. This will depend on the customs of the country and the community.

Livelihood

At community level, informal apprenticeships with master trainers or local businesses can provide individuals with disabilities opportunities to learn employable skills and gain practical experience. The business community can provide valuable support to CBID by providing on-the-job training, hiring workers with disabilities, mentoring entrepreneurs with disabilities and providing advice on current and emerging skills requirements to vocational training centres. Micro and small enterprise development programmes can provide business skills training and advisory services. They can provide access to credit to assist women and men, including people with disabilities, to start their own businesses and become self-employed. Such programmes are often operated by the ministry responsible for trade and industry or by a separate government agency, as well as by NGOs. Special efforts are often required by a CBID programme to ensure the inclusion of youth and adults with disabilities in such programmes.

Reference:

1.Asia-Pacific Development Center on Disability-http://www.apcdfoundation.org/?q=system/files/cbid.pdf

2.WHO-ILO-UNESCO Joint Position Paper- https://www.ilo.org/skills/pubs/WCMS_107938/lang--en/index.htm

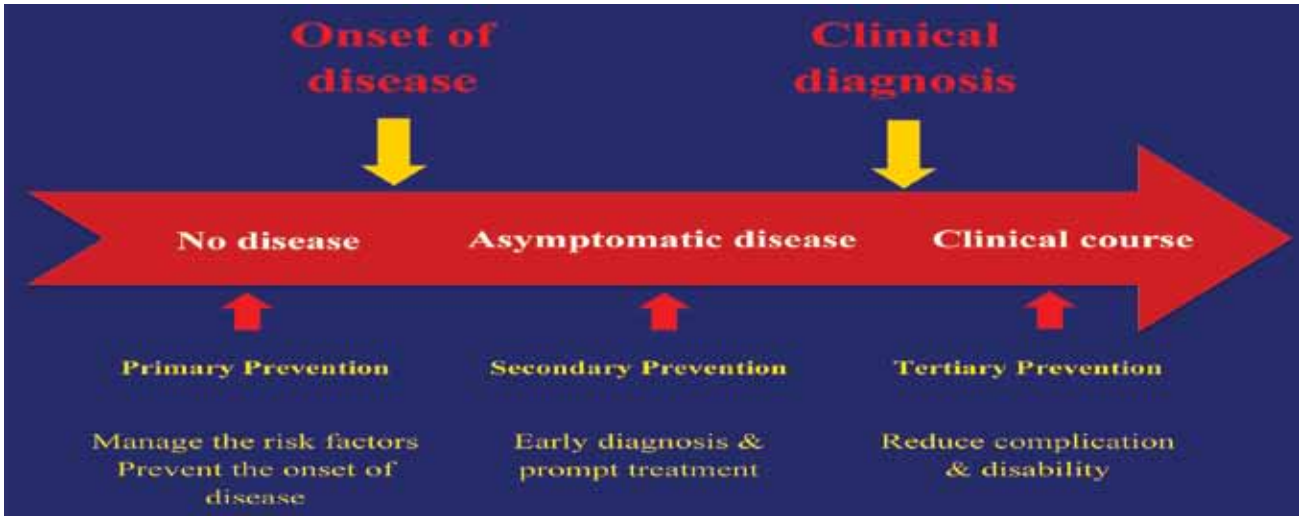
Topic 25 Intervention Medical Therapeutic and Alternative[21]

25.1 Understanding the term 'intervention'

The term intervention in day to day usage means something that is done in-between two things such as an act that helps to resolve or changes the course of some issues. In the context of rehabilitation of persons with disabilities (PwDs), the term intervention is used for a more systematic and planned activity. It 'broadly' means providing some assistance so that any problem arising out of impairment does not increase further to make it a disabling condition. We can thus consolidate our understanding of the term intervention as any pre-meditated activity which is undertaken to improve the existing condition of an individual with disability.

The term intervention has different connotations in different fields. In the medical field the purpose of intervention is to improve the human health (Smith, Morrow and Ross, 2015). In education it means undertaking strategies for assisting children to learn if they are experiencing difficulties in learning. In the field of technology intervention applies to setting right the functioning of an instrument.

Levels of intervention: In rehabilitation the intervention is carried on at 3 levels.



The Primary or the Universal level intervention pertains to protecting 'all' in a community. This level is prior or before the onset of a problem and means preventing a condition or a disease by happening in the community. Take for example prevention of certain diseases like tuberculosis, polio, meningitis which is done through the Universal Immunization Program (UIP) (1985) of Govt. of India. The UIP provides universal immunization coverage to pregnant women and to infants. So UIP is said to be the primary intervention. The BCG vaccine under this program is to guard infants from diseases like tubercular meningitis. The oral polio vaccine (OPV) is to protect children from poliomyelitis. If the primary or universal level of intervention fails, then there is a secondary level of intervention i.e. of curing or reducing the severity or duration of an existing disease say by operating for curator purposes. Beyond this level the third i.e. the tertiary level is restoring the function lost through disease or injury by rehabilitative measures such as providing aids and appliances and therapies.

[21]Content of the topic authored by Dr. Varsha Gathoo, AYJNISHD (Divyangjan), Mumbai

25.2 Types of intervention

You would have already studied the CBR Matrix of WHO (2010). From this matrix try and recollect the first two columns pertaining to health and education. Based on these columns in the field of rehabilitation of PwDs, we can categorize the intervention into 3 broad types of intervention namely medical, therapeutic and alternative modes.

1. **Medical Intervention:** This intervention is undertaken by medical doctors and qualified para-medical professionals. It includes both-surgical and non-surgical interventions which could be long term or short term treatments. The DoEPwD of the Govt. of India's Ministry of Social Justice & Empowerment has various provisions for such surgical interventions for PwDs. Some examples of surgical interventions are as follows:

   For hearing impairment: The cochlear implants surgery is a medical intervention in which an ENT surgeon surgically inserts an electrode into the cochlea of a deaf individual. This helps in transmitting the stimulations to the auditory nerve. However this medical intervention has to be well supported by language stimulation both at home and at school or early intervention centers.

   For visual impairment: The refractive errors can be corrected by medical interventions such as refractive surgical procedures. The cataracts surgeries are also commonly undertaken surgical procedure.

   The RPwD Act (2016) has recognized certain medical conditions such as Parkinson's disease and Multiple sclerosis. The Act has also included certain Blood disorders such as Thalassemia, Hemophilia, Sickle cell disease which will need medical intervention.

   Medical interventions also include drug therapy i.e. giving prescribed medicines for certain disabilities. For example while there is no medicine to cure the Autism spectrum disorder (ASD), the individuals with these disabilities may require medicines that can help them manage high energy levels, control anxiety, depression or seizures.

2. **Therapeutic intervention:** Many of the disabilities cannot be cured or treated medically, but can be managed well by therapeutic interventions which helps the individuals to undertake their daily living activities. A therapeutic intervention is an effort made by a therapist such as psycho, speech, physio or occupational therapist to improve the well-being and make the PwD an independent person. This includes training the individuals with disabilities across different age groups ranging from babies, children, adolescents to adults. Special educators are also trained to provide therapeutic interventions to children with disabilities. Generally a team approach that includes therapists, special educators and parents or care givers serves to bring out the best outcome of intervention. Take for example a case of a baby or a child with hearing loss. An audiologist diagnoses the hearing loss and fits a proper hearing aid or a device and the special educator and speech therapist team together for language stimulation activities both at the centre and for home training. A team of occupational therapist, physio therapist provides a range of therapeutic interventions such as training children with cerebral palsy or those with intellectual disabilities in daily living skills that includes walking, dressing,

eating, bathing etc. There are mobility instructors who provide training to children with visual impairments or those with multiple disabilities such as deaf blindness. Specialized therapists are also available who can undertake behavior modification therapy for children with attention disorders or specially trained occupational therapist for children with ASD who require sensory integration interventions.

3. **Alternative Modes of Intervention:** In spite of the best efforts, sometimes the traditional approaches to intervention or the modes simply do not yield the desired results. In such cases therapists and experts try what is called as alternative mode of intervention. One such example is the Augmentative and alternative communication acronymed as AAC. This type of intervention is useful for those PwDs such as those with cerebral palsy or ASD who have communication disorders and who find speaking a very difficult task. Such individuals can be provided intervention to use the non-verbal communication methods such as sign language and picture boards to convey their wants and feelings. There are specialized sophisticated speech-generating devices and mobile apps which can be an alternative mode to verbal communication. These devices also serve an additional purpose as the learners acquire new vocabulary and language at the same time helps others to understand what the PwDs wants to communicate. With the advent of technology such devices have developed features of touch screen, eye gaze, head tracking etc for severely disabled who have difficulties in hands movements.

References

RPwD Act (2016) retrieved from http://www.disabilityaffairs.gov.in/upload/uploadfiles/files/RPWD%20ACT%20

Smith, Morrow and Ross (2015) retrieved from https://www.ncbi.nlm.nih.gov/books/NBK305514/

UIP (1985) retrieved from https://www.nhp.gov.in/universal-immunisation-programme_pg

Topic 26 Child Development[22]

Development is a process by which children grow physically and mentally and learn increasingly complex skills. It includes skills such as making sense of environment, communicating with others, making purposeful movements, caring for one self and reading and doing simple mathematics. In short it is process that enables child from tiny, helpless new born to an adult who is capable of looking after most of her own needs. It happens in a sequence for all children but the rate varies from child to child.

There is tremendous variability in human development. Some children make faster than others in all areas of learning, and other make slower progress. Some progress quickly in some areas and slower/ experience difficulty in other area

Usually, children who develop normally tend to follow approximately the same time schedule in learning skills in different areas. That is most children acquire skills in same sequence at about same age. E.g. children without disabilities learn to roll over by around 3 or 4 months of age, learn to sit up by at about 6 to 8 months. They begin to babble at about 6 to 8 months and learn to meaningful word like mama by around 12 to 14 months of age.

The early years, birth to 6 years are critical developmental period in child's life. Lot can be done at this stage which will have lasting effect on later years.

Developmental areas: During the course of development children learn different types of skills and behaviour which are broadly grouped in six areas of growth:

1. Motor skills
2. Self-help skills
3. Cognitive skills
4. Communication skills
5. Sensory skills
6. social skills

In each area children acquire skills at certain age. All domains /areas are inter related. The growth in one area affects growth in other area .e.g. a child who has learnt to take turns while communicating will also develop social skills like sharing and playing with other children. Development is dynamic, constantly changing process.

Children with disabilities follow different sequence of development. Depending on different impairment and degree of impairment they learn different skills in different sequence/ order. It is important to note that and remember that all children learn …

[22]Content of the topic authored by Ms. Vimal Thawani, Project Director, Blind People's Association, Ahmedabad

Thus Milestones are behavioral or physical checkpoints in children's development as they grow. These are the core skills all children should be reaching.

Missing one or two abilities should not cause alarm, as every child develops differently. However, if they are missing multiple abilities, be sure to check with concerned team of professionals.

Most of the parents having children with disabilities will have concerns over their development, which is very natural.

Developmental delay is when child does not reach her developmental milestones at expected time. If the child is temporarily lagging behind or is minor delay that is not delayed development. If child is delayed in many areas at the same time, e.g. gross or fine motor, language and communication, social and cognitive skills may be considered as delayed development.

Usually parents are the first to notice that their child is not progressing at the same pace like other children. In such cases they must we need to consult experts for further confirmation.

There are standardized check list to check and confirm.

Topic 27 Role of Multidisciplinary Team[23]

Children with disabilities, especially children with multiple disabilities have varied educational and therapeutic needs. They need Individualized intervention program depending on their needs, strengths and limitations. Most of them require medical, therapeutic and special education program, accordingly different professionals are required to develop appropriate plan to achieve common goal.

"A multidisciplinary team is a group of individuals from multiple disciplines who meet to pursue a common goal, such as evaluating a student for placement in special education or creating an individualized education program (IEP) for a student. Multidisciplinary teams are sometimes referred to as *child study teams* or *student support teams*, among other terms. The professional collaboration of a multidisciplinary team, helps to ensure that their work regarding students is comprehensive and as unbiased as possible.

We all know that no single professional can meet children's complex needs. Multidisciplinary teamwork is about making the most of different skills to meet their needs, and creating satisfying and supportive working groups.

Thus a **Multidisciplinary Team** is a group of professionals from one or more clinical and rehabilitation disciplines who together make decisions regarding recommended treatment of child.

All of them have different areas of expertise, so that they can combine their skill sets if necessary to tackle complex and challenging conditions of the child. The team meets regularly to discuss their work so that each child has a care plan best suited to their individual needs.

Advantages:

1. Saving resources, avoiding duplication of workload Teamwork aims to stimulate group cohesion and cooperation towards professional and service objectives. Multi-professional care uses teamwork to bridge divisions and conflicts between and within professional groups in care services, hence stimulating a more effective and coordinated use of resources. Multidisciplinary approach may provide a more cost-effective solution to service users.
2. Avoiding frustration of parents and build-up of trust If different professions approach the service user one by one and ask similar or the same questions during the initial assessment, it would result in making the them feeling uncomfortable and even frustrated. A multidisciplinary teamwork approach would eliminate unnecessary duplication of workload spent on background assessment and share certain background and key information.
3. Multidisciplinary team can ensure a centralization of expertise and allow better communication and coordination between different professions. This approach enhances the professional skills and knowledge of individual team members by providing a forum for learning about the strategies, resources, and approaches used by various disciplines. It encourages them to provide

[23]Content of the topic authored by Ms. Vimal Thawani, Project Director, Blind People's Association, Ahmedabad

the best combination of services with excellent quality.

4. Bridging the gap: Such teamwork approach provides a 'check and balance' mechanism to ensure that the interest and rights of all concerned professions are addressed to. Moreover, it allows the identification of service gaps or breakdowns in coordination between agencies or individuals.

5. Effective time management: From the perspective of parents and children and from the perspective of service providers multidisciplinary teamwork can avoid the duplication of workload and allow more effective use of time.

6. Workers can become specialists in an area – care workers therefore experience care from a more experienced and specialized member of staff.

The multidisciplinary team consists of:

The team works together for assessment in different areas, preparing IEP, having common goals, teaching strategies and methods, also teaching learning material to be used to achieve the common goals

References

American School Counselor Association. (2004). Ethical *standards for school counselors* Retrieved January 26, 2006, from http:www.schoolcounselor.org/content.asp?contentid=173

American School Counselor Association. (2004). *Position statement: Cultural diversity*. Retrieved January 26, 2006, from http://www.schoolcounselor.org/files/PS_Cultural%20Diversity.pdf

American School Counselor Association. (2004). *Position statement: Students with special needs*. Retrieved January 19, 2006, from http://www.schoolcounselor.org/files/Special%20Needs.pdf

American School Counselor Association. (2004). The Role of the School Counselor. Retrieved January 26, 2006, from http://www.schoolcounselor.org/contentasp?contentid=240

Bowen, M. L., & Glenn, E. E. (1998). Counseling interventions for students who have mild disabilities. *Professional School Counseling, 2*, 16–25.

Topic 28 Skills for Holistic Development

Introduction

Community-based inclusive development (CBID) has its roots in Community- based Rehabilitation (CBR) which is defined as "a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities. WHO CBR Guidelines suggests CBID as a twin track approach.

There is scarcity of resources in this area, there is a lack of awareness among persons with disabilities and family. In such a difficult situation, the success of the program depends on the workers.

Human resources are fundamental to the successful implementation of CBR. Several papers delineate CBR workers into three main levels: grass-roots workers, mid-level rehabilitation workers, and professionals (Wirz, 2000; Dunleavy, 2007; Chappell and Johannsmeier, 2009; Dawad and Jobson, 2011; Rule, 2013). They are both involved in assessing function, providing information, and educating persons with disabilities and their families in daily living tasks and communication, basic equipment provision, and physical rehabilitation, as well as advocacy, liaising with the community and referring to appropriate specialist services (ILO, UNESCO and WHO, 2004; Finkenflügel, 2006; Dawad and Jobson, 2011). The main distinction appears to be determined by the amount of training and the skill level.

Types of Skills to be required for Community Inclusive Development Work:

1. **Disability Knowledge:**

   The role of field workers is very important in CBR. The success of the program depends on their skills. Even if these workers have worked in other development work before, it is very important to give them intensive training on disability. Disability is a very broad topic. Therefore, it is necessary to give these workers an understanding on impairment, disability, models of disability, and dimensions of rehabilitation. C.B.R. field staff need to have an understanding of the 21 types of disability, its symptoms, and signs for proper identification during the survey, and also to be skilful for intensive intervention.

2. **General and Clinical Skills:**

   This is evident that disability treatment is not readily available at the village level, e.g. a preliminary examination of a visually impaired child may not be possible at village level. In this situation the child and the family cannot get proper guidance for further actions, and development of the child. Therefore, the field worker needs to be efficient enough to make functional assessments at very grassroots level. They need to have the skills to carry out functional assessment of each person/child with disability successfully. They also require skills to develop rehabilitation goals with the support of technical and professional staff. Therefore, the CBR Trainings should consist this component as very important.

3. Specific Clinical Skills:

Disability is a subject connected with health. Individuals with disabilities and children need to be given a specific type of therapy and training tailored to their disability. This therapy and training can improve their mobility, ability to work and health. These therapies and trainings are usually given by the professionals and experts. But it would be difficult to provide such required therapies, trainings to persons with disability at grass root level. Hence, an alternative arrangement is that the CBR field staff can be imparted basic skills as mentioned below.

4. Orientation and Mobility Training:

Children with visual impairments typically need encouragement to explore their surroundings. To them the world may be a startling and unpredictable place, or it may not be very motivating. Orientation and mobility training (O & M) helps a blind or visually impaired child know where he is in space and where he wants to go (orientation). It also helps him be able to carry out a plan to get there (mobility). Orientation and mobility skills should begin to be developed in infancy starting with basic body awareness and movement, and continuing on into adulthood as the individual learns skills that allow him to navigate his world efficiently, effectively, and safely. The CBR Field staff should be given training on Orientation and Mobility; the CBR field staff should ensure that they give trainings to children with visual impairment and low vision to enable them have independent movement, have sensory awareness, and also learn spatial concepts.

a) GATE Trainings:

Assistive technology is an important means for people with disability to carry out every day-, leisure-, and work activities, and sometimes even to sleep, and to participate in societal life. The World Health Organization (WHO) has initiated the Global Cooperation on Assistive Technology (GATE), which aims to improve the access to assistive technology worldwide so that "everyone in need has access to high-quality, affordable assistive products to lead a healthy, productive and dignified life. WHO CBR Guidelines has mentioned specifically about various types of assistive devices and technology for different types of disability under Health Chapter. The CBR Field Staff should be given in depth training on assistive devices; use of assistive devices, maintenance of assistive devices. It is also important to motivate them to explore and develop indigenous assistive devices and technology.

b) Activity of Daily Living Skills (ADL):

Activities of daily living (ADLs), include the fundamental skills typically needed to manage basic physical needs, comprised the following areas: grooming/personal hygiene, dressing, toileting/continence, transferring/ambulating, and eating. The field workers should be skilful in imparting these ADLs skills to persons with disability and very importantly to the children with disability. In order to ensure this, it is necessary to have in-depth training of CBR staff on ADL. In this training, it is more important to work individually with all types of persons with disabilities / children and learn from personal experience learning.

c) Basic Therapeutically Intervention Skills.

Children with disabilities, especially those with severe disabilities, are in dire need of therapeutic interventions. These therapeutic interventions are offered by specialist professionals. But getting this expert facility at the village level is a big challenge. As an alternative, CBR workers can also work as a health worker. With proper and intimate training these skills can be acquired by a CBR worker. These include therapies such as speech, physiotherapy, counselling, vocational trainings.

5. Communication Skill:

CBR field workers work directly with people with disabilities, their families, and the community. It is very important for the workers to have knowledge and skills in the language used by the local people. In addition to this, CBR field workers also have to raise awareness in the community so communication skills are also required for them to convey this message effectively. Effective communication skills are also needed to motivate people with disabilities and their families to actively participate in the activities of the program. CBR field workers also need to have effective communication skills for lobbying for rights of persons with disability, and inclusion of persons with disability in Government schemes.

6. Cultural Competencies:

The CBR program is implemented with the help of the community. Each community has its own unique identity. It is because of their way of life, their dress, their traditional customs, and their culture. This needs to be understood if the CBR team works in the community. Their customs, culture, the way of living may be different, but they should be respected. The CBR Field staff needs to have this competency to understand that cultures vary, and what may be culturally appropriate for one group of people may not be the same for another group. They also needs to be skilful to assess that how CBR program will affect local customs and traditions, what resistance to the programme may be expected and how this resistance would be managed. Therefore, the skilful field workers could only manage to a balance between changing inaccurate beliefs and behaviours related to people with disabilities and adapting programmes and activities to the local context.

7. Management Skills:

The success of the CBR program depends on its effective management. Many activities have to be implemented before, during, and after CBR program. This skill is very important for proper planning of the activities of the program, setting the goals of the program, effective implementation of the activities. The CBR Team should be given intensive and in depth training to ensure that CBR Programs will achieve set targets, and program gets sustained. The following topics are suggested by the WHO CBR Guidelines to be covered in the training program.

- Setting The Mission And Vision Of The CBR Programme
- Identifying needs and available local resources;
- Defining the roles and responsibilities of CBR personnel and stakeholders;

- Developing a plan of action;
- Mobilizing resources for programme implementation.
- Participatory management
- Sustaining CBR Programs
- Effective leadership
- Effective Participation and Convergence
- Effective Community Ownership.

8. Community Resource Mobilization:

The most difficult and challenging task in the CBR program is to identify local community resources, and to use those resources for the activities of the CBR program. Because the main objective of the CBR program is to rehabilitate persons with disabilities using the local community resources. One of the reasons to use local resources is that by reducing the dependency on human, financial and material resources from external sources will help ensure greater sustainability. Communities should be encouraged to use their own resources to address the problems they face. The use of local resources should be given priority over external resources. The Project team should learn how to identify the community resources through various resource mapping exercises. They should be given practical experiences on resource mapping as well as resource mobilization. The community resource mobilization skills also include convergence and networking skills. The CBR field workers are also required to understand that duplicity of the program activity is waste of resources hence, they should learn lobbying and network skills for the convergence, and to make disability inclusive development work.

9. Higher Level Cognitive Skills:

It is not necessary to run the CBR program in a specific framework. Rehabilitation and Inclusive Development activities have to be undertaken in the CBR program keeping in view the local conditions, local community needs and needs of persons with disability. To ensure successful implementation of the CBR Program and its achievement, participation of persons with disability, their family members and community members is essential. Therefore, innovation in the CBR program is essential for individuals with disabilities, family and community to become more interested in the CBR program, and to participate enthusiastically in activities. Therefore, the CBR team needs to have the skills to create innovative methods, programs, and strategies for training, public awareness programs, advocacy, networking and convergence, and also for creating community ownership and participation. Hence, CBR Team should have higher level cognitive thinking skills as well as, critical thinking skills.

Conclusion:

A skillful C.B. The R team is the key to the success of the program. Therefore, every organization should periodically organize the necessary training for the CBR team to learn these skills and become

experts. This skill is not only going to benefit people with disabilities, but it is also going to benefit the community, the organization and the CBR Team itself. On the other hands, the cost incurred on the training of CBR team can also help in greatly reducing the cost of Project activities in future. The skillful CBR Team is an asset to other organization.

Reference:

Jansen-van Vuuren, Julia & Aldersey, Heather. (2019). Training Needs of Community-based Rehabilitation Workers for the Effective Implementation of CBR Programmes. Disability, CBR & Inclusive Development. 29. 5-31. 10.5463/dcid.v29i3.742.

WHO CBR Guidelines (2007)

Online Access:

https://academic.oup.com/acn/article/31/6/506/1727834

https://www.researchgate.net/publication/285782608_Opening_the_GATE_to_inclusion_for_people_with_disabilities

Topic 29 Assistance to Disabled Persons (ADIP) Scheme[24]

Explanation of relevant terms

1. PwDs: Persons with Disability
2. CwDs: Children with Disability
3. WwDs: Women with Disability
4. MSJE: Ministry of Social Justice and Empowerment.
5. SwDs: Students with Disability

Content

Assistance to Disabled Persons for Purchase/Fitting of Aids and Appliances (ADIP Scheme):

Impairment restricts opportunities for leading functionally productive lives of persons with disability. A person having polio cannot move due to his/her impairment in leg, a person with low vision cannot read a book because of his/her low vision. This make them unable to participate in education, economic, social, cultural and community life. But, functional ability of persons with disability such as movement, speech, hearing, can be improved by using assistive devices. In addition to this, the modern technology has made very good advancement, and developed very innovative, high standard assistive devices for different types of disability. These assistive devices can reduce the effects of disabilities, and enhance the education, social, economic, cultural, and community activities and life.

For example, a wheel chair, an artificial limb, crutch, a brace, a splint can greatly improve the mobility of individual with locomotor disability who has a restriction in movement. Similarly, with the help of adigital hearing aid, persons with some residual hearing can be helped to carry on many activities of daily living. Low vision devices will help people with low vision to read, access print and undertake other activities resulting in their rehabilitation.

On the other hand, the persons with disability and their family have very poor economic conditions, they can not afford such an expensive assistive device for persons with disability. Many times, they are not aware about the availability of such assistive devices and that these can improve functional ability of persons with disability. Also they are not aware of how to use these assistive devices. Therefore, such assistive devices are beyond reach of persons with disabilities. To increase the access of these assistive devices which will improve functional ability, mobility of persons with disability, and enabling them to live independent and empowered life, Government of India has launched specific scheme named ADIP.

The ADIP Scheme is in operation since 1981 with the main objective to assist the needy persons with disability in procuring durable, sophisticated and scientifically manufactured, modern, standard aids

[24]Content of the topic authored by Mr. Bharat Joshi, Manager, Blind People's Association, Ahmedabad

and appliances that can promote their physical, social and psychological rehabilitation by reducing the effects of disabilities and enhance their economic potential. Assistive devices are given to PwDs with an aim to improve their independent functioning and to arrest the extent of disability and occurrence of secondary disability. The aids and appliances supplied under the Scheme must have due certification.

The scheme also envisages conduct of corrective surgeries, wherever required, before providing an assistive device. Under the Scheme, grants-in-aid are released to various implementing agencies (Artificial Limbs Manufacturing Corporation of India (ALIMCO)/National Institutes/Composite Regional Centres/District Disability Rehabilitation Centres/ State Handicapped Development Corporations/ NGOs, etc.) for purchase and distribution of aids and assistive devices. The Scheme was last revised w.e.f. 1.4.2014 and further modified and approved for continuation during the remaining period of the 14th Finance Commission i.e., up to 31.3.2020.

Aim and Objective of ADIP Scheme:

- The Scheme aims at helping the disabled persons by bringing suitable, durable, scientifically-manufactured, modern, standard aids and appliances within their reach.
- To assist the needy disabled persons in procuring durable, sophisticated and scientifically manufactured, modern, standard aids and appliances that can promote their physical, social and psychological rehabilitation, by reducing the effects of disabilities and enhance their economic potential.

Scope of the Scheme:

- The Scheme will be implemented through the Implementing Agencies. The Agencies will be provided with financial assistance for purchase, fabrication and distribution of such standard aids and appliances that are in conformity with objective of the Scheme.
- The Implementing Agencies will take care of/make suitable arrangements for fitting and post-fitting care of the aids and appliances distributed under ADIP Scheme.
- The scope of the Scheme has been further enlarged to include use of mass media, exhibitions, workshops etc. for exchange of information and promoting awareness and distribution and use of aids/appliances.

Eligibility of Implementing Agency under the Scheme

The following agencies would be eligible to implement the Scheme on behalf of Ministry of Social Justice and Empowerment, subject to fulfilment of laid down terms and conditions:

- Societies, registered under the Societies Registration Act, 1860 and their branches, if any, separately.
- Registered charitable trusts
- Registered with NITI AAYOG-DARPAN

- The agencies should preferably possess professional/technical expertise in the form of professionally qualified staff (from recognized courses) for the identification, prescription of the required artificial aids/appliance, fitment and post-fitment care of the beneficiaries as well as the aid/appliance.
- The agency should also preferably possess infrastructure in the form of machinery/equipment for the fabrication, fitment and maintenance of artificial aid/appliance to be given to a disabled person under ADIP Scheme.
- District Rural Development Agencies, Indian Red Cross Societies and other Autonomous Bodies headed by District Collector/Chief Executive Officer/District Development Officer of Zilla Parishad.
- National/Apex Institutes including ALIMCO functioning under administrative control of the Ministry of Social Justice and Empowerment/Ministry of Health and Family Welfare.
- State Handicapped Development Corporations.
- Local Bodies- Zilla Parishad, Municipalities, District Autonomous Development Councils and Panchayats.
- Hospitals registered as separate entity, as recommended by state/central government
- Nehru Yuvak Kendras.

Note: Grant-in-aid under the Scheme will not be given for commercial supply of aids/appliances.

Eligibility of the Beneficiaries

A person with disabilities fulfilling following conditions would be eligible for assistance under ADIP Scheme through authorized agencies:

- He/she should be an Indian citizen of any age.
- Should be certified by a Registered Medical Practitioner that he/she is disabled and fit to use prescribed aid/appliance. Holds a 40% Disablement Certificate.
- Person who is employed/self-employed or getting pension and whose monthly income from all sources does not exceed Rs. 20,000/- per month.
- In case of dependents, the income of parents/guardians should not exceed Rs. 20,000/- per month.
- Persons who have not received assistance from the Government, local bodies and Non-Official Organisations during the last 3 years for the same purpose. However, for children below 12 years of age this limit would be 1 year.

Quantum of Assistance to be given to Persons with Disability under ADIP Scheme.

- Aids/appliances which do not cost more than Rs. 10,000/ - are covered under the Scheme for single disability. However, in the case of Students with Disability (SwDs), students beyond IX

class, the limit would be raised to Rs.12,000. In the case of multiple disabilities, the limit will apply to individual items separately in case more than one aid/appliance is required.

The quantum of assistance and income limit under the ADIP scheme is as follows:

Quantum of assistance and income limit under the ADIP scheme

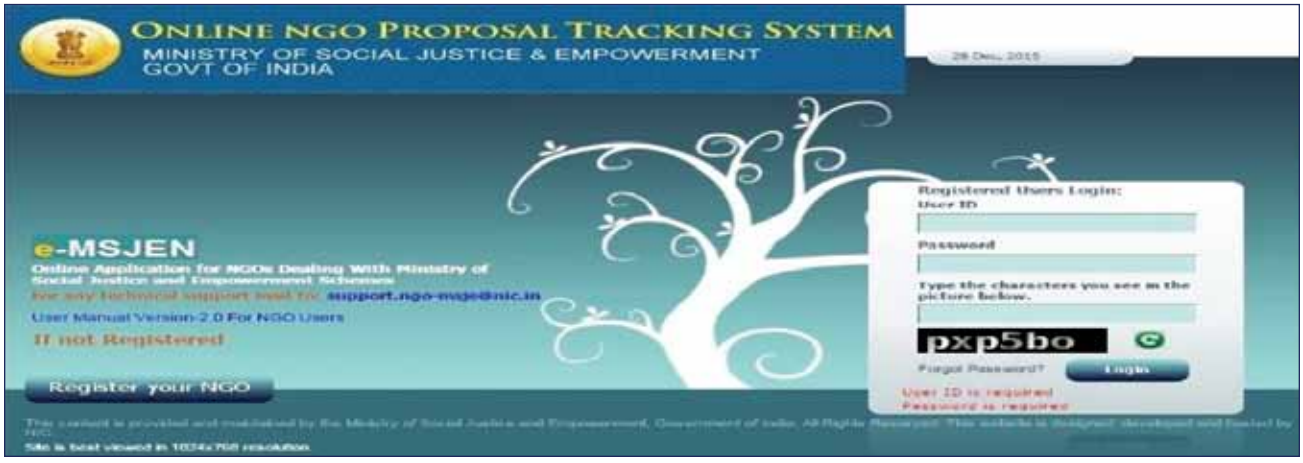
Total Income of Persons with Disability/ Family	Amount of Assistance
1. Up to Rs. 15,000/- per month	Full cost of aid/appliance
2. Rs. 15,001/- to Rs. 20,000/- per month	50% of the cost of aid/appliance

Travelling cost would be admissible separately to the PwD and one escort limited to bus fare or railway, subject to a limit of Rs. 250/- each person, irrespective of number of visits to the Centre.

- Further, boarding and lodging expenses at the rate of Rs. 100/- per day for maximum duration of 15 days would be admissible, only for those patients whose total income is upto Rs.15, 000/- per month and the same will be allowed to attendant/escort.
- Special Quantum of Assistance for latest and specialized Assistive Devices
- Motorized tricycles and wheelchairs for severely disabled and for Quadriplegic (SCI), Muscular Dystrophy, Stroke, Cerebral Palsy, Hemipeligia and any other person with similar conditions, where either three/four limbs or one half of the body are severely impaired. The extent of subsidy provided is Rs 25,000. The minimum age for availing motorized tricycle and wheelchairs is 16 years. The assistance will be provided once in 10 years.
- For providing modern assistive devices for all categories of PwDs both physical and mental and multiple disability impaired groups, e.g. Daisy Book players and other Talking Devices, Net Book Laptop and Digital Magnifiers for visual impairment and Behind the Ear (hearing aid) for hearing impairment, the items will be decided by an Expert Committee constituted in the Department of Disability Affairs with the approval of Minister for Social Justice &Empowerment.
- The extent of financial support would be limited to Rs. 10,000 for each disability and Rs. 12,000 for students with disabilities in respect of devices costing upto Rs. 20,000. Further, all expensive items costing above Rs. 20,000, except cochlear implant, eligible for assistance under the scheme, subject to income ceiling, would be listed out. Government of India shall bear 50% of cost of the items thus listed by the Committee and the remainder shall be contributed by either the State Govt. or the NGO or any other agency or by the beneficiary concerned subject to prior approval of Ministry on case to case basis; limited to 20% of the Budget under the Scheme.
- **Special Provision for Cochlear Implant**

  Ministry of Social Justice and Empowerment has recognized Institutes of national stature from each zone to recommend children eligible under the Scheme for cochlear implant, with a ceiling of Rs.6.00 lakh per unit to be borne by the Government. Ministry has also identified and recognized the Institutes in the zones wherein the surgery will be undertaken. Ministry

will identify suitable agencies for providing cochlear implant (500 children per year) under the Scheme. Income ceiling for the beneficiaries will be same as for other aids/appliances.



For any technical support mail to support.ngo-msje@nic.in

Procedure for Receipt of Grant-In-Aid by an Implementing Agency

The organizations will submit their application online on e-MSJE online NGO Proposal Taking System of Ministry of Social Justice and Empowerment, Govt of India.

Documents to be attached with Application.

A copy of Registration Certificate u/s 51/52 of Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act (PWD Act), 1995.

A copy of Registration Certificate under Societies Registration Act, 1860 and their branches, if any, separately, or Charitable Trust Act.

A copy of Rules, Aims and Objectives of the Organization.

A copy of Certified Audited Accounts and Annual Report for the last year.

Names of the Members of Management Committee of the Organization.

List of identified beneficiaries and types of aids/appliances required by the organisation for supply/ fitting to the identified beneficiaries.

Estimated expenditure for distribution/fitting of aids/appliances amongst the identified beneficiaries.

An Undertaking that the funds will not be utilized for any other purposes.

An Undertaking to maintain a separate account of the funds received from the Ministry under the scheme.

The Implementing Agencies already receiving grant-in-aid under the Scheme should also furnish the list of beneficiaries assisted from the grant-in-aid released to them in the previous year as per

proforma given in Annexure-IV in CD in Excel programme and summary of beneficiaries covered in hard copy. Utilization certificate as per Annexure-V may be given.

A calendar of activities for entire financial year including probable dates for holding camps etc. for distribution of aids/appliances and also maintain separate account for that.

An Undertaking that the organisation will provide post-distribution care to the beneficiaries as well as aids/appliances, on demand.

Organisation should be financially sound and viable and has requisite capability to mobilize the resources.

The organisation shall have working rapport with the District Administration and shall have capacity to utilize the expertise available with District Administration for identification of aids/appliances.

The implementing agencies shall keep manuals / literature on main features, maintenance and upkeep of devices, one-year free maintenance would be provided by them for assistive devices. 2% of the annual allocation will be earmarked for monitoring and evaluation of expenses.

Conclusion:

It has been the constant endeavour of the Government to provide the persons with disability with aids/appliance at minimum costs. The requirement for providing of aids/appliances, which are essential for the social, economic and vocational rehabilitation of the persons with disability. The New Rights of Persons with Disability Act 2016 explicitly mentions to provide appropriate assistive devices to students with disabilities at free of cost, developing technology, assistive devices for inclusion and participation of persons with disability. The Government of India has taken very impressive and affirmative action such as update the ADIP scheme and updated list of assistive devices to be given under the ADIP scheme. Secondly, the Govt of India has launched Accessible India Campaign aims who disabled persons, has come into sharp focus, particularly after the enactment of the Rights of Persons with Disability Act 2016.

Topic 30 Indigenous Devices[25]

The term "indigenous technology" is used in the broadest sense in this topic. It refers to the use of local, indigenous knowledge, skills, and methods of production. The most important criterion for production to be considered indigenous is that the production process has been thoroughly assimilated into local conditions by the local people on a sustainable basis.

In addition to factory-based and other conventional forms of production, the informal sector also produces assistive devices in a decentralized way, often in rural areas. Specific needs motivate families, helpers of people with disabilities and other community members to produce devices with whatever materials and production techniques are available to them.

The technology follows certain criteria by which it can easily function able and sustainable. The criteria's like user-specific, appropriate technology and production methods, mass production, prescription, NGO-government cooperation, Raw materials etc.

A) User-specific Devices

The term user specific is a central issue in production, so far generally neglected, is the extent to which devices are user-specific. For example an orthoses must be fitted to the size of a user's leg, not simply taken off a shelf. At minimum, a workshop must take specific measurements of the shape of the affected leg and the location or height of various joints.

Brace and limb making in the village.

Although a wheelchair does not require the same degree of precise measurement, it must also be considered a highly user-specific device. Making wheelchairs in one "universal" extra-large size makes no more sense than making clothes in one extra-large size. People are of different sizes, and will therefore require different-sized wheelchairs. This is a problem of particular concern in the Asia-Pacific region, as wheelchairs imported from other regions (often through donations) and designed to fit people in those regions are often too large for local people.

Just like clothes, wheelchairs can still be used if they are the wrong size but they will be uncomfortable and awkward. For children, this could adversely affect their growth and development. Producing "one-size-fits-all" wheelchairs may be useful when a wheelchair is to be used only under special conditions, as in a hospital, or on a very short-term basis, as for a wheelchair temporarily loaned to a user whose regular wheelchair is being repaired. But it would be wrong to assume that such wheelchairs are suitable for long-term, daily use.

B) Appropriate Technologies and Production Methods

Devices appropriate for the environment of a developing country often use a simpler, less sophisticated technology than the devices adopted in developed countries. Unfortunately, this

[25]Content of this topic authored by Mr. Jagannath Mallik, Ortho-Prosthetic Engineer, Blind People's Association , Ahmedabad

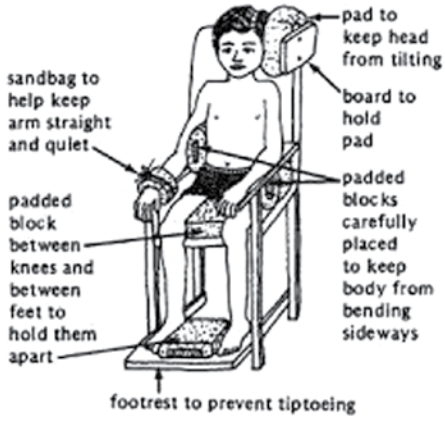
often leads them to be regarded as inferior, even if their usefulness, durability and ease of repair could make them superior under local conditions.

However, poor methods of production can sometimes result in bad experiences with appropriate technology, which leads people to mistrust appropriately produced devices. The devices produced and the methods of producing them must be at both an appropriate level of technology and a high level of technique: simple, but professional.

Use of local workmanship like Carpentry, Black smith ,cycle repairing, tailoring ,cobbling and other art and local skills, to make the devices more functional .

C) Mass Production

Mass production of some assistive devices and their parts may help reduce their costs through economies of scale. It may also reduce the time required for production.



In many cases, however, mass production of assistive devices is Impossible or undesirable, because it generally requires finished products to be almost identical. Although wheelchairs can be mass-produced, for example, they must still fit the requirements of each individual user. For a child growth, the proper size and fit of a device are all important.

Theoretically, devices may be produced using new flexible “just-in-time” methods that would allow them to achieve the economies of scale found in a factory while still being responsive to user requirements..

The advantages of mass production could also be realized for some user-specific devices if the mass-produced devices were adjustable. For example, some wheelchairs with adjustable height, footrest position and width are now available.

Even when the finished devices must or should be custom-built, mass production of parts can still reduce costs through economies of scale. Where possible, mass production of parts makes finished devices cheaper, quicker to produce, more easily available, and easier to repair. Producing parts through a machine reduces their variability, thus there is greater assurance of uniform quality.

D) Prescription

For the appropriate prescription of aids and appliances there should be a proper communication between the medical professionals and rehabilitation professionals, but its lack in our country. There is an unfortunate gap between doctors and other health workers, who know little about assistive devices, and technicians, who know little about the medical or anatomical aspects of disabilities. If the two groups could work more closely with one another and learn something about each other’s work, they would be better able to meet user needs.


Bilateral below knee amputation and exoskeletal below knee resin prosthesis

Prescription must take into account the availability of support services for repair and maintenance, in the long and short term. A device which cannot easily be repaired or maintained is not a good or useful device.

E) NGO-Government cooperation

There are many fine examples in the Asia-Pacific region of cooperation between Governments and NGOs in the provision of assistive devices. NGOs have played an active role, with government support, in developing local capacity for the production of assistive devices. Governments often provide the funding, equipment or infrastructure needed for specific NGO-initiated projects. Governments are also able to support NGO efforts by coordinating diverse agencies to enhance production and distribution.

Effective coordination can lead to better dialogue and exchange of information among people in different parts of a country who may be engaged in similar efforts in production or design, including community members and local workshop technicians.

F) Raw Materials

Raw materials commonly used in Asian and Pacific developing countries for various types of assistive devices include:

(a) Aluminum, in the form of tubes and strips (for wheelchairs, white canes and orthoses);

(b) Steel, in the form of tubes and strips (e.g., for wheelchairs, knee joints, walkers and orthoses);

(c) Wood (for wheelchairs, prostheses and crutches);

(d) Thermoplastics of different types, such as polypropylene (for prosthetic sockets);

(e) Polyester resin (for sockets);

(f) Epoxy and polyurethane (for prosthetic feet);

(g) Polyvinyl chloride (PVC) (for orthoses);

(h) Nylon, polyethylene (for prostheses and orthoses);

(i) Natural rubber (for prosthetic feet);

(j) Glass fiber (for orthoses);

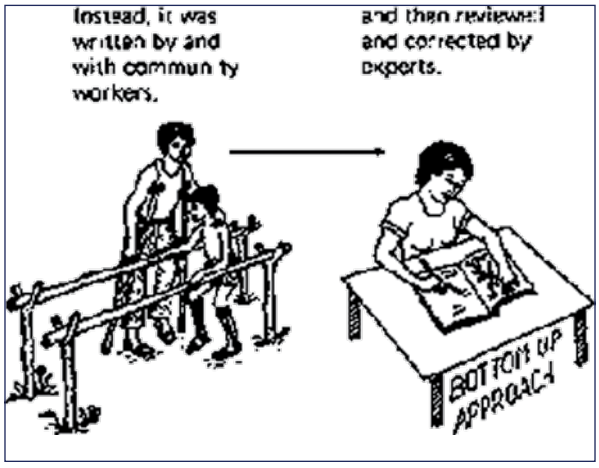
(k) Leather (for shoes, prostheses, orthoses);

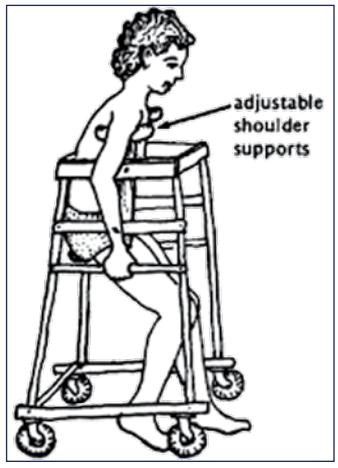
(l) Different types of solvents and catalysts, canvas, cloth and plaster of Paris (POP).

(m) Locally available Bamboos, teak woods and the other types of woods are very useful in preparing crutches, parallel bars and other walking devices.

Some countries have chosen to use only indigenously available raw materials. The advantages of this approach are that it is more likely to lead to the development of local capabilities, it is often lower in cost, and there is greater assurance of the supply of the materials.

There are some images of locally prepared devices as shown below.





Topic 31 Repair & Maintenance[26]

Repair of Assistive Devices like Tricycle, Wheel Chair, Walker, Calipers, Artificial Limbs, Braces and Splints can be easily possible at the community level. There are facilities like cycle repair shop, carpentry shop, black smith shop, tailoring shop as well as shoe repairing shops were available at village / community level.

In these small shops operations like riveting, cuttings, welding, assembling, mending, puncturing, stitching, drilling and other simple operations can be possible ,because they have the necessary tools and machineries in their shops.

The local level technicians in these village shops has excellent workmanship and art to repair all these devices, the only thing is to make clear understanding about the operation of the assistive devices and what operations should do make the device functional. The assistive device user should not worry to come to the advanced workshops of city/town/urban areas for small repairs and maintenances, except there's a replacement of functional parts/High wear and tear of the device/to make a new device/specific health issues and for other genuine reasons related to devices.

The chief component of the community based rehabilitation i.e CBR worker should play an important role to solve these minor problems at community level. The CBR worker should undergone the basic training on uses, repair and maintenance of different assistive devices. He or she should have the good communication with the staffs of the town/city based workshop staffs when necessary.

Below there are list of some essential tools and equipments and materials for the repair and maintenance of assistive devices and some images of repair of different assistive devices.

TABLE – I	
Sr. No.	**Name of essential Tools**
1	Scissors
2	Ball Pen Hammer
3	Chisels of different sizes
4	Mallet hammer
5	Smooth Files of different sizes
6	Rough files of different sizes
7	Shoemaker Anvil
8	Chisels for leather work
9	Hand Saw
10	Hack saw
11	Vice Gripping Plier
12	Spanner Set
13	Screw Driver(flat/star head)
14	Puncture Kit

TABLE – II	
Sr. No.	**Name of Essential Materials/equipment**
1	Velcro hoops and loops
2	Readymade Leather straps
3	Nylon /cotton webbing straps
4	Press buttons
5	Rubber solutions
6	Bifurcated Rivets
7	Metallic/copper rivets
8	Aluminum Rivets
9	Nuts and Bolts of different sizes
10	Soft Leather
11	Chrome/ Hard Leather
12	D-ring(plastic/Metal)
13	Roller Buckle
14	Soft Lining Materials

[26]Content of this topic authored by Mr. Jagannath Mallik, Ortho-Prosthetic Engineer, Blind People's Association , Ahmedabad

TABLE – I	
Sr. No.	**Name of essential Tools**
15	Hand Pump
16	Allen Key Set
17	Benders(Bar)
18	Drill bits
19	Wrench set
20	Measuring Tape
21	Nipper
22	Leather Plier
23	Hole Punch set
24	Leather Chisels
25	Leather needle & Thread
26	Plier
27	Centre punch
28	Eyelet Punch
29	Box spanner set
30	Plumbing vice with Base

TABLE – II	
Sr. No.	**Name of Essential Materials/equipment**
15	Plastic/Aluminum Strips
16	Screws and Nuts
17	Stockinet
18	Rubber sheets
19	Readymade Velcro straps
20	Elevation Sheets
21	Shoe laces
22	Leather sewing needle and Threads
23	Eyelets
24	Washers
25	Steel grip tape
26	Hand Drill
27	Heat Gun
28	Portable cutting machine
29	Extension Electric cord
30	Needle and Thread

Repairing of Artificial Limbs

Repairing of Upper Limb Arm

Repairing Wheel Chairs

Repairing of Lower Limb Prosthesis

Repairing of Wheel Chair

Basic fitment, training and repair of assistive devices[27]

Repair of Assistive Devices like Tricycle, Wheel Chair, Walker, Calipers, Artificial Limbs, Braces and Splints can be easily possible at the community level. There are facilities like cycle repair shop, carpentry shop, black smith shop, tailoring shop as well as shoe repairing shops were available at village / community level.

In these small shops operations like riveting, cuttings, welding, assembling, mending, puncturing, stitching, drilling and other simple operations can be possible ,because they have the necessary tools and machineries in their shops.

The local level technicians in these village shops has excellent workmanship and art to repair all these devices, the only thing is to make clear understanding about the operation of the assistive devices and what operations should do make the device functional. The assistive device user should not worry to come to the advanced workshops of city/town/urban areas for small repairs and maintenances, except there's a replacement of functional parts/High wear and tear of the device/to make a new device/specific health issues and for other genuine reasons related to devices.

The chief component of the community based rehabilitation i.e CBR worker should play an important role to solve these minor problems at community level. The CBR worker should undergone the basic training on uses, repair and maintenance of different assistive devices. He or she should have the good communication with the staffs of the town/city based workshop staffs when necessary.

Below there are list of some essential tools and equipments and materials for the repair and maintenance of assistive devices and some images of repair of different assistive devices.

TABLE – I

Sr. No.	Name of essential Tools
1	Scissors
2	Ball Pen Hammer
3	Chisels of different sizes
4	Mallet hammer
5	Smooth Files of different sizes
6	Rough files of different sizes
7	Shoemaker Anvil
8	Chisels for leather work
9	Hand Saw
10	Hack saw
11	Vice Gripping Plier
12	Spanner Set
13	Screw Driver(flat/star head)
14	Puncture Kit
15	Hand Pump

TABLE – II

Sr. No.	Name of Essential Materials/equipment
1	Velcro hoops and loops
2	Readymade Leather straps
3	Nylon /cotton webbing straps
4	Press buttons
5	Rubber solutions
6	Bifurcated Rivets
7	Metallic/copper rivets
8	Aluminum Rivets
9	Nuts and Bolts of different sizes
10	Soft Leather
11	Chrome/ Hard Leather
12	D-ring(plastic/Metal)
13	Roller Buckle
14	Soft Lining Materials
15	Plastic/Aluminum Strips

[27]Content of this topic authored by Mr. Jagannath Mallik, Ortho-Prosthetic Engineer, Blind People's Association, Ahmedabad

TABLE – I	
Sr. No.	**Name of essential Tools**
16	Allen Key Set
17	Benders(Bar)
18	Drill bits
19	Wrench set
20	Measuring Tape
21	Nipper
22	Leather Plier
23	Hole Punch set
24	Leather Chisels
25	Leather needle & Thread
26	Plier
27	Centre punch
28	Eyelet Punch
29	Box spanner set
30	Plumbing vice with Base

TABLE – II	
Sr. No.	**Name of Essential Materials/equipment**
16	Screws and Nuts
17	Stockinet
18	Rubber sheets
19	Readymade Velcro straps
20	Elevation Sheets
21	Shoe laces
22	Leather sewing needle and Threads
23	Eyelets
24	Washers
25	Steel grip tape
26	Hand Drill
27	Heat Gun
28	Portable cutting machine
29	Extension Electric cord
30	Needle and Thread

Repairing of Artificial Limbs

Repairing of Upper Limb Arm

Repairing Wheel Chairs

Repairing of Lower Limb Prosthesis

Repairing of Wheel Chair

Topic 32 Orientation & Mobility[28]

***(Note:** While mobility is important and a relevant topics in case persons with restricted mobility as well as due to visual impairment. The chapter will confine to orientation and mobility in case of visual impairment only)*

1. Definitions

1.1 Mobility

Mobility is defined as physical "movement" and the negotiation of any obstacles and hazards. It is the aim of obtaining freedom of movement without coming to any harm, safety in travelling as well as minimizing the level of stress placed upon a visually impaired person. While Braille gives intellectual independence, a well-developed sense of mobility facilitates independent movement. It enables the person to detect hazards associated with travelling and to take evasive action.

Mobility refers to total physical movement which involves a change in spatial location accomplished in an upright position under one's own power. It describes all situations ranging from moving around within a single room, in a house to travelling from one town to another or even between countries.

It is the action of travelling, of going from one place to another. To be mobile, a person should be able to gather and use sufficient information from the environment to avoid hazards and to reach his destination safely. Thus it is the ability to move in the environment in relation to oneself from one place to another. In order to do this, a visually impaired person may use a lazer cane, smart cane, long cane, a guide cane or just a bamboo stick. A person with locomotor disability may use crutches, elbow crutches, calipers, tricycle, wheelchair, rollators or ground mobility device etc. Both these groups may take the help of a human guide or an escort.

1.2 Orientation

Orientation is the ability to locate oneself in one's environment. It is a skill that is related to the use of the remaining senses of a person to establish one's position in, and in relation to significant objects in the environment.

Orientation involves having an awareness of space and an understanding of the situation of the body within it (Stone, 1995). The process of using the available environmental information to select and follow the correct path is called orientation. It has been established that when vision of a person is completely or partially impaired, he has to depend upon his remaining senses to be able to move around freely. The senses of hearing, touch, smell, kinesthetic and taste can all be used to help him to recognize his position in relation to the obstacles and landmarks around, in the environment.

The training that teaches the visually impaired persons to move around the environment freely and independently is popularly known as "Orientation and Mobility" (O & M).

[28]Content of topic authored by Dr. Bhushan Punani, Executive Secretary, Blind People's Association

2. Importance of Orientation and Mobility

The ability to move in and around the environment is critical and many times inability to do so affects the individual psychologically, socially, emotionally, economically and physically. (Stone, 1995). One of the main effects or impacts of visual impairment is in the ability to move around.

2.1 Personal Development: A restricted movement of individuals may influence their development, understanding of concepts and quality of life considerably. It would also restrict their exposure to the environment and the knowledge of the world around them would be limited. Training in O&M would enable them to avail a variety of real experiences and enhance their understanding of the concepts, give them more confidence and all these would result into personal development.

2.2 Independence in Movement: The loss of power to move about freely and safely is arguably the greatest deprivation inflicted by blindness (Koestler, 1976). As being able to travel freely is very important for the sense of independence, O&M training is an important pre-requisite for the integration of visually impaired persons into the community and working life. It enables them to become more independent in indoor as well as outdoor mobility. It allows them more freedom and makes them less dependent on family and friends. It sharpens remaining senses through sensory training, develops coordination of movement and improves posture. That results into better acceptance of the individual in the community and by the peer group.

2.3 Social Inclusion: Mobility enables an individual to perform daily activities like going to a grocery shop, temple, common place, venues of social activities, houses of relatives, neighbours and friends etc. Through such movement, individual is able to interact with others and to develop inter-personal relations. It would enhance the quality and quantity of social contacts and integration in community. The extent of social interaction would be enhanced further if the individual is able to use the public transport and go to far off places and other towns.

2.4 Self Confidence: When an individual is not able to travel around freely, it has devastating effect on his/her self-concept (Stone, 1995), self-confidence and desire to compete and progress. Most people with visual impairment remain confined to their homes, live a solitary life and accept visual impairment as *fate accompli*. Such individuals have to depend upon others even while moving in a familiar environment. They have to depend upon the convenience of others for their movement, daily activities and participating in social activities. While independence in movement would develop self-confidence and enable them to perform these activities at their own convenience and pleasure. It would enhance their movement outside home and encourage community participation.

2.5 Safety of the Individual: It enhances the safety of the individual and his fellow beings. It is essential for correcting gait and postural defects. It is not just an overcoming of practical difficulties, but it is also a step towards developing and maintaining one's own self- image. Mobility education will also be one way to get young people fit and the improved fitness will lead to an ability to undertake more intensive training (Stone, 1995)

2.6 Comprehensive Rehabilitation: To be able to move independently within environment is one of the pre-requisites for employment (Hill, 1986), gainful occupation, economic rehabilitation or income

generation. It is a step toward comprehensive rehabilitation, self-confidence and liberation from the solitary home confinement of a person. The success of the vocational training as well as community based rehabilitation programmes also further proves the importance and necessity of independent travel. It also helps in changing public attitudes towards visual impairment.

2.7 Mobility and Sports: There is close inter-action between mobility and sports. Training in O&M is a pre-requisite for promoting sports among the visually impaired. At the same time, participation in sports enhances understanding of the environment, enables a person to overcome fear of movement in the unknown space and improves concentration which in turn results into better mobility. These days' persons with visual impairment are playing cricket, foot-ball and chess at national and international level.

3. Mobility Techniques

To travel safely in relation to the environment, a visually impaired person can use one of the following techniques or a combination thereof:

3.1 Sighted Guide: While the principal objective of O&M training is attaining freedom in movement, help of another person is essential under certain circumstances. A visually impaired may require assistance of a sighted guide while crossing a busy road, moving in a less familiar environment, searching a visual sign or moving in a crowded place. Very specific and environment specific techniques have been developed for the sight guides in case of following situations:

3.1.1 While Approaching Narrow Spaces

3.1.2 Ascending and Descending Stairs

3.1.3 Being Helped to a Chair

3.1.4 Passing through Doorways

3.2 Walking Alone is very useful in a familiar environment; to protects them from hitting object and hurting himself; to enable them to walk alone, independently and unaided. It is particularly useful for performing their activities of daily living and personal grooming; increasing their spatial perception. It allows them to remain a master of their own will and prevents dependence on others; and can be used in conjunction with other techniques. Following specific techniques have been developed to enable an individual to walk alone:

3.2.1 Trailing

3.2.2 Protective Techniques

- 3.2.2.1 Upper Arm and Forearm Techniques
- 3.2.2.2 Lower Hand and Forearm Technique

3.2.3 Locating Dropped Articles

3.2.4 Using Landmarks Indoor

3.2.5 Direction Taking

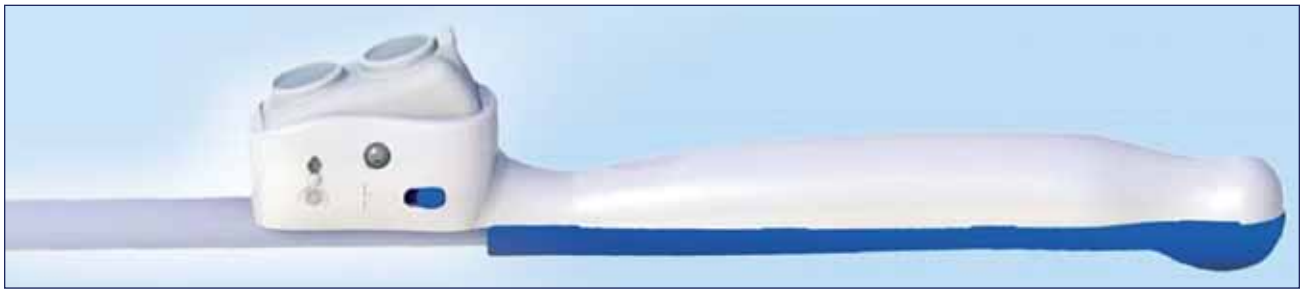
3.3 Cane Techniques: Long cane techniques are used to detect elevation changes and obstacles in the travel path that are below waist level. Basic cane techniques enable the traveler to locate a clear path of travel, negotiate varying terrains, and locate and move around obstacles and hazards in the travel path safely and efficiently. They are used in unfamiliar or uncontrolled environments as well as in those environments that may be both familiar and controlled but which have elevation changes or obstacles in the travel path that the traveler needs to detect[29]. The following systematic techniques have been developed to enable a person with visual impairment to gain efficiency in cane techniqu2

3.3.1 Pre-cane Devices

3.3.2 Use of a Long Cane

3.3.3 Right Type of Cane

3.3.4 Qualities of Cane



3.3.5 Holding the Cane

3.3.6 Using the Cane

3.3.7 Squaring off

3.3.8 Adaptation of the Cane Technique

3.3.9 Shore-lining

3.4 Human Guide Technique: While the principal objective of O&M training is attaining freedom in movement, help of another person is essential under certain circumstances. A visually impaired may require assistance of a sighted guide while crossing a busy road, moving in a less familiar environment, searching a visual sign or moving in a crowded place.

Salient Features

a) It is the skill of travelling with a sighted companion.

b) Training has to be imparted to the visually impaired as well as the sighted person.

c) The sighted person should know how to guide a companion in various circumstances.

d) All the members of the family of the visually impaired should know how to use the sighted-guide techniques correctly.

e) A type of non-verbal communication exists between the visually impaired person and the guide

[29]https://tech.aph.org/sbs/04_sbs_lc_study.html

and the latter does not have to tell the former every time regarding the change in direction and other walking situations.

Visit website https://eyerounds.org/tutorials/Sighted-Guide-Technique-Overview.pdf for more details on this technique.

3.5 Guide Dogs: Using trained guide dogs for mobility is popular in Europe, South Africa, Australia and America. This technique has not been adopted in the developing countries due to Lack of training facilities for training the guide dogs, very high cost of maintaining such dogs, crowded places and lack of traffic regulations, risk from stray dogs and other wild animals, religious considerations of not allowing dogs into the kitchen, bed rooms or many a times into the house etc.

4. Newer Developments in the Field of Mobility:

While earlier, one long cane, folding cane and bamboo canes were used for mobility. Now a variety of new devices, canes and appliances have been developed to enhance mobility and safety of persons with visual impairment. Most landmark developments are:

4.1 Smart Cane: This is an electronic travel aid which fits on the top fold of the white cane. It serves as an enhancement to the white cane and overcomes its limitations by detecting knee-above and hanging obstacles. It detects obstacles using sonic waves and the presence of obstacles is conveyed through intuitive vibratory patterns. It is powered using rechargeable battery like cell phone and can be used in both indoor and outdoor navigation modes. It has been designed to accommodate varying types of user grips which are commonly used by visually challenged. This device has been developed by IIT Delhi, manufactured by Phoenix Medical Systems and distributed by Saksham Ability. Visit website http://smartcane.saksham.org/ for more details on this product and the organization.

4.2 Torch-It: It is technical, economical, smart solution for visually impaired people. It is device which detects the obstacles in their path while walking. Two distance sensors detects obstacles horizontally as well as vertically and gives all data to the controller and controller read the data and response via vibrating motor and buzz sound. The indoor sensor helps people in their inner visually dark world and outdoor can help them to crossing the road alone, help them in mobility and navigation. Another sensor detect the vertical distance: level of ground and response according the programming; When pot hole is there the distance measure from ground to torch it increases then controller reacts via Buzz sound and When step up is there the distance between ground and torch decrease so the controller reacts via vibration at the end of torch.

Most important advantage is the torch-it can easily fit on the cane, and it gives the more reliable function that the user use their stick also and become smart. Here another switch is their which converts the torch-it virtual cane to a torch-it cane. These two sensors are working to find the above knee level distance accurately and detects the right-left obstacles simultaneously and react vice versa and the user can understand for example the obstacle in right direction then the right side motor vibrate and user change its direction to left to avoid obstacles. Kindly visit website https://mytorchit.com/ for more details on this product.

4.3 Low Vision Devices: Now there are a large number of low vision devices which enhance mobility and safety of persons with low vision. There are variety of optical and non-optical devices which can be used to enhance mobility of person with visual impairment. There are also spectacle mounted devices which can enable a person with visual impairment to identify objects, recognize individuals and to identify symbols and read sign board.

Bioptic Telescope

Kindly refer to publication http://www.vision2020india.org/wp-content/uploads/2016/10/cehj-jan-2013.pdf for more details on low vision devices

Kindly visit site https://www.sankaranethralaya.org/patient-care-low-vision-clinic.html for various types of low vision devices (This is also source of picture)

References:

Punani, Bhushan; and Rawal, Nandini (2000): *Handbook: Visual Impairment*, Ahmedabad: Blind People's Association

Stone, Juliet (1995): *Mobility for Special Needs,* London: Cassell, P. 198

Jaimitra, S. (1986): *New Trends in Orientation and Mobility,* LBMRC Research and Newsletter, 11 (1), April, P. 5

Web references have been included in the text

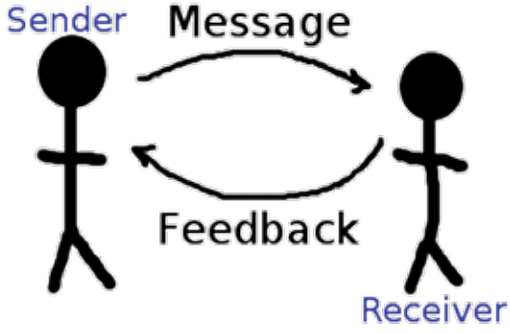
Topic 33 Total Communication[30]

What is Communication?

Communication is an exchange of information, ideas and feelings between two or more people. People sharing ideas, information, opinions and feelings may contribute to the operations of teams and the work of individuals.

Communication is a two-way activity between two or more people. There are various modes of communication, some of which are used more commonly in some workplaces than others.

Communication thus requires:



- Someone to say / share information - e.g. “I want a pen”.
- Someone to say it to / listen to what is said - “Ramesh, I want a pen”.
- A way to say things so that both people understand. “Ramesh, I want a pen”. Ramesh gives the pen to the boy.
- Reason / need to communicate - I need a pen to write in my book.

In the absence of any one of the above mentioned four factors, the process of communication will not happen. All the four are equally important.

With whom do we communicate?

There are many people with whom we communicate on a day -to-day basis for different reasons. Think about the number of people with whom the Deafblind child communicates every day. Think about how many people you can add to this list and increase the number of people with whom he can have a communication/interaction. They could be:

- Family members
- Friends and neighbours
- People around us at school and at work
- In the community
- Unfamiliar people and strangers

[30]Content of this topic authored by Mr. Akhil Paul, Director, Sense International India, Ahmedabad

Why do we communicate?

- To express a need - “I am hungry. Give me food”
- To express an experience - “I fell down today”
- To express an opinion - “I don’t like to eat vegetables”
- To express a feeling - “I am happy”
- To ask a question - “What is this?”
- To make a choice - “I want music, not ball”
- To make a suggestion - “Blue paper will look better for wrapping the gift”
- To make friends - Hi, I am Rita. What’s your name?
- To make conversation - Yesterday we went to the beach near my house. It was so cool and pleasant. Is there a beach near your house?

All these reasons help us to initiate communication. In the absence of these reasons it would not be necessary to communicate with anyone. It is important for us to give children with Deafblindness as many reasons as possible to communicate.

Make a list of the different reasons for which your child communicates and think about how you can increase the number of reasons he has to communicate with others. The more the number of reasons he has the better will be his level of communication.

Categories of Communication

There are a wide range of ways in which we communicate and more than one may be occurring at any given time. The different categories of communication include:

Spoken or Verbal Communication, which includes face-to-face, telephone, radio or television and other media.

Non-Verbal Communication, covering body language, gestures, how we dress or act, where we stand, and even our scent. There are many subtle ways that we communicate (perhaps even unintentionally) with others. For example, the tone of voice can give clues to mood or emotional state, whilst hand signals or gestures can add to a spoken message.

Written Communication: which includes letters, e-mails, social media, books, magazines, the Internet and other media. Until recent times, a relatively small number of writers and publishers were very powerful when it came to communicating the written word. Today, we can all write and publish our ideas online, which has led to an explosion of information and communication possibilities.

Visualizations: graphs and charts, maps, logos and other visualizations can all communicate messages.

We all need to feel connected, and yet we all connect differently. That’s why, for people with communication challenges, especially deafblind, we use a total communication approach that supports people to connect in the right way for each individual.

By using this approach, we make the complicated simple and empower people to communicate and express themselves – be it through speech or sign, touch or movement, gesture or sound, art or dance.

What is Total Communication approach?

The total communication approach is about finding and using the right combination of communication methods for each person. This approach helps an individual to form connections, ensures successful interactions and supports information exchanges and conversations. A combination of methods are used, which reinforce each other and strengthen meaning for the individual.

Methods of Communication:

Here are some examples of different formal and non-formal types of communication that can be used:

- **Non-verbal:** including body movements, breathing patterns and eye pointing. Textures, smells, temperature, intensive interaction and routine can also support communication by allowing an individual to anticipate what is going to happen next.
- **Language-based communication:** including speech, lip reading, Tadoma, deafblind manual alphabet, giving and receiving information in large print, braille and block alphabet, and sign systems, including Sign Language. Sign systems may be independent sign, on body sign or hand under hand sign.
- **Symbol systems:** including using objects of reference (real objects and object symbols), Picture Exchange Communication System (PECS), line drawings, pictures and photographs.

These methods of communication can be used in any combination and will be individual to the person. We need to work closely with each person to identify preferred methods and how to maximise understanding and expression.

When looking at communication it is important to understand the two different types of language skills, expressive and receptive. How somebody expresses themselves can form a foundation for learning and offer a starting point on which to build communication development.

Expressive communication is when you are sending a message, this may be in response to another person or to initiate communication. **Receptive communication** is when you receive a message from another person. An individual's expressive and receptive communication skills may not be the same. People will use a combination of the communication methods listed above, both expressively and receptively. For example, a person may receive and understand information in sign language and need symbols to help reinforce the meaning, but will use sign language and speech to express themselves.

Reference:

Handbook on Deafblindness- Sense International (India)- www.senseintindia.org

Topic 34 Alternative & Augmentative Communication[31]

Introduction to Communication

"Communication is a bridge". It's a basic need of any living creature. Everybody needs to communicate to fulfil their needs. Communication is a medium through which we exchange our feelings, our needs and desires. We use varied ways to send and receive messages. Communication need not be only talking to one another, but it could be also reaching out to the other person and receiving information from the other person as well using any mode. Communication opens all doors and enables us to reach one another and access our environmental information. It also helps us to exercise control over our environment.

Augmentative and Alternative Communication (AAC)

Augmentative and Alternative Communication is an aid for communication with a device or a design of an entire system with which a person can compensate and communicate. An AAC system or device can use formal language (spoken or signed) or symbols that are different from what people usually use, e.g. pictures or objects. AAC includes aided and unaided systems. Aided system includes picture charts, computer technology and many more; while unaided system includes signs, gestures and many more. AAC helps in understanding any person and also in expressing self. AAC helps people with disabilities in communicating and to be part of social activities and play social role that include interpersonal interaction, learning, education, employment activities, and home management and so on. AAC helps child in attaining the quality of life by enhancing child's ability to communicate whenever required. Ability to communicate depends on understanding child and only then there is a possibility of development and implementation of communication program by taking into consideration child's unique characteristics.

Aided communication – it includes additional equipment; e.g. picture charts, computer or special communication technology and many more. Aided system in AAC is 'low- tech' or 'high- tech'. Both of these techniques can be used by people who are not able to spell or read, and also by people who are highly literate. Low- tech communication system involves a pen, paper, alphabet charts, charts and picture or symbol books and tangible symbols. High- tech communication system involves use of devices (battery) to operate. It ranges from simple high- tech to very sophisticated systems. Simple high- tech systems involves single message devices, pointer boards, toys or books that speak when touched, while very sophisticated systems involves specialized computers and programs, electronic aids that speak and/ or print.

Unaided communication- this system does not involve use of any electronic device. It includes body language, signs, eye pointing (looking at a person or an object), facial expression, vocalization, and gestures.

AAC not only includes devices but also different methods and low cost and low tech systems like pictogram symbols. It can be at an abstract level for some individuals and so cannot be used for

[31]Content of this topic authored by Mr. Akhil Paul, Director, Sense International India, Ahmedabad

all. At the time of beginning AAC with an individual, it's suggested to start at the level of child's communication and then to start intervention to facilitate initiation of communication and exchange in a variety of environment according to appropriate level of an individual.

According to Martinsen & von Tetzschner (1996), there are three groups of children who need AAC. The groups are as following: the alternate language group, the expressive language group and the supportive language group.

- **The alternate language group-** it's useful for children who have little or no speech to communicate and finds it difficult to understand speech. Children with autism and severe cognitive impairment are part of this group. They use gesture for communication. The goal is to provide input in assisting the student to understand language and learn interaction skills for an individual and to enhance opportunities in expressive communication.
- **The expressive language group-** The group contains individuals with severe motor involvement and severe speech motor dysfunction. The concern with this group is, as they grow older, there is a discrepancy in understanding and expressing speech. The goal is to provide a path in expressing their interest, needs, comments and opportunities in participating in the curriculum and focus on the development of literacy skills.
- **The supportive language group-** the group includes individuals with moderate motor speech dysfunction. They have problem with both speech and language. Articulation of speech is poor during the birth till preschool years, although such children become intelligible speakers later in future. There is a possibility that the group includes children with Down Syndrome, apraxia of speech, severe oral–motor impairments, severe articulation disorders and developmental delay.

When a child is not able to communicate, a child can be given opportunity to use low tech material like real objects, pictures, or symbols. Such low tech communication boards are easy to create. A comprehensive AAC assessment of child is done when an augmentative communication intervention of child is not available as a part of process of assessing child. An AAC assessment often combines information that is collected through standardized tests, combined interviews, observations and period of diagnostic intervention that includes trial use.

Concrete objects and picture schedules are used when the child is not able to understand or anticipate a routine schedule or steps of activities. Such schedule that includes objects, parts of objects, symbols and pictures helps child in understanding and anticipating the next activity. It is very important to present items in sequence the way they will occur. When it is observed that the child is not being attentive towards the symbols, pictures or objects; a flash light is used to direct child's attention towards the object, symbol or the picture. This method is called Aided Language Stimulation. This not only helps child in using communication board but also it is helpful in making child understand what is being said.

Incidental teaching episodes are used in Environmental Communication Teaching (ECT) as it is a short, positive towards functional communication. ECT includes 3 major components: 1. Use of structural analysis and modifications; 2. Use of cues, prompts, and descriptive feedback; and use of AAC techniques and approaches (McCloskey & Fonner, 1999).

A communication system typically reflects several important considerations:

- It incorporates a various modes of communication, for example, pictures and sign language, depending on the purposes of the communication.
- It is specifically designed for a person, who has that level of vocabulary that reflects the individual's needs and interests for communication with others.
- There is a possibility that it may have a 'display' on which the vocabulary is laid out, and the visual and physical features of the display will affect efficiency of the use of the system to communicate by a person.
- It can be a high tech and use electronic devices.
- It can be a low tech and use non-electronic devices, like a picture book that is combined with sign language and speech.
- The design will permit the user to have two way communication; that is, receptive and expressive communication which is appropriate for a person; e.g., receptive communication includes tangible symbols and sign, wherein expressive communication involves tangible signs only.
- The design gives the user mechanisms for expressive communication. This includes appropriate input and output; e.g. the user can touch a micro-switch that activates a synthesized voice signal to 'help me'.

AAC System

There are various antecedent and consequence successful strategies for teaching students with severe disabilities wherein AAC is used. In such situations; verbal, gestural, model, and physical prompts are used by communication partner to encourage the student to use a manual sign or picture to express his/her needs. Sometimes use of AAC can be promoted by the proximity of the partner or the materials. It is very important to place partner themselves, the material, or communication systems within students' reach. If students get systematic instruction across multiple stimuli e.g. cues, people and setting; about using AAC, he/ she can start generalizing. Motivating students to use AAC system is very important. In such situation, use of turn taking by communication partner helps the student to take the lead. The student will be motivated to use a symbol only when a teacher differentiates responses depending on whether or not the symbol is used. Also use of AAC symbols in students' ongoing natural routine activities will help him/ her to motivate towards it. Just like non-symbolic communication in routine activities, the teacher can target specific symbol for each activity during the day; e.g., showing picture symbol for food time, outdoor activity, music activity and so on. Often the environment is created to receive desirable response from the student; e.g. a desired object is placed out of reach but in full view of the student.

Along with antecedent strategies, consequence strategies are also effective to teach use of AAC to students with severe disabilities (Snell et al, 2006). Many a times, teachers also use reinforcers that are specific to the communication request; that is food in response to eat, toy in response to play and so on. This strategy is called reinforcer specificity. Responses of students can be shaped with the creation of preferred activities or materials that is dependent on the AAC response. The use of nonpunitive error correction by a teacher can be beneficial; e.g. asking child to show the picture that

he/ she can use for outdoor activity. It is very much important to reinforce the student during all approximations of the desired AAC use; e.g. the student needs to be praised even at the time when he/ she only touches the picture instead of showing or handing it to the teacher.

Picture Exchange Communication Systems

PECS is that one aided communication system that is often used with individuals with severe disabilities including autism which do not have vocal repertoire. This system was made by Bondy and Frost in 1994 as a means of obtaining desired items or needs (Frost and Bondy, 2002). The system includes many phases to teach communication. In the beginning, the students learnt to request objects by exchanging a picture of it. This involved participation of teachers, parents, or peers who will quickly accept the picture in exchange for requested real object. Progressive approximation shaped the exchange process; e.g. touching picture, holding picture up, bringing picture to the teacher and so on. Use of prompting strategy by the teacher also promotes the correct responding. The process continues till the student masters the exchange process with the single picture. After some time, request for desired objects are promoted by the teacher along with use of more pictures and requested objects from additional people and additional settings. After some period of time, the student will learn making choices between two pictures.

Simple Voice Output Device

This device; simple VODs needs only one press of one or few buttons and it produces a voice output or message that has been pre-programmed. These devices help students in participating variety of activities; that include choice making, responding to questions in comprehension, and involving in social activities. It's a requirement to add symbol on the device to help add meaning to the message the student is delivering. After activating the pre-programmed option on the device, the student will be able to respond to the question by other person and also be part of conversation within a group. This helps them enhance in their social activities.

Multiple Symbol Voice Output Devices

This is complex device compared to simple VODs. This allows students who are ready to move beyond just a single or few messages to many messages. This device is very much useful for students who are able to combine symbols to create multiple word utterances or students who have larger vocabulary of known words. This system helps in expanding known symbols and helpful for students who know abstract symbols.

References:

1.Handbook on Deafblindness by Sense International India

2.Creating Learning Opportunities, a step- step guide to teaching students with vision impairment and additional disabilities, including deafblindness by Voice & Vision India

3.Kathleen Mary Huebner, Jeanne Glidden Prickett, Therese Rafalowski Welch, and Elga Joffee (1999). Hand In Hand, Essentials of Communication and Orientation and Mobility for Your Students Who Are Deaf-Blind: Volume I. AFB Press

4.Diana M. Browder and Fred Spooner (2011). Teaching Students with Moderate and Severe Disabilities. The Guilford Press.

Topic 35 Mental health issues[32]

Mental health is equally important as physical health but unfortunately it is not taken as seriously, in fact we hide if we observe any symptoms within our self or among anyone in the family.

Mental health is an important part of overall health and well-being. Mental health includes one's emotional, psychological and social well-being. It affects how we think, feel, and act. It also determines how we handle stress, relate to others and make healthy choices. Mental Health is important at every stage of life i.e. from childhood and adolescence through adulthood.

As per WHO, "Good mental health is related to mental and psychological well-being". WHO's work to improve the mental health of individuals and society at large includes the promotion of mental well-being, the prevention of mental disorders, the protection of human rights and the care of people affected by mental disorders.

It's important to remember that a person's mental health can change over time, depending on many factors. When the demands placed on a person exceed their resources and coping abilities, their mental health could be impacted. For example, if someone is working long hours, caring for an ill relative or experiencing economic hardship they may experience poor mental health.

Mental illness are conditions that affect person's thinking, feeling ,mood or behaviour, such as depression , anxiety, bipolar disorder or schizophrenia, such conditions may be for short term or long lasting or chronic and affect someone's ability to relate to others and day today functioning .

Mental disorders comprise abroad range of problems, with different problems. They are characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with other.

Fortunately most of the disorders are treatable. The important step is to take help and seek treatment. unfortunately stigma attached with mental illness is so much that individual herself and family members do not come out and take treatment instead they hide their symptoms or lock them at home .

Mental illness, especially depression, increases the risk for many types of physical health problems, particularly long-lasting conditions like stroke, type 2 diabetes, and heart disease. Similarly, the presence of chronic conditions can increase the risk for mental illness.

There is no single cause for mental illness. A number of factors can contribute to risk for mental illness, such as

- Early adverse life experiences, such as trauma or a history of abuse (for example, child abuse, sexual assault, witnessing violence, etc.)

[32]Content of the topic authored by Ms. Vimal Thawani, Project Director, Blind People's Association, Ahmedabad

- Experiences related to other ongoing (chronic) medical conditions, such as cancer or diabetes.
- Biological factors, such as genes or chemical imbalances in the brain
- Use of alcohol or recreational drugs
- Having few friends
- Having feeling of loneliness or isolation

Health systems have not yet adequately responded to the burden of mental disorders. As a consequence, the gap between the need for treatment and its provision is wide all over the world. In low- and middle-income countries, between 76% and 85% of people with mental disorders receive no treatment for their disorder.

In addition to support from health-care services, people with mental illness require social support and care. They often need help in accessing educational programs which fit their needs, and in finding employment and housing which enable them to live and be active in their local communities.

Early Warning Signs

Not sure if you or someone you know is living with mental health problems?

Experiencing one or more of the following feelings or behaviors can be an early warning sign of a problem:

- Eating or sleeping too much or too little
- Pulling away from people and usual activities
- Having low or no energy
- Feeling numb or like nothing matters
- Having unexplained aches and pains
- Feeling helpless or hopeless
- Smoking, drinking, or using drugs more than usual
- Feeling unusually confused, forgetful, on edge, angry, upset, worried, or scared
- Yelling or fighting with family and friends
- Experiencing severe mood swings that cause problems in relationships
- Having persistent thoughts and memories you can’t get out of your head
- Hearing voices or believing things that are not true
- Thinking of harming yourself or others
- Inability to perform daily tasks like taking care of your kids or getting to work or school

Positive mental health allows people to:

- Realize their full potential
- Cope with the stresses of life
- Work productively
- Make meaningful contributions to their communities

Ways to maintain positive mental health include:

- Getting professional help if you need it
- Connecting with others
- Staying positive
- Getting physically active
- Helping others
- Getting enough sleep
- Developing coping skills

Topic 36 Mental Health[33]

India and other developing countries have 80% of the population living s in villages. **It therefore follows that** persons with disabilities (PwDs) also reside in rural areas. Small percentage of PwDs can avail of services which are largely confined to cities. PwDs were given services of education and rehabilitation in IBR (institutions based rehabilitation). It was not possible and viable to cover all disabilities in IBR. Most of the urban rehabilitation centers have an age limit of up to 35 years and also capacity limit of a few hundred persons . Vocational training trades were not suited for rural areas. IBR was also very costly. India like other countries started looking for a strategy for reaching out to people with disabilities in rural areas.

CBR was developed in the 1980s, to give people with disabilities access to rehabilitation in their own communities using predominantly local resources .The WHO & UN promoted CBR as a means of delivering services at the community level through the primary health care system. CBR was conceptualized in 1974 and developed in the 1980s, to give people with disabilities access to rehabilitation in their own communities using predominantly local resources.

In 1979 the first edition of a Manual called “Training in the Community for People with Disabilities” (TCPD) was brought out

CBR became widely known and, on a mostly small scale, practiced almost everywhere and WHO has reported that programmes using the title of CBR exist in about 90 countries.

WHAT IS COMMUNITY BASED REHABILITATION (CBR)?

CBR is a strategy within general community development for the rehabilitation, equalization of opportunities, and social inclusion of all people with disabilities

CBR is carried out through the combined efforts of people with disabilities, their families, communities and the generic services of health, social welfare and employment

A 2004 joint ILO, UNESCO and WHO paper repositioned CBR as a strategy for rehabilitation, equalization of opportunity, poverty reduction and social inclusion of people with disabilities.

CBR as a strategy came about as a response to the needs and problems of the community such as the fact that disability is not known or understood, poverty is the main issue that affects the development of persons with disability, services of rehabilitation are not present in the community, people with disabilities are excluded, assistive devices are not available and people with disabilities are unaware of their rights and entitlements.

As the programmes were implemented and awareness was created, people with disabilities became aware of their rights and also became organized. The Charity approach led to the social model and

[33]Content of this topic authored Ms Nandini Rawal, Executive Director, Blind People’s Association, Ahmedabad

ultimately the rights based model. CBR then was seen as an integral part of community development and also was perceived as being part of the entire scenario of community development.

Recommendations to develop guidelines on community-based rehabilitation (CBR) were made during the International Consultation to Review Community-based Rehabilitation which was held in Helsinki, Finland in 2003.

Mental health

In view of the "Alma ata Declaration" the goal being health for all by 2000 and defining health as physical, mental and social well-being.

A.V. shah (1982) has expressed that mental health is "the most essential and inseparable component of health …an integrated component of public and social welfare programs…."

The emphasis is on prevention of diseases as well as maintenance and promotion of health in the community (Michel 1982).

Mental illness

The term use to describe the disorder or condition that negatively affect cognition (Thought), Behavior and/or affect mood to such a point where it causes a significant amount of distress and functional impairment for a prolong period of time.

Mental illness is a serious public health problem. According to world health organization and the Howard School for public health, mental illness accounts for nearly 11 percent of total worldwide disease burden (Disease burden is determined by the calculation of daily adjusted life years. The DALY (Daily adjusted life years) statistic measures loss of years of healthy life from death or disability due to diseases). In countries that are considered "established market economics" (U.S., Britain) mental illness is the second only to heart diseases as the most.

Why community based rehabilitation for mentally ill persons

Mental illness is such type of decease in which a person mostly loss love and belongingness in community. In case of mania and schizophrenia the thinking of people of that community has that person with this type of problem cannot live with the normal persons and they behave differently from these type of persons, and the result goes to most severity of the case, whether the need should be different from community side for the mentally ill persons.

This is universal truth that a person who is normal or abnormal feels more comfortable in his/her own community. For the mentally ill person social security and love is equal important part of treatment as medicine is. And the family, society or community of that person can provide more social security and love to that person rather than other any type of options available for the treatment for the mentally ill persons.

In terms of availability, accessibility, acceptability and affordability of the facilities for rehabilitation, community based rehabilitation is again comes in mind as a best way of rehabilitation.

Mental Health -The Blind People's Association (India) BPA Experience:

After enactment of the persons with the disability act in the year 1995, in which mental illness was included as the seventh disability, the BPA decided to further its involvement with the severe mentally ill and integrated them in to its program level activity. The Blind people association covered 3, 00,000 persons through its community based rehabilitation programs and included components of mental health program.

The Project Objectives

a) Reaching the maximum number of unreached population of the persons with psychiatric disabilities in Gujarat through PHC Medical Officers and CBR field functionaries who are in direct contact with them.

b) Giving timely intervention both medical and therapeutic, social skills and life skills training.

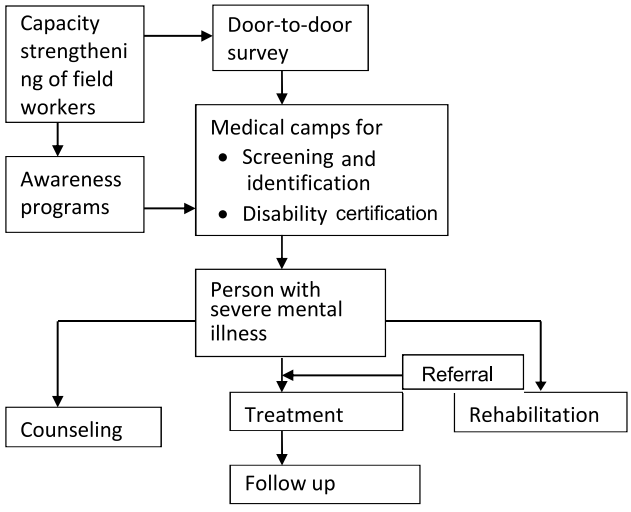
c) Resource room cum counselling centre at the BPA, the Central Coordinating Agency for intervention purpose.

d) Long term plans to provide short-term orientation to include medical professionals from private sector, teachers, health workers, and other development agencies in the private sector.

Beneficiaries and Target Group

The project included people with any kind of mental dysfunction and covered ***all age group, caste and class***. In the rural areas, persons with psychiatric problems are misunderstood, vulnerable and abused. Children, women, economically less-privileged people are at the receiving end and do not have any kind of support for mental health. As these groups remain confined to their homes, they remain bereft of preventive as well as curative and rehabilitative services. The project will make provision for providing services to these special groups on priority basis.

Implementation strategy and process of Community Based Rehabilitation -



Capacity strengthening of field workers

There were one month training program for field workers for identifying the mentally ill person and for identifying specific type of illness in mentally ill persons, with exposure visit of mental hospital. Also there were training program for the BPA staff, core staffs of the partner NGOs were trained in the principle of CBR, mental illness and disabilities, and techniques of rehabilitation.

Door-to-door survey and screening

Door-to-door survey and mental health camps were used to identified the severe mental ill persons the identification criteria was fill the checklist of symptoms of schizophrenia and bipolar disorder after filling the checklist the field worker could only justified that this person has any one of these type of disorder during screening camps psychiatrist certified that this person has such disorder with this much of degree.

Referral linkages

Referral linkages were established with the hospitals for mental health at Ahmedabad, Vadodara, Jamnagar, and Bhuj, with the GG Medical at Jamnagar, with the outpatient services of the civil hospital at Navasari, Surendranagar, Jamnagar, Limdi as well as JB Mehta Hospital at kapadwanj and with the local PHCs and CHCs. Linkages were established with social defense office at the district and the state level, the panchayat offices, the department of health and family welfare, government of Gujarat and the media.

Day care services

These types of centers were developed for especially non curable persons under the one type of follow up program, in day care center trainer used to train those persons in some economical activities for their economical rehabilitation.

Disability certification and availing of benefits

During the camp psychiatrists had certified the persons who were non curable and which help these persons for their further social security like pass for transportation etc.

Awareness program and community involvement

A verity of method used to educate the community about mental illness, the treatments and promote positive mental health. Rallies street plays, posters, wall painting, group meetings, etc., were used and the stakeholders were involved in the planning and implementing of these activities.

Care givers support group

The BPA facilitated the formation of caregivers groups and educate them on the consequences of severe mental illness. The groups were equipped to carry out supportive and advocacy roles.

References:

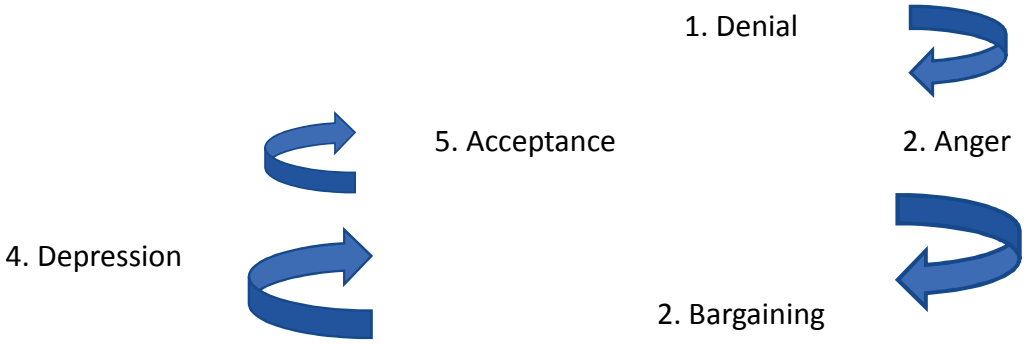
Impact Assessment of Mental Health Program Implemented by Blind People Association (BPA) Through Community based rehabilitation (C.B.R.). By Shiv Govind Singh, Entrepreneurship development institute of India

Topic 37 Adjustment Cycle and Coping Mechanism[34]

Parents are the first to be confronted with the fact that their child is not "normal" but has some form of disability. This starts sometimes from as early as when the sonography is done and when the doctor points out that all is well with the fetus and that something could be wrong. Their lives are suddenly shell-shocked and the long waiting game begins. When the child is born, their worst fears are confirmed and they are faced with the hard reality that their precious child has a disability. All their dreams are shattered and they feel totally ravaged.

Five Stages of Grief by Elisabeth Kubler Ross & David Kessler are as follows:

Denial, anger, bargaining, depression and acceptance are a part of the framework that makes up our learning to live with something shocking.



Kubler-Ross added the two steps as an extension of the grief cycle. In the shock phase, you feel paralyzed and emotionless.

The first onset of grief is marked with denial of the fact the parents have a child with a disability. They feel it is not possible, this cannot be our child, what have we done to deserve this? They are numb, unable to understand what is going on in their lives.

People in the family also blame the mother for this sad event and the mother goes from denial to severe grieving. She mourns the fact that she has failed in some way…that her child is not "normal". The grieving is soon replaced by anger at the injustice of God, as have done no wrong during their life time. Their anger is vented at the Doctor, their own circumstances, possibly something during the pregnancy.

It is some time before they come to grips with reality. Then the Bargaining stage starts…

The parents start bargaining with themselves and with God…maybe if I quit a bad habit, something good will happen. If I visit a temple bare feet in the sun, my child will get better!! This bargaining helps in bringing in some semblance of peace and calm to the parents, makes them think of alternatives for the future.

[34]Content of this topic authored Ms Nandini Rawal, Executive Director, Blind People's Association, Ahmedabad

The bargaining after some time makes the parents realize that this is not the solution so they are pushed back into some more grieving. They feel helpless, anxious, nervous and alone. They keep looking at their child and keep feeling helpless and defeated. The time comes when they realize that they are losing time by moping.

This stage helps them to move on to the next stage of finally coming to terms with the situation and accepting that the situation cannot be changed…They have to find a way out. They accept the fact that the situation cannot change, they have to change, they have to take the lead and find a way out of their grief. That does not mean that the parents are suddenly happy and optimistic. It only means that they have accepted that their child has a disability and they have to look after it in the best way possible.

This stage leads on to them becoming proactive about finding about medical care, therapy, rehabilitation planning etc. They meet similarly afflicted parents and children and start finding out alternatives and ways of helping the child.

At all stages, the support of loved ones, family, spouse, their parents is essential for maintaining the balance of the parents. Words of support, an amenable environment in the house goes a long way in helping the parents to cope better. Using the services of professionals who can guide them also is necessary.

Inclusive Community Development

Topic 1: CBID Concepts and Implications

What is Community & What is Community Development:

1. MEANING OF COMMUNITY:

- Consists of ALL men, women and children living within a fixed geographical area (for example, a village).
- Includes all people irrespective of caste, creed, customs, values or age.
- Every community has disadvantaged groups within it: the elderly, women, children, scheduled castes and scheduled tribes (SC/ST), people with disabilities (PWDs), the list can go on

2. MEANING OF COMMUNITY DEVELOPMENT:

- Community Development aims at caring for the well-being (economic, social, environmental and cultural) of all those in the community, especially the disadvantaged groups.

3. MEANING OF EMPOWERMENT WITHIN THE COMMUNITY:

- Here we look at using the strengths of the members within the community to care for the growth and well-being of their own members through appropriate action and leadership.

4. COMMUNITY BASED INCLUSIVE DEVELOPMENT (CBID):

- CBID aims at ensuring that persons with disabilities are fully included in all aspects of community life and have full access to all facilities and services, so that they can live with dignity, engage actively, and contribute to their community.
- Here the focus is on the removal of barriers in society which exclude persons with disabilities. The focus is also on persons with disabilities themselves, who need to build their capacity and be supported in view of attaining their rights.

5. WHY ARE PWDS EXCLUDED FROM THE DEVELOPMENTAL ACTIVITIES?

- There are several reasons why persons with disabilities are overlooked in mainstream development programmes:
  - Those in charge are not aware of the needs and capabilities of persons with disabilities, who are not very visible in society.
  - Persons with disabilities often have limited mobility, so they stay around the house and do not attend community meetings. They are thus easily overlooked when new projects are started and are not invited to raise their voices during project design. Hence their needs are not taken into account in the projects.

What is Disease, Impairment, Disability, Handicap?

The words "disease", "impairment," "disability," and "handicap," are often used interchangeably. However, they have very different meanings.

- '**Disease**' is generally understood to be a medical condition with a specific set of symptoms.
- '**Impairment**' refers to problems in bodily function and structure as a result of a health condition – for example, blindness or paralysis.
- '**Disability**' has a broader meaning. It refers to impairment, limitations in activities (such as the inability to go to the toilet) and restrictions in participation (such as difficulties in being employed, going to school or making use of public transport). Disability is influenced by the interaction between the individual and his or her social, cultural and physical environment. There are plenty of situations in the environment that are disabling, and a distinction can be made between those that cannot be changed (for example, high mountains) and those that can be changed (stairs can be changed into a ramp or replaced by an elevator).
- '**Handicap**': A person with disability is prevented from fulfilling a normal role at home, in school, at workplace and in the community because of the disabling conditions that exist in the community. This is the handicap.

How to interact with persons with disabilities?

- Be respectful. Speak directly to the person with disability and not to his or her interpreter or assistant.
- Talk in the same way as you speak with anybody else.
- Never treat an adult or elderly person like a child.
- Make sure, when communicating, that you are at the same eye level. This is the best way to show that your attention is directed to him or her and that you are listening to what he or she is saying.
- Offer assistance if you feel that this may be needed, but never help someone without asking whether he/she wants assistance. If you assist someone, ask how they want you to help them.

- Do not stare at someone if something seems unusual to you.
- Talk about people by mentioning their name and do not refer to their impairment (Eg.: "that blind boy").
- Treat the person as you would treat anyone else and as you would like to be treated by others.

What are the causes of Disability?

Disability can be caused:

1. During pregnancy because:

- Mother does not eat nutritious food.
- Mother takes medicine without consulting a doctor.
- Mother tries to induce abortion by injection, medicine, indigenous medicine.
- Mother gets injured due to accident.
- Either parent uses alcohol or smokes during pregnancy.
- Mother gets communicable disease during pregnancy such as – T.B, Jaundice, German Measles etc.
- Mother's blood group is RH negative.
- Of an early (below 18 yrs) or late (after 35) pregnancy.
- Of prolonged labour pain.

2. At the time of birth due to:

- Faulty forceps delivery or breech delivery.
- Lack of sufficient oxygen to the baby at the time of birth.
- Head injury at the time of birth.
- Any communicable disease acquired by the newborn baby.

3. After birth due to:

- Diseases such as Polio, Jaundice, T.B, Meningitis, Encephalitis, Measles etc. Infectious diseases
- Lack of nutritious food.
- Sound and environmental pollution.
- Delay in immunization.
- Pesticides used in food, water, air and workplace.
- Radiation from atomic power plants (when habitations are close to these).

- Poisonous foods consumed by poor people.
- Fluoride poisoning (from fluorosis in drinking water – leads to bone deformities).
- Hazardous work condition, lack of basic safety measures at workplace.
- Road accidents.
- Usage of prohibited medicines/banned drugs.
- Depression - the leading cause of disability, effecting Mental Health
- Non-communicable diseases like diabetes, stroke, cardiovascular disease, arthritis and cancer

Prevention of Disability:

General Preventive Measures

- Marriage between very close blood relations like uncle, niece, first cousin should be avoided to prevent hereditary disorders.
- Avoid pregnancies before 18 years and after the 35 years.
- Consult a doctor before planning the pregnancy:
  - If there is incidence of birth defects in your family.
  - If you have had difficulty in conceiving or have had a series of miscarriages, still births, twins, delivery by operation (Caesarean), obstructed labour/prolonged labour (more than 12 hours) and/or severe bleeding in previous pregnancy.
  - If you have RH - negative blood type.
  - If you have a non-communicable disease.

Care during Pregnancy:

- Avoid hard physical work such as carrying heavy loads.
- Avoid other accident-prone activities such as walking on slippery ground or climbing stools and chairs.
- Avoid unnecessary drugs and medications.
- Avoid smoking, chewing tobacco, consuming alcohol and narcotics.
- Avoid X-rays, and exposure to any kind of radiation.
- Avoid exposure to illnesses like measles, mumps etc. especially during the first 3 months of pregnancy.
- Take precautions against lead poisoning.
- Eat a well-balanced and nourishing diet, supplemented with green leafy vegetables, proteins and vitamins.

- All women of childbearing age need folic acid intake, especially between the 6th to the 9th month of pregnancy.
- Ensure weight gain of at least 10 kgs during pregnancy.
- Good prenatal and obstetrical care for pregnant women.All pregnant women should be given tetanus injection.
- Consult a doctor, in case of swollen feet, persistent headache, fever, difficulty or pain in passing urine, bleeding from the vagina, and yellowness of eyes (jaundice)
- Women at 'high - risk', (weight < 38 Kg, height < 152 cm, weight gain during pregnancy <6 kg, those with severe anemia - Hb < 8mg, those having frequent pregnancies, having a history of miscarriage/ abortion/premature deliveries), must get expert prenatal care.

Care at the time of birth

- Delivery by trained personnel only, preferably in a hospital where all facilities are available.
- If a baby does not cry immediately after birth, resuscitation measures should be undertaken at once.
- Babies born prematurely and with a low birth weight (<2.5 Kg) may need Neonatal Intensive Care.
- If the baby's head appears to be abnormally small or large then a physician should be consulted, preferably a pediatrician. The approximate head size for a male child at birth is 35 cm and for female child is 34.5 cm.
- To protect a child from infections, breast - feeding must be started immediately after birth. First milk (colostrum) must be fed to the baby and should not be thrown away, as it has antibodies which are protective.

Early Childhood Care:

- Do not allow a child's temperature to rise above 101-degree F because of any reason. It can cause 'febrile seizures.'
- If a child gets a fit, take him to doctor immediately.
- Every child should be immunized against infectious diseases as per the recommended schedule of immunization.
- Do not allow a child to have too much contact with paint, newsprint ink, lead etc. as they are toxic.
- Take precautions against head injury, and other accidents.
- Ensure that the child gets a well-balanced diet and clean drinking water.
- Introduce additional foods of good quality and in sufficient quantity when the child is 4 -6 months old.

- Vitamin A deficiency and its consequences (including night blindness) can be easily prevented through the intake of Vitamin A.
- Protect a child from Meningitis and Encephalitis by providing a hygienic environment which is free of overcrowding.
- Use iodized salt as a precaution against goiter and cretinism.
- Do not use hairpins, matchsticks etc. to remove wax from the ears.
- Use ear protectors to reduce the exposure to high levels of noise, if children are living or working in a noisy environment.
- Do not slap a child on the face as this may lead to injury of the eardrum and consequent hearing loss

*(Above Matter: Source: **A Handbook for Parents of Children with Disabilities**)*

Care in later life

- Live a healthy lifestyle
- Use helmets when driving two wheelers, in construction work etc.
- Avoid falls, especially in old age.

Topic 2 Models of Disability

Topic 1 : Models of Disability

Topic 2 : Implications of Various Models on Community Participation

Topic 3 : Legislative Provision Supporting Inclusive Community Development

Human Rights & Disability:

- Human rights are the basic rights and freedoms that belong to every person in the world, from birth until death. They apply regardless of where you are from, what you believe or how you choose to live your life.
- They can never be taken away, although they can sometimes be restricted – for example, if a person breaks the law, or in the interests of national security.
- These basic rights are based on shared values like dignity, fairness, equality, respect and independence.
- These values are defined and protected by law.

There are four kinds of Human Rights:

- **Social Rights** – improve the well-being and standard of living of all members of society. They include – rights to highest attainable standard of physical and mental health, right to adequate housing, food and sanitation, right to inclusive and accessible education.
- **Economic Rights** – income-generating activities or income supports that allow people to have the necessities of life. They include – right to social security, right to earn a living.
- **Cultural Rights** – protecting, developing and enjoying one's cultural identity. They include – right to participate in mainstream culture, arts, recreation, leisure and sport, right to access places of cultural performances.
- **Civil and Political Rights** – allow people to have equal citizenship. They include – the right to life, liberty and security, right to freedom of opinion, right to protection from torture and violence, right to vote and run for political office.

Models of Disability and Implications

1. **Charity Model:**

   Person with disability is not in control of his / her own life but rather *a receiver of care, cure and protection.*

2. **Medical Model:**

   Person with disability is seen as one whose body or mind is not working and *needs to be fixed*.

3. Social Model:

Person with disability is disabled due to the barriers in society – *these barriers prevent his / her participation in daily life.*

4. Human Rights Model:

Person with disability is seen as one *who should have access to everything within the society / community on an equal basis with others.*

Legislative Provisions Supporting Inclusive Community Development:

- The Universal Declaration of Human Rights
- Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities (CRPD)
- The Rights of Persons with Disability Act 2016

(Details of above can be sourced from the official website of Government of India)

Human rights Model

Topic 3 Government Programs Supporting ICD

Topic 1: Inclusive Community Development : Concept & Significance

Topic 2: Central Schemes & Provisions

Topic 3: State & Local Schemes & Provisions

M4: Community Empowerment & Resource Mobilisation for ICD

Topic 1: Resource Mobilisation

Topic 2: Stakeholders & their Participation

Topic 3: Community Empowerment: Concepts & Levels

Inclusive Community Development:

We are different (diverse) in many ways eg age, gender, disability, state of health, where we live, the community we belong to…..Each of us enjoys full human rights as per the Constitution of India. Inclusive Community Development respects this right and is a method for full inclusion of every person in the development process.

Disability Inclusive Development takes into account the participation of all persons with disability in all programmes of the Government on "an equal basis with others." The programmes are especially in the sectors of health, education, livelihoods and social.

The ultimate aim is to eradicate poverty through identifying barriers that prevent participation and access. Break Barriers Open Doors.

Principles of Inclusive Community Development:

Persons with disabilities are entitled to human rights just as much as people without disabilities.

To make sure that no is left behind in the development process it is important to focus on four principles:

- **Attitudes:** Respect and dignity
- **Communication:** Information must reach everyone and everyone should be heard and understood.
- **Accessibility:** Create a barrier-free environment
- **Participation:** Active involvement of all persons with disabilities

Central & State Schemes:

(Trainees are given an assignment to find out from the websites of the various Central and State Government Ministries to find out details of the different mainstream flagship programmes eg Samagra Shiksha, National Rural Livelihoods Mission, National Health Mission, Social Assistance Schemes. It

is important that Flagship mainstream programmes are studied since the focus is on inclusion and participation rather than exclusive schemes. Trainees are encouraged to collect both Central and State Policies eg youth, education, livelihoods, senior citizens and audit them for disability inclusion)

Resource Mobilisation and Community Empowerment

(Refer to material prepared for Unit 2)

Stakeholders & their Participation

Stakeholders who can implement Inclusive Community Development are:

- Mainstream NGOs : open projects and programmes for persons with disabilities
- Government (Central & State & Local Level) : Create access to all programmes through legislation and policies that are in convergence with RPD Act 2016
- Disabled People Organisations (DPOs) : Advocate for their rights and influence Governments. Support other stakeholders in promoting inclusion. Train their own members to strengthen their voices and make them heard.
- Local Communities : Ensure full inclusion within their communities of all Government programmes and schemes
- Disability Specific NGOs : Can support all the above stakeholders in facilitating inclusion through their expertise.

Topic 4 Participatory and Asset-based Approaches to Engagement

Topic 1: Concept of Community Engagement

Topic 2: Participatory Approaches

Topic 3: Community Assets & Its Implications

Meaning of Community Engagement:

Working together with and through groups of people living together in the same area and facing similar situations (eg persons with disabilities, lack of basic facilities). The aim of working together is to look for solutions for solving problems together, for improving the present situation on a long-term basis.

The solution decided can move from a short-term intervention to long-term programmes that look at social, economic, political, environmental factors that improve the quality of life.

Types of Community Engagement:

Members of the community can come together for

- Community Building or development
- Discussing and sharing in such a way that different points of are listened to and considered before taking a decision.
- Improving services within the community
- Bringing about social change in the community (eg activism, advocacy, interest groups – DPOs)

Participatory Approaches:

Consider the following points when working together:

- Plan and prepare carefully, taking into consideration the needs of all participants.
- Include people who are directly affected.
- Focus on a clear common goal and encourage working together for the common goal.
- Listen to each other, invite people to listen to new ideas.
- All must know how the final decision will be taken
- Decisions decided must be such that all are convinced the solution will make a difference and that difference can be seen.
- Work together so that the action decided will continue for a long time with support of all stakeholders (eg involvement of Government, village groups, leaders.)

Community Assets and its Implications:

(This will be elaborated in the next Module)

Topic 5 Participatory Rural Appraisal/Learning and Action (PRA/PLA)

Title of the Modules

M2: Planning, Implementing Participatory and Engagement Strategies

Topic 1 : Concept of PRA (Participatory Rural Appraisal)

Topic 2 : PRA Tools of Community Engagement

Topic 3 : Methods of Sharing PRA Results with the Community

M3: Planning & Conducting Community Meetings

Topic 1: Community Meetings: Types & Essentials

Topic 2: Guidelines for Conducting Participatory Community Meetings

Topic 3: Documentation of Community Meetings

M4: Strategies for Mapping & Profiling the Community

Topic 1: Meaning & Principles of PRA for Asset Mapping

Topic 2: Use of PRA for Community Capacity Maping

Topic 3: Methods of Sharing Assets & Community Capacity Mapping

Concept of PRA (Participatory Rural Appraisal)

PRA is conducted within a community to listen to and understand the ground reality. The views of the primary stakeholders and other key functionaries (within the community and the Government) are gathered about a specific area and its problems. It gives a chance for all to listen to each other, be open to other points of view and plan together programmes for improving a situation.

Through different tools and techniques, information, knowledge and shared experience can be converted into plans and activities for improving situations on the ground.

PRA is a means to mobilize resources within and outside the community to improve the ground situation in a manner where all benefit.

While conducting PRA the following should be kept in mind

1. Conduct the PRA as per availability of the community members and should not be rushed. There should be flexibility and maximum participation and the voices of the marginalized must be heard.
2. All information and views should be validated through other means, other views and methods.
3. Only collect information that is connected with specific problems faced.

4. The focus is always the community, learning and planning actions in a participatory manner to improve quality of life.

PRA Tools of Community Engagement

As per the specific situation and depending on the type of information and views required different tools can be used to conduct a PRA.

- Brainstorming
- Focussed Group Discussions
- Priority Grid
- Transect Walks/Maps
- Resource Mapping
- Social Mapping
- Stakeholder Analysis
- Gender Analysis
- Case Studies
- Daily Activity Clocks……

Methods of Sharing PRA Results with the Community

The members of the PRA team (Fieldworkers, NGOs) are only present to support the community and are not experts. It is the community members who are gathering information and views. Thus it is important that the community be allowed to document through means which are most suitable.

The results of the analysis between the PRA team and the community members should be shared through whatever has been prepared by the community through visuals presentations, oral presentations, models developed and discussions.

(For details refer to www.fao.org/3/x5996e/x5996e06.htm)

Topic 6 Collaborating with Government Agencies

What is Advocacy?

Many poor people, including persons with disabilities remain poor because they cannot access their basic human rights either as individuals or as a group. Through Advocacy the individual, group either by themselves or through other support groups bring about change in policy, process, practice and attitudes to realize their rights.

Who can Advocate for Persons with disabilities?

- Persons with disabilities
- Parents
- NGOs
- Communities and their leaders
- DPOs and their leaders
- Politicians
- Local Government Officials
- Women Group Leaders
- Community Groups
- Elected Representatives at all levels

Advocacy can be done:

- For Persons with disabilities
- With Persons with disabilities
- By Persons with disabilities

Types of Advocacy:

- **Individual Advocacy :** Done by any one of the above for an individual
- **System Level Advocacy :** Done by any one or more of the above to bring about change in the system such as policy, laws, schemes so that the whole group can benefit.
- **Self – Advocacy (either as Individual or as a Group):** People trained to speak for themselves.
- **Professional Advocacy :** People who are paid to provide an advocacy service.

Advocacy Strategy, Action Plan & Presentation:

1. **What do you want to change?**
   - Identify an issue of barrier you or your group want to change.

- Analyse the area where change is needed. Is the barrier attitudinal, physical, educational, policy…?

2. Speak it out!

- How does it affect your human rights? What are the possible causes
- What rights are being violated? Link it to laws.
- How does this problem affect the lives of persons with disabilities?
- How does this addressing the problem improve the lives of persons with disabilities?
- Who needs to be involved to solve the problem?

3. Gather information.

- What laws protect you and support the rights denied?
- What evidence, statistics or information do you have on the right being denied?
- With whom can you work together to solve the problem?
- What are the steps needed to take action?
- Who will take/complete the steps?
- When will the steps be completed

4. Formulate an action plan.

The Action Plan should be presented to the larger group and interested stakeholders so that the experience and views of others can be taken into consideration.

The Golden Rule for making presentations to stakeholders who are responsible for addressing the rights….. treat the audience in the exact same way that you would like the audience to treat you.

Networking& their usefulness

Networking connects people and some of the advantages of networking are:

- Mobilize resources
- Share information
- Access health, education, livelihoods and other rehabilitation services
- Access government entitlements
- For lobbying and common bargaining
- Build the capacity of the DPO members
- Take up mutually beneficial activities.

Topic 8 Supporting Community Action

Change in the Context of CBID:

CBID is a means to ensure that all persons with disabilities in a village, cluster of villages, Block, District, State have access to all Government Development Programmes on an equal basis with those who do not have a disability. A CBID programme identifies barriers to access and facilitates the removal of these barriers. Of particular interest are inclusion in programmes of health, education, livelihoods and social assistance.

Thus if we are focusing on Change, it is very important to answer the questions – what is the problem one is trying to solve and how will one know that the problem is solved?

The following terms are used to understand Change when a problem is being tackled:

- **Impact :** the long term change brought about in the system *eg* persons with disability are enrolled with a separate job card in MGNREGA.
- **Outcome :** Changes that persons with disabilities are experiencing *eg* admission in schools in their village.
- **Output :** Immediate benefit because of some activity *eg*a child who is blind learning Braille within his village
- **Activity :** A specific intervention that is undertaken *eg*a camp organized for issuing of Disability Certificate.
- **Input :** Resources necessary for doing an activity *eg*Organising the visit of a Doctor to identify and assess persons with mental illness.

Change Agents, Networks, Collaborations:

For Change to take place as outlined above – impact, outcome, output, activity, input the following principles may be followed:

- *Involve Key Stakeholders* : who are the people who can help to solve the problem eg persons with disabilities, parents, community, Government functionaries… These people must be involved from the very beginning.
- *Communicate :*inform key stakeholders all the time. Persons with disabilities and the community must be convinced that the Change will benefit them in very concrete ways.
- *Break It Down :*Think Big, Start Small, Go For an Early Win. Starting small and making a difference which is benefitting people can create more enthusiasm and participation.
- *Identify Key Change Agents :*Among the key stakeholders identify people who can bring about change eg DPO leader, parent, Government official, politician. Advocate, train, keep them informed and motivated.

- *Reinforcement:* Celebrate success, share it, publish it. Let the community know what has happened so that the enthusiasm to continue is further strengthened.
- *Invest in Innovation :*How can technology be used eg Mobile, Apps to ensure documentation, monitoring, evaluation

Leadership for Change:

For bringing about Change among persons with disability, leadership among DPOs is key. A leader should be able to perform in the following areas:

- Express and interpret DPO vision
- Coordinate DPOs activities
- Monitor and improve upon DPO's performance
- Nurture interpersonal relationships
- Ensure active participation of members of DPO
- Provide direction to DPO
- Take initiative in networking and establishing linkages with other organisations.
- Represent the DPO in various platforms.
- Follow democratic values.

Qualities of good leaders who facilitate change:

- Visionary
- Self-starter
- Motivator
- Communicator
- Change Agent
- Risk taker
- Committed
- Responsible

(Refer to previous units for material)

Topic 9 Local Leadership and Groups

Material for this topic has been included in earlier handouts prepared for other Units. Trainers and trainees are expected to refer to web links provided in the detailed session plans.

Professional Behaviour & Reflective Practice

Topic 1 Roles & Responsibilities of CBID Worker

Content:

- Working with individuals and families
- Bringing communities together
- Identifying resources in the community

A. Working with individuals and families:

- **Identification of persons with disabilities and their family members through simple assessment tool**

  CBID worker will identify persons with disabilities through a simple assessment tool. The Washington Group (WG) short set is a set of questions designed to identify persons with disabilities. Detailed Individual Development Plan (IDP) is required to be developed to address barriers faced by people with disabilities. This could be done through individual assessment9s) and an interview.

  CBID worker uses counselling skills to support them better understand and listen to persons with disabilities and their family members. Through active listening, a good rapport is built, trust forms with persons with disabilities and their family members. CBID worker will be referring persons with disabilities to rehabilitation centre, counsellors, psychiatrist as per the requirement.

- **CBID workers understand community:**

  Definition: Community is a group of people who come together to work and live. They are a group of people bonded by the common interest. It is a group interrelated to each other.

  It is important to identify and understand social, economic, physical, political, environmental and demography of community. Knowledge and skills on participatory rural appraisal tools (PRA) and techniques in community development work such as knowledge on entering in community, baseline surveys, appraisal, awareness building, needs and resource

identification, organizing and facilitating, planning, implementation and evaluation.

Community Development is a collaborative, collective action taken by local people to enhance the social, economic, political and environmental conditions of their community.

United Nations definition: Community Development is a process of social action in which the people of a community organized themselves for planning and actions; define their common and individual needs and solve their problems; execute the plans with a maximum of reliance upon community resources; and supplement these resources when necessary with services and materials from government and non-government agencies outside the community and to help people to develop economically and socially viable communities which can assist, strengthen and adequately support individual and family growth and enhance the quality of life.

B) Bringing communities together:

- **CBID workers understand development programme:**

  CBID worker understands the Panchayati Raj Institutions (PRIs), government departments viz. Social Welfare, Health, Education, WASH, Rural Development, Agriculture, horticulture, animal husbandry, Dairy, Sericulture etc.

  In India, the Panchayati Raj now functions as a system of governance in which gram panchayats are the basic units of local administration. The system has three levels: Gram Panchayat (village level), Mandal Parishad or Block Samiti or Panchayat Samiti (block level), and Zila Parishad (district level).

  Disability is a State subject and development worker needs to understand schemes and programs of State. CBID worker understands RPwD Act 2016, National Trust Act, RCI Act 1992 etc. Health, education, rural development, Agriculture and allied departments programs.

- **CBID workers as motivators:**

  CBID worker requires advocacy and networking skills, excellent communication, interpersonal and team building skills. CBID worker should have the ability to good listening skills. He/she should not be judgemental and have an always-positive attitude. Requires creative thinking and problem solving ability. It is important to have compassion and the ability to empathise with people's life experience particularly with people with disability and their family members including women with disability. CBID worker requires to link people with disability and their family members with ongoing government schemes and panchayats system.

  CBID worker has the ability to mobilise the community including persons with disabilities and their family members in facilitating to form Disabled Persons' Organisation (DPO). Disabled person's organizations or DPOs are representative organizations or groups of persons with disabilities, where persons with disabilities constitute a majority of the overall staff, board, and volunteers in all levels of the organization. It includes organizations

of relatives of persons with disabilities where a primary aim of these organizations is empowerment and the growth of self-advocacy of persons with disabilities.

C) Identifying resources in the community

Content:

- Natural Resource Management (NRM)
- Health, Education, WASH and infrastructure
- Community based organisations (CBOs)
- Panchayati Raj Institutions (PRIs)
- Advocacy

CBID worker understand and identifies resources

Definition: Community resources are resources in an area that fulfils the requirement for the people.

Every community has its own needs and assets, as well as its own social and cultural structure. The community has a unique web of relationships, its own history, strengths, weakness, threats and opportunities that define it.

A community mapping supports to uncover not only needs and resources but also the underlying culture and social structure that will support a CBID worker to understand how to address the community's and individual needs and utilization of its resources.

Community resources or asset is anything that can be used to improve the quality of community life. It can be a person, community leaders, respected community member who can be empowered to realize and use their abilities to build and transform the community. Physical structure or place viz. a school, hospital, *panchayat ghar*, rehabilitation & therapy centre. It can be a community service that makes life better for some or all community members - public transportation, early childhood education centre, community recycling facilities, cultural organization. It can be a small or big business that may provide jobs and supports persons with disabilities and their family members.

Mapping will encourage community members to understand the community's assets and about the utilisation. Consideration of resources is the first step in their learning how to use their own resources to solve problems and improve community life. CBID worker need to have knowledge of tools for identifying community resources in the community. Generally, available resources are taken for granted and need to be highlighted when a community is trying to solve a problem or meet a need. Tools and several methods used in community mapping profiling; community mapping, community calendars, transect walk and semi-structured interview, focus group discussions.

CBID worker requires identifying existing Self Help Groups, Farmers Interest Groups and Joint Liability Groups along with various community based organisations in the community. Including persons with disabilities and their family members in the community based institutions will possible to mainstream

disability in development. It is important to understand the funds, function, functionaries, and system of PRIs.

Definition: Advocacy is an act, which supports the desired change, which we want to see.

An ability to conduct networking with various government departments, PRIs, CBOs, institutions etc. Advocacy is one of the key requirement for mainstreaming disability in development. Purpose of advocacy to empower, speak up, safeguarding, enabling and supportive for the persons with disabilities and their family members. Basic knowledge is important on disability laws and entitlements, working of institutions, information on key decision makers, facts & status, barriers and solutions and existing resources

Topic 2 Limits to the Role of a CBID Worker

Content:

- Cultural and personal boundaries
- Define boundaries of role
- Define own limitations

Introduction:

CBID workers should be aware of the cultural beliefs, customs, rituals, systems & practises of the community & social groups with which she/he is working. They should learn to respect the values & believes. They should know what behaviour is accepted & what is not accepted. They should not make any comments, fun & acts which hurts the believes & value systems of that community. Always accept people & respect everybody unconditionally. Use respectful language with non-discriminatory attitude. Respect people irrespective of their class, caste, religion, race, colour, creed, gender, affiliations, language, ethnicity, education, region, age, sex, position & disability. Everybody should be treated with dignity, equality & friendliness particularly aged people, women, children. The CBID workers should not bring their personal egos into professional working relations.

Dos

- Use appropriate language when you address to person with disabilities, call them with names & speak to the person directly & not to the family member.
- Do make appropriate referrals for specialized treatment & rehabilitation services
- Speak with encouragement, motivate, give good guidance, good examples & success stories of persons with & without disabilities
- Do respect the village, community leaders & show acceptable behaviour, talk politely, respect their personal time & space.
- Have a proper dress code based on the local culture.
- Do good observations in the community.
- Do take permission before entering the houses, ask persons with disabilities, family members & community members if they have time to speak,
- Be a good listener and listen to them without prejudice, thank them for their contributions, support & cooperation.
- If you have no info about something, then accept & tell the community / individual that you have no info about this and will get back to them.
- Do ask for information if you don’t know

- Your attitude should not become a barrier in the development of the community/ individual.
- Do express challenges faced by you as a person with disability & how you overcame them, specially, as a woman with disability.
- Accepting Tea/coffee & water is ok as it is minimum hospitality in any culture.
- Do good use of your time & establish good relationship with persons with disabilities, families, community members.
- Do learn skills & knowledge of how & what the community does about their development
- Do read & sign code of conduct, know about child & adult safeguarding policy
- Do read & sign policy & code of conduct - prevention of sexual harassment of women at work place
- Do take support for mobility if you are person with disability from community members
- Do learn local sign language as this will help you to interact with persons with speech & hearing impairment
- Mobilise families & communities for promoting disability inclusion & development.
- Create awareness about disability & importance of participation of persons with disabilities in the society
- Generate awareness & motivate family members & community about non-discrimination, not to show negative attitudes towards persons with disabilities without challenging or hurting anybody

Don'ts

- Do not provide medical & rehabilitation services by yourself, particularly providing medicines, physiotherapy, speech therapy, occupational therapy, vocational therapy, rehabilitation -fitting of aids & appliances, sign language etc.
- Do not project yourself as a medical Doctor / paramedic or rehabilitation expert in the field for gaining fame or monitory benefits.
- Do not use the words like CP, MR, OPH, HI, deaf & dump etc
- Avoid touching people while interacting, especially with opposite sex & other genders, which is not accepted.
- Do not touch, change place nor use assistive devises like crutches, canes, hearing aids, wheel chair, walker, without permission of a person with disability.
- Do not speak loudly to a visually impaired person as they can hear, do not talk loudly into a hearing aid of a person with hearing impairment as it is disrespecting them.
- Do not take photos of persons with disability without written permission from person with disability, or from family if it is a child.

- Photographs should not show disability of person.
- Do not disclose the name of person in a success or failure story especially to outsiders, or do not share photos without prior written permission,
- Do not use any religious quotes or politically coloured statements while talking or facilitating group meetings
- Do not indulge in discussions relating to caste, colour, creed, gender, religion, and no teaching of any religious prayers etc.
- Do not enter the houses in odd timings unless it is real need & emergency
- Do not accept any gifts, favours, produces, money from persons with disabilities and their families
- Do not use / convey negative thoughts, feelings & messages, & false information
- Do not speak anything that disturbs / breaks the relationships & damages the person & his/her families.
- Do not wear culturally inappropriate dress, jewellery
- Do not use laptops, cameras, books, pen & mobile phones in front of new / unknown people in the community
- Do not impose your decisions rather help / facilitate a person to take his / her own decisions example for undergoing physiotherapy, surgery, appliances etc.
- Do not go with a attitude that i know everything
- Do not intrude into the personal space of a person with disability
- Do not make false promises, tell what you know, what you do not know
- Do not lose confidence in & with people
- Do not express political egos, caste egos, etc.

Topic 3 Impact of Personal Frameworks on Role

Content:

- Impact of trainee's gender, religion, caste, family, educational, socioeconomic on their understandings of disability.

Introduction:

Personal understanding of disability

The CBID worker should first and foremost understand that along with the impairment of the person, there are other social, cultural and economic barriers which are a hindrance to the empowerment of a person with disability. These barriers may prevent the CBID worker himself/herself who may be in the same position to proceed with the rehabilitation work. Some areas where the personal knowledge and perception of persons with disabilities by CBID worker.

- Understanding of the concept of disability
- Knowledge & skills to identify the needs of persons with disabilities
- Understanding of the social situation of the family and the attitude of community towards persons with disabilities.
- Community resources available
- Understanding the cultural practices within the community.

Perception	Inputs to change perception
Perception of disability by a CBID worker	
• A person's disability is due to the curse/sin on the family	It is a health issue and not a curse – disability caused due to marriage within relations, lack of proper nutrition during pregnancy
• Disability cannot be cured or prevented	Can be cured by assessing the extent of disability and identify if it can be cured with the right interventions for the respective disability (can mention the list of disabilities in random) at the appropriate age through the respective professional.
• A person with disability cannot work, cannot travel outside home	Give examples of people working and what necessary adaptations have been made at the workplaces to accommodate a person with disability (click references below)

Perception	Inputs to change perception
• A child with disability cannot go to school	Explain the importance of education for all children irrespective of the disability A child with disability can attend school and the school infrastructure made accessible to accommodate children with disabilities. Adaptation in the teaching methodology by teachers to teach children with disabilities with adaptive teaching learning materials could be explained. The existing government support towards the education of children with disabilities could also be informed. Give examples of children who are studying and the (site the RPWD Act 2016 – chapter 3)
Perception of Gender and disability:	**(site the RPWD Act 2016)**
• A woman with disability cannot get married and give birth to children	Give examples of women with disabilities who have married and also excelled in their profession _ Eg: Sudha Chandran - Dancer (give local examples if available)
• A man with disability can work but not a woman	Same as above and also other examples of women at work. How adaptations are made at the office to accommodate persons with disabilities 
• A women or man with disability confined to homes and cannot participate in any auspicious event within the family or community	(site the RPWD Act 2016 – chapter 5 – 29) give local examples of persons with disabilities participating in social and cultural events in the community. CBID worker to communicate that many times the participation in social events within and outside family would gradually remove the stigma.
• Religion and caste a barrier for empowerment of persons with disabilities.	Community interaction and sensitization and involvement of the community is a means to address these sensitive issues.
• Only upper caste people get all facilities	Community mobilization and sensitization of locals and policy makers has made a change and reservations are available for persons with disabilities and those of the different castes – awareness to be created in the community.

Lived / shared experience of disability – case story presentation

Anjali and Ramu, sister and brother, both with locomotor disability affected by polio. Parents are daily wage earners and from an upper caste family, Ramu is sent to school using the limited resource the family had earned. In spite of the school being far, the mother or father carries Ramu to the school. Parents were concerned about Ramu's education and never bothered to send Anjali to school. One reason because she is a girl with disability and another is they will have to choose between the two for using the resources for education and they choose Ramu since he is going to take care of the family in future. Therapy was out of question for both the children as the father could not afford. Parents discuss about Ramu's marriage after his education and employment, while they say Anjali can sit at home along with them since nobody will marry her and the relatives have already said that Anjali need not go to school. This is when the CBID worker enters the community and tries to talk to parents of all the children with disabilities in the community.

Personal Reflection:

Based on the above case story, analyze the below scenarios on how the CBID worker's focus is the client and not his/her situation:

1. The CBID worker finds out that both the children require therapy, but he/she cannot do it because he/she is not a skilled therapist (or) he/she is from a lower caste and/(or) a different religion, so the family gives excuses to avoid the worker coming.
2. The family depends on the daily wage of the father and cannot afford for any therapy or rehabilitation to the children
3. The CBID workers is from an upper caste and hesitates to enter a house of a lower caste family which has children with disabilities
4. CBID worker realizes that the girl is not sent to school and does the household chores while the boy has been educated.

Possible outcomes with the client being the core of the intervention:

- **Scenario 1, 3:** The CBID worker finds out that both the children require therapy but he/she cannot do it because he/she is from a lower caste and a different religion.

The CBID worker should not refrain from going to meet this family, rather could take the support of another colleague who is a therapist and also from the same caste and religion as that of the family in order to make them understand that these are not barriers when they work together towards the rehabilitation of the children. Importance of assessment of the children in order to provide the right therapy to be explained. Could follow the two adult rule during therapy and to have one of the parent during the therapy sessions for the girl.

If the above situation is not feasible, try to talk to the community leaders on the severity of the disability in the long run in order to get the children for therapy on a regular basis and follow the same process of assessment and therapy for the children through the colleague.

- **Scenario 2:** The family depends on the daily wage of the father and cannot afford for any therapy or rehabilitation.

The CBID worker himself/herself should explain either individually or through the community leader or his/her colleague and state that he/she realizes the economic burden in the family which prevents them from treating the children and also mention the opportunities available for the mother and also for the father. The CBID worker could first try and explain the need for getting the disability certificate and the facilities available when the children have their disability certificate. Support in getting the certificate which will in turn help the family get a maintenance grant/disability pension which will be an additional support to the family and the therapy for children. The CBID worker could support the mother of the family to get connected to a self-help group.

- **Scenario 4:** CBID worker realizes that the girl is not sent to school and does the household chores while the boy has been educated.

After the therapy and the economic support to the family the CBID worker by now has gained the confidence of the family in spite of his/her gender/caste/religion. So now he/she is able to find the space to talk to the family on the importance of educating the girl child. Identifies a school closer to the house and speaks to the school authorities to admits the child in the school and assures of therapy for the girl on a regular basis.

Conclusion:

Community Based Inclusive Development is a possible solution for all the above barriers. Bringing all stakeholders in the community – people with disabilities, family members, self-help groups, disabled people's organizations, community members, local authorities, panchayat leaders, village leaders to be sensitized and involve all stakeholders in all interventions would give a sense of responsibility.

References:

https://en.wikipedia.org/wiki/Javed_Abidi
https://www.thebetterindia.com/16449/famous-indians-with-disability/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4256815/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4367071/

Topic 4 Workplace Laws and Policies

Content:

- Child protection laws
- Safeguarding children and adults at risk
- Prevention of Sexual Harassment at Workplace (POSH)

Session Name: Child Protection Laws

Overview of the Protection of Child Rights Act, 2005, Protection Of Children from Sexual Offences Act, 2012, the structure under which it is enacted.

The Commissions for Protection of Child Rights Act 2005 was enacted by India in order to protect the child rights in India. Under this law, there is provision for establishment of National Commission and State Commission for protection for child rights. The NCPCR and SCPCR has statutory powers in matters of child rights violation in India. They have a full time chairman and other expert group members. The commission has power to investigate any complaints received and it works as semi-judicial authority as well.

The Protection of Children from Sexual Offences (POCSO) Act, 2012 deals with sexual offences against persons below 18 years of age, who are deemed as children.

This act is applicable to the whole of India and provides protection to children under the age of 18 years against sexual offences.

The Act defines sexual abuse as – "penetrative and non-penetrative assault, as well as sexual harassment and pornography, and deems a sexual assault to be "aggravated" under certain circumstances, such as when the abused child is mentally ill or when the abuse is committed by a person in a position of trust or authority vis-a-vis the child, like a family member, police officer, teacher, or doctor."

As per international child protection standards, the Act also casts a legal duty upon a person who has knowledge that a child has been sexually abused to report the offence; if he or she fails to do so, he/ she may be punished with imprisonment and/ or a fine.

Brief introduction to other Acts mentioned under the focus area.

Constitutional provisions for children in India

- Several provisions in the Constitution of India impose on the State the primary responsibility of ensuring that all the needs of children are met and that their basic human rights are fully protected.
- Children enjoy equal rights as adults as per Article 14 of the Constitution. Article 15(3) empowers the State to make special provisions for children.

- Article 21 A of the Constitution of India directs the State to provide free and compulsory education to all children within the ages of 6 and 14 in such manner as the State may by law determine.
- Article 23 prohibits trafficking of Human beings and forced labour.
- Article 24 on prohibition of the employment of children in factories etc, explicitly prevents children below the age of 14 years from being employed to work in any factory, mine or any other hazardous form of employment.
- Article 39(f) directs the State to ensure that children are given equal opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and guaranteed protection of childhood and youth against moral and material abandonment.
- Article 45 of the Constitution specifies that the State shall endeavour to provide early childhood care and education for all children until they complete the age of 6 years.
- Article 51A clause (k) lays down a duty that parents or guardians provide opportunities for education to their child/ward between the age of 6 and 14 years**.**
- Article 243 G read with schedule-11 provides for institutionalizing child care to raise the level of nutrition and the standard of living, as well as to improve public health and monitor the development and well-being of children in the Country.

The Right to Education Act 2009 – This Act make education as a fundamental right for children up to age of 14 years. The RTE Act has several provisions for providing free and compulsory education to all children. Later on the Act was amendment for provisions related with children with disabilities in mainstream schools.

The Juvenile Justice Act 2015 came into effect in 2016. The objective of the Act is to focus on the issues related with children in conflict with law and also for vulnerable children in need of care and protection. The juvenile need a separate judicial process if they are in conflict with law. It has provisions for establishment of Juvenile Justice Board and Child Welfare Committee at district level.

Protection of Children from Sexual Offences Act, 2012 safeguard child from sexual abuse. As per NCRB report, the child abuse in India has increased a lot and there was need for separate law for dealing such issues. The POSCO Act have very strict provisions for punishing the culprits of child abuse and save children below the age of 18 from sexual offences.

Roles and responsibilities of the Commission for Protection of Child Rights Act 2005, at the Central and State levels.

Levels constituted by the State Commission to for redressal of child protection issues at the village level and their functions.

Functions of NCPCR and SCPCR as mentioned in the Act

1. Examine and review the safeguards provided by or under any law for the protection of child rights

2. Inquire into violation of child rights and recommend initiation of proceedings in such cases
3. Examine all factors that inhibit the enjoyment of rights of children affected by terrorism, communal violence, riots, natural disaster, domestic violence, HIV/AIDS, trafficking, maltreatment, torture and exploitation, pornography and prostitution and recommend appropriate remedial measures
4. Look into the matters relating to the children in need of special care and protection
5. Study treaties and other international instruments and undertake periodical review of existing policies, programmes and other activities on child rights.

Focus areas of the Commission are as below.

a) Child Rights
b) Right To Education
c) Juvenile Justice
d) Street Children
e) POCSO
f) any other

Understanding importance of the law for CBID worker while functioning at the community level.

The CBID worker shall have knowledge of the constitutional and legal provisions related with child protection, safeguarding and welfare. Since the CBID staff work in the field, among the community, he or she is the frontline worker. As a frontline worker, CBID worker must have knowledge about the child rights and related laws. CBID worker can educate and empower community on child rights issues. Apart from this if there is any violation of child right in the project area, the CBID worker shall and must help community to take actions as per various relevant laws on child rights.

Government of India: Acts related to children:
https://www.ncpcr.gov.in/index1.php?lang=1&level=0&linkid=18&lid=588

Draft National Child Protection Policy Dec 2018:
https://wcd.nic.in/sites/default/files/Download%20File_1.pdf

Session Name: Safeguarding of children and adults at risk
Learning Outcomes to be Achieved: will help the learner to interpret and abide by key rules and regulations that govern the conduct of the CBID worker (both related to the institution and community)

The responsibility & obligation to Safeguarding - Raising awareness about the value of safeguarding and about the session

Few facts as background information for CBID worker.

There are 472 million children in India under the age of 18 years, representing 39% of the country's total population. A large percentage, 29% of that figure constitute children between the ages of 0 to 6 years. There are 10.13 million child labourers between 5-14 years in India (Census 2011)

Child Protection & Child Safeguarding

To define/differentiate the scope of child protection and child safeguarding

Safeguarding of children: A set of organisational policies, procedures and practices designed to ensure that no harm comes to people as a result of contact with an organisation's programmes, operations or people.

Child Protection: Child programmes, projects and advocacy measures designed to protection is a programming approach involving prevent and respond to abuse, exploitation, neglect and violence against children. It generally focuses on risks and issues caused externally to the organisation, while safeguarding focuses on those caused internally.

The CBD worker shall also look into the emotional and nutritional component of a child during her/ his visit to household.

Child Abuse and its symptoms

To understand what constitutes abuse and how to identify abuse

Child abuse consists of anything that individuals, institutions or processes do or fail to do that directly or indirectly harms children or reduces their prospect of safe and healthy development into adulthood.

In order to identify abuses, there are different tools have been developed by different organisations working on child rights. These tools for identifying child abuses, risk and risk assessment in any organisation or place. Based on this a set of preventive actions can be taken.

Child Safeguarding Standards

1. **Policy:** There should be a child safeguarding policy in an organisation.
2. **People:** A committee shall be formed to look into the measures for child safeguarding in an organisation and its projects. The capacity building of staff must be done on child safeguarding as well.
3. **Procedures:** There should be a well-defined procedure for grievance redress in organisation. Any complaints related to violation of child safeguarding, should be discussed only in designated committee and the identity of child shall not be revealed to people.

Accountability: The responsive action is a must for implementation of child safeguarding policy. The incident management system should be accessible. The safeguarding focal person shall ensure that the office has safeguarding resource and updated referral list.

Contact with children: Ensure physical contact is at times appropriate. A list of 'Do" and 'Don't' shall be developed for staff and employee.

The training organization child protection policy and framework. This is to give them an understanding for their subsequent field work and how to put something in place if they later work where there are no such policies.

Summary and clarifications

The CBID worker shall have understanding and knowledge of Panchayati Raj institutions at grass root level and also visit child helpline of the district for any further support.

References:

Children and Adults at Risk – Safeguarding policy of CBM
https://cbmindia.org.in/e-update-files/CBM-Child-Safeguarding-Policy.pdf

Session Name: Prevention of Sexual Harassment at Workplace (POSH)
Learning Outcomes to be Achieved: will help the learner to interpret and abide by key rules and regulations that govern the conduct of the CBID worker (both related to the institution and community)

Introduction to raise awareness about gender issues and discrimination.

What is? Sexual Harassment and Gender Discrimination

Workplace sexual harassment is a form of gender discrimination which violates a woman's fundamental right to equality and right to life, guaranteed under Articles 14, 15 and 21 of the Constitution of India.

The Supreme Court has defined sexual harassment as any unwelcome, sexually determined physical, verbal, or non-verbal conduct. Examples included sexually suggestive remarks about women, demands for sexual favours, and sexually offensive visuals in the workplace.

The definition also covers situations where a woman could be disadvantaged in her workplace as a result of threats relating to employment decisions that could negatively affect her working life.

- **Dimensions and types of SHWP**

  - **Concept and importance of prevention of SHWP**

    Sexual harassment at the workplace has always been one of the central issues of the women's movement in India since a long time. In the earlier times, women experiencing sexual harassment at workplace had to file a complaint under Section 354 of the Indian Penal Code that dealt with the charges of criminal assault of women for outraging her modesty, and Section 509 which punished for using a word, gesture or act intended to insult the modesty of a woman. The elimination of gender-based discrimination has been one of the fundamentals of the

Constitutional edifice of India.

- **Background to Vishaka Guidelines and other important judicial pronouncements**

  The Vishaka guidelines were laid down by the Supreme Court in ***Vishakha and others v State of Rajasthan*** judgment in 1997. It imposes three key obligations on employing institutions - prohibition, prevention, and redress. The institutions are mandated to establish a Complaints Committee. This was to look into matters of sexual harassment of women at the workplace. These guidelines are legally binding.

Introduction to

- **Sexual Harassment Of Women At Workplace (Prevention, Prohibition And Redressal) Act, 2013**

  Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013, has been enacted by the Government of India, to end all forms of violence against women and supporting women to live with dignity.

- **Relevant provisions in the Act (with or without Service Rules)**

  Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act was passed in 2013.

- Sexual harassment is any one or more of "unwelcome acts or behaviour", committed directly or by implication.

- **They include:**

  i) Physical contact & advances

  ii) A demand or request for sexual favours

  iii) Sexually coloured remarks

  iv) Showing pornography

  v) Any other unwelcome physical, verbal or non-verbal conduct of sexual nature

- Additionally, the Act mentions five circumstances that amount to sexual harassment:

  1. implied or explicit promise of preferential treatment in her employment
  2. implied or explicit threat of detrimental treatment
  3. implied or explicit threat about her present or future employment status
  4. interference with her work or creating an offensive or hostile work environment
  5. humiliating treatment likely to affect her health or safety

IC Team:

- **ICC** - Every employer must constitute an Internal Complaints Committee (ICC) at each office or branch with 10 or more employees.

- For the ICC to act, it is not compulsory that the victim must write a complaint.
- If the woman is unable to make a complaint on account of her "physical or mental incapacity or death or otherwise", her legal heir may do so.
- The identity of the woman, respondent, witness, any information on the inquiry, recommendation and action taken should not be made public.

Fair Procedure:

Each employee has the right to a respectful workplace. Sexual harassment of any kind at workplace prevents the individual from work at his/her best abilities. It affects the person physically, emotionally and socially. Some of them may experience trauma in the form of stress, anxiety, headache, sleep disorders, lose confidence, low self-esteem, and may have far reaching consequences. Therefore, sexual harassment at workplace is not to be regarded as a minor issue.

SHWWP Act, 2013 in the light of Service and Conduct Rules

After the enactment of the 2013 Act and the 2013 Rules, it is now made very clear that the concerned Disciplinary Authority has to follow the Service Rule provisions to reach the finality of a proceedings initiated against a proven act of sexual harassment. We may, therefore, look at various aspects of two of the most prominent service rules in operations in the government sector, in the light of the provisions made in the 2013 Act and the 2013 Rules and try to make out the procedural steps as prescribed by the Department of Personnel & Training, Government of India.

The implementation of the law by employers, in letter and spirit, begins with the constitution of the complaints committee, and encouraging women to report sexual harassment in the workplace. The law imposes a duty on the complaints committee, to conduct an inquiry on receiving a complaint, and this write up expounds upon how to conduct an inquiry, what are the principles to be followed in conducting an inquiry; and the different stages in conducting the inquiry following principles of natural justice, in which both parties are given an opportunity to be heard.

The Act in Section 11 provides two different procedures to be followed for conducting an inquiry- if the respondent is an employee then the inquiry shall be conducted in accordance with the service rules; and where no service rules exist then the inquiry shall be held as per manner prescribed in the Rules; or in the case of a domestic worker, the LCC shall forward the complaint to the police, within seven days for registering the case under section 509 of the IPC, and any other relevant provisions of the said Code. This write up focus on inquiry into complaint when Respondent is Government employee.

Awareness of the IC team available for the CBID workers

- **SHe-Box:** The ministry of women and child development has set up what it calls the Sexual Harassment electronic–Box (SHe-Box), an online complaint system for registration of complaints related to sexual harassment at workplace. This can be used by employees of the government and private sectors.

- **List of extended workplace**

  As per the Act, workplace includes:

  - Government organizations, including Government company, corporations and cooperative societies;
  - Private sector organisations, venture, society, trust, NGO or service providers etc. providing services which are commercial, vocational, educational, sports, professional, entertainment, industrial, health related or financial activities, including production, supply, sale, distribution or service;
  - Hospitals/Nursing Homes;
  - Sports Institutes/Facilities;
  - Places visited by the employee (including while on travel) including transportation provided by employer;
  - A dwelling place or house.
  - To show practical examples of SHW incidents we may face.

References:

https://wcd.nic.in/act/sexual-harassment-women-workplace-preventionprohibition-and-redressal-act-2013
http://www.shebox.nic.in/
https://cbmindia.org.in/e-update-files/CBM-Policy-on-POSH.pdf
https://www.sashaindia.com/index.php/elearning

Topic 5 Code of Conduct, Consent and Confidentiality

Content:

- Introduction to report writing
- Components of a report
- Database management system or simple files
- Comprehensive development plan for an individual client
- PRA Report
- Maintenance of reports by SHGs and DPOs

Introduction

A report is a written presentation or description of realistic information based on a study or research. Reports form the basis for solving problems or making decisions. The length of reports varies; there are short reports and long reports.

Following are the points make effective report

- Clear and accurate
- Easy to understand
- Appropriate for the people who read
- Well content and clear headings

Component of a report:

Reports follow a standardised format based on the needs. This allows the reader to find the information easily and focus on specific areas. Most reports also follow certain structure, but please look at your assignment and make report accordingly.

- Title of the report
- Table of Contents
- Introduction (or Terms of Reference and Procedure)
- Progress of the activities
- Disability inclusion, gender and child safeguarding
- Findings and/or Discussion
- Conclusions
- Recommendations and/or
- Reference

The major part of the report will consist of the Introduction, Findings and/or Discussion, Conclusions, and Recommendations.

Database management system

Survey details in excel format to maintain at project level

Comprehensive development plan for an individual client

Comprehensive development plan is essentially planning document that identifies what your goals and objectives are for a particular period. Although there are many different ways to create an individual development plan, overall it can be divided into 3 steps:

Step-1 **Identify goal**	**Step-2** **Break down goal into SMART objectives or actions**	**Step-3** **Monitor or evaluate the progress at regularly**
Make a list of goals that you would like to achieve. Examples: The child will able to walk with support	Training of parent to support child Home base 1 hr physiotherapy services by parent Daily exercises	Weekly monitoring Fortnightly Monthly basis

PRA Report

Rapid Rural Appraisal (PRA) report, started in mid 80's. PRA mostly focus on the empowerment of people through participatory approaches.

It is a participatory method to collect information or data by local communities for decision-making and implementation of development programme.

Steps for PRA

- Transects- systematic walks and observation
- Informal mapping-
- Draw diagram
- Assessment

Reports to be maintained by SHGs and DPOs/OPDs

Self Help Groups (SHGs) are involved in various economic and social activities, which is important for their empowerment process. SHGs ensure people's participation in the development process.

SHGs have their own agenda, rules and regulations and have their own system of functioning.

The following are the records maintenance by SHG:

- Meeting book
- Copy of Rules & Regulations
- Application forms for membership
- Attendance register
- Receipts and Payments Register
- Savings and Loan register
- Individual Pass Book
- Individual loan application
- Bank pass book

Reports to be maintained by DPOs/OPDs

Disabled person's organizations (DPOs) or Organization of persons with disabilities (OPDs) are the associations of persons with disabilities to promote self- representation, advocacy, participation, equal opportunity and mainstreaming persons with disabilities in development process. DPO's play a major role in bringing social change in society. DPOs not compulsory to registered under any Act and function independently like a Non-government organisations. There are network of ODPs on a block level to national and international level and have importance role in the development of the persons with disabilities. All the records and reports about the activities and programme conducted by DPOs.

The following are the records maintenance by DPO/OPDs:

- Meeting book
- Rules and regulation (by-law)
- Copy of registration (if registered under any Act)
- Annual action plan
- Attendance register
- Membership forms
- Copy of the national and international laws related persons with disabilities
- National and state specific GOs (Government Orders)
- Correspondence file
- Savings and Loan register Cash Book (if operating as SHGs/going for saving/loans)
- Bank and individual pass book (if operating as SHGs)
- Individual loan registered (if DPO going for saving and loans)

Topic 6 Reporting Formats

Content:

- Introduction to report writing
- Components of a report
- Database management system or simple files
- Comprehensive development plan for an individual client
- PRA Report
- Maintenance of reports by SHGs and DPOs

Introduction

A report is a written presentation or description of realistic information based on a study or research. Reports form the basis for solving problems or making decisions. The length of reports varies; there are short reports and long reports.

Following are the points make effective report

- Clear and accurate
- Easy to understand
- Appropriate for the people who read
- Well content and clear headings

Component of a report:

Reports follow a standardised format based on the needs. This allows the reader to find the information easily and focus on specific areas. Most reports also follow certain structure, but please look at your assignment and make report accordingly.

- Title of the report
- Table of Contents
- Introduction (or Terms of Reference and Procedure)
- Progress of the activities
- Disability inclusion, gender and child safeguarding
- Findings and/or Discussion
- Conclusions
- Recommendations and/or
- Reference

The major part of the report will consist of the Introduction, Findings and/or Discussion, Conclusions, and Recommendations.

Database management system.

Survey details in excel format to maintain at project level

Comprehensive development plan for an individual client

Comprehensive development plan is essentially planning document that identifies what your goals and objectives are for a particular period. Although there are many different ways to create an individual development plan, overall it can be divided into 3 steps:

Step-1 **Identify goal**	**Step-2** **Break down goal into SMART objectives or actions**	**Step-3** **Monitor or evaluate the progress at regularly**
Make a list of goals that you would like to achieve. Examples: The child will able to walk with support	Training of parent to support child Home base 1 hr physiotherapy services by parent Daily exercises	Weekly monitoring Fortnightly Monthly basis

PRA Report

Rapid Rural Appraisal (PRA) report, started in mid 80's. PRA mostly focus on the empowerment of people through participatory approaches.

It is a participatory method to collect information or data by local communities for decision-making and implementation of development programme.

Steps for PRA

- Transects- systematic walks and observation
- Informal mapping-
- Draw diagram
- Assessment

Reports to be maintained by SHGs and DPOs/OPDs

Self Help Groups (SHGs) are involved in various economic and social activities, which is important for their empowerment process. SHGs ensure people's participation in the development process.

SHGs have their own agenda, rules and regulations and have their own system of functioning.

The following are the records maintenance by SHG:

- Meeting book
- Copy of Rules & Regulations
- Application forms for membership
- Attendance register
- Receipts and Payments Register
- Savings and Loan register
- Individual Pass Book
- Individual loan application
- Bank pass book

Reports to be maintained by DPOs/OPDs

Disabled person's organizations (DPOs) or Organization of persons with disabilities (OPDs) are the associations of persons with disabilities to promote self- representation, advocacy, participation, equal opportunity and mainstreaming persons with disabilities in development process. DPO's play a major role in bringing social change in society. DPOs not compulsory to registered under any Act and function independently like a Non-government organisations. There are network of ODPs on a block level to national and international level and have importance role in the development of the persons with disabilities. All the records and reports about the activities and programme conducted by DPOs.

The following are the records maintenance by DPO/OPDs:

- Meeting book
- Rules and regulation (by-law)
- Copy of registration (if registered under any Act)
- Annual action plan
- Attendance register
- Membership forms
- Copy of the national and international laws related persons with disabilities
- National and state specific GOs (Government Orders)
- Correspondence file
- Savings and Loan register Cash Book (if operating as SHGs/going for saving/loans)
- Bank and individual pass book (if operating as SHGs)
- Individual loan registered (if DPO going for saving and loans)

Topic 7 Work Targets

Content:

- Introduction to work plans
- Work plans for a CBID worker
- Work plan for an intervention/event/task

Scope of work plan

An agreement of the work to be performed that includes

- Deliverables
- Time line
- Milestones
- Reports

Introduction to work plans

A work plan is a set of goals and processes by which a team can accomplish those goals. A work plan breaks down all the tasks, and assigns different items to specific project members, providing them with individual timelines. It helps project managers to oversee the big picture while managing smaller project parts.

Identify the goal for your work plan

Write a background or intro
Define the objectives

SMART- concept for setting the right goals and objectives may be really helpful.

- **S-Specific.** What exactly are we going to do for whom?
- **M-Measurable**. Is your objective quantifiable and can you measure it? Can you
- count the results?
- **A-Achievable**. Can you get it done in the time allotted with the resources you
- have?
- **R-Relevant.** Will this objective have an effect on the desired goal or strategy?
- **T-Time bound**. When will the objective be accomplished? When will you know you are
- done?

The work plan will help CBID worker to ensure what has planned, what need to be done and the achievement in programme implementation.

Why prepare work plan

A work plan is important because it is the foundation for helping the project objectives and achieve ultimate goals. Having a plan helps to define the full scope of a project but it also helps you stay focused, set goals and objectives, meet deadlines, measure indicators and debrief the entire project.

Work plan help us to:	Work plan help us to reduce:
• Think ahead and prepare for the future • clarify goals • Identify issues that will need to be addressed • Choose between options consider • Make the best use of resources Motivate staff and the community Assign resources and achieve the best results	• poor planning • overambitious goal • undefined problems • unstructured work plans

The Structure and Content of a Work Plan for a CBID worker

It is an outline of a set of goals and processes by which a CBID team and/or CBID worker can accomplish those goals, this will also help to break down a process into small, achievable tasks and identify the things to achieve.

The following are the point should be taken into consideration

- Partnerships among people in the community (community partnership)
- Budget
- Close alignment with the community's need

Date/Timing	Task/ action to be taken	Responsible persons	When to be completed	Status

Identifying risks and assumptions to complete the work plan

Every project has the potential to run into challenges that can delay progress and successful completion. Therefore, it is necessary to identify potential challenges and develop a contingency plan

Risk/ Assumption	Mitigation

Importance of monitoring and review

Monitoring help to keep track of all activities including team performance in a particular duration, identify potential programme/challenges and taking corrective action to ensure that the project is within scope, on budget and meets the specific deadlines.

Introduction to preparing work plan for an intervention/event/task

A work plan is a written document designed to streamline a project. The goal is to create a visual reference for the goal, objectives, tasks and who is responsible for each area.

Overall Workplan

Results	Activity/event/task	Completion Date by Quarter											
		Year 1											
		Q1			Q2			Q3			Q4		
		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Result 1	1.1												
	1.2												
	1.3												
	1.4												
Result 2	2.1												
	2.2												
	2.3												
	2.4												

Work plan for a CBID project

Project No.		
Developed by		
Working Title		

Results	**Activity**	**Person Responsible**	**Year 1**			
R1: Survey, Capacity Building & sensitization	**Training of CBR Personnel**		**Q1**	**Q2**	**Q3**	**Q4**
1.1	Training of CBR Workers for 6 months @ Rs.15000.00 per person for 8 person 1st year & 6 persons in 2nd year					
1.2	Monthly Review Cum Training of CBR Workers @Rs.600.00 /monthly review meeting for 6 months in 1st year, 12 months in 2nd year & 12 months in 3rd year					
1.3	Training/Exposure Visit of Staff @ Rs.2500.00 for 4 persons in 1st year & 4 persons in 2 nd year					
1.4	Community level Meetings- Central village level for awareness building among PWDs, their parents/ carers and other stakeholders @Rs.100.00/ meeting for 20 meeting in 1st year, 30 meeting in 2nd year and 30 meetings in 3rd yr					
1.5	Awareness Material collection, preparation and dissemination of orders, notifications, schemes and legal materials concerned to PWDs @ Rs.1500.00/month for 8 months in 1st year, 12 months in 2nd year & 12 months in 3rd year					
1.6	Folk Media Programmes for sensitisation @Rs.400.00/show for 10 shows in 1st year, 15 shows in 2nd year & 15 shows in 3rd year					
1.7	Information Bulletin/Newsletter-Quarterly @ Rs.15.00/ copy for 1000 copies in 1st year, 1000 copy in second year & 1000 copy in third year					

Topic 8 The CBID team

Content:

- Needs of persons with difficulties and the roles of various specialists to meet those needs.

Needs of persons with disabilities:

People with disabilities have the same needs we all do and has the same wants, dreams, and desires as anyone else. While some health conditions associated with **disability** result in poor health and extensive health care **needs, others do** not.

To empower people with disabilities, the active involvement of various stakeholders such as health professionals, special educators, rehabilitation professionals, family members, persons with disabilities themselves etc., is important. Since every individual with disabilities has, different rehabilitation needs, it is important to identify the needs in consultation with persons with disabilities and their family members. To explore the roles of the people involved in the rehabilitation process, a stakeholder analysis to be carried out along with individual need analysis.

Members of the Rehabilitation Team and their roles:

Persons with disabilities: should always be at the centre of the team and any planning or decision making concerning them.

Family members of persons with disabilities: essential for them to be involved if rehabilitation is to be successful.

Occupational Therapist: Assist in complete rehabilitation of the person with disability. Supports in the early identification of children with disabilities. Work with functional and vocational (work related) problems.

Physiotherapist: Work with physical and movement problems. Assist health teams, CBR workers, and community health workers in the delivery of rehabilitation services to people in rural communities.

Audiologist: health-care professional specializing in identifying, diagnosing, and treating hearing or balance problems

Speech and Language Therapist: work with speech, communication and feeding problems

Orthotist: assess for, fabricate and fit assistive devices and other rehabilitation aids

Prosthetist: assess for, fabricate and fit artificial limbs

Doctor: may give a diagnosis, carry out surgery or medical intervention.

- **Orthopaedic:** type of doctor who treats any problems related to bones and joints
- **Neurologist:** type of doctor who treats any problems related to the brain and nervous system

Special educator: to provide instruction and support which facilitates the participation of students with disabilities in the regular classroom. Working closely with families to achieve the learning outcome for students. Ensuring a safe environment for students. Develop IEP for students. Supports the mainstream teachers to adapt and modify curriculum. Preparing teaching learning materials, which will ease the classroom teaching.

CBID worker: co-ordinates the total rehabilitation of persons with disabilities in the community, they are the bridge between the people and the professionals.

Topic 9 Workplace Safety

Content:

- Travel safety
- Safety in the community
- Maintaining physical health and safety

Introduction:

Safety is the condition of being protected from harm or other non-desirable outcomes, caused by non-intentional failure. **Security** is the condition of being protected from harm or other non-desirable outcomes caused by intentional human actions or human behavior.

Health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.

'Wellbeing' refers to a positive rather than neutral state, framing **health** as a positive aspiration.

Some points to remember when you are traveling to field:

- Please be familiar about the communities and villages where you are working, know the communities well if any issues such as inter religion, caste or any form of issues prevailing so that you can be sensitive and avoid any discussion.
- Always remember that some might watch out for you - always don't draw attention especially when a female staff in the field alone working.
- Please keep one spare phone with you having sufficient air time in case your regular phone is not functional or any network issues you can use it when needed in emergency.
- Let your friends and family updated time to time and also keep them track you especially when you are traveling alone.
- If you are traveling in share autos/ mini truck, ensure that it is not too overloaded and avoid any unprecedented incident and always take informed decision while traveling such commuters.
- Keep your medicine or any personal protective kit, food and water so that you can avoid any food and waterborne infections and mange minor health discomfort when no facility available.

Safety in community

Community safety is about feeling **safe**, whether at home, in the street or at work. It is **defined** as promoting the concept of **community** based action to inhibit & remedy the causes and consequences of criminal, intimidatory and other related anti-social behavior.

Some tips:

- Know your colleagues and field work team this will help to get some support in the field and work coordination for controlled environment.
- Know your communities gate keepers and Pradan and keep them in good rapport for support and safeguarding you and your work.
- Be familiar and friendly with various stake holders such as government functionaries and other local bodies for smooth function and coordination of work.
- Please don't do routine work and movement you might be easily tracked
- Know the location and hotspot for frequent crime and other incidents you can avoid going or manage it well if you have visit.
- Always remember avoiding the wrong time, wrong place and wrong person.
- Don't share your identity, work nature and contacts to unknown person in the field this might seriously create impact on the safety some time.
- Keep emergency and lifeline contact of your community such as nearby fire, police, hospital other key contacts avoid using control room this might delay support.
- Maintain healthy life style food and nutrition and calories.
- Do regular health checkups and preventive measures.
- Know the working environment timing, transport, traffic issues and commuters.

Topic 10 Women's Safety and Wellbeing

Content:

- Introduction to Women's wellbeing, safety, and challenges
- Dealing with issues related to reproductive health and sanitation
- Needs of women with disabilities

Introduction to Women's wellbeing, safety and challenges:

When we are talking of wellbeing, safety and challenges, it mainly focuses on a woman who has good health and access to her needs, who is safe in her community/house and in the region and all the challenges are met by the system.

These are few of the challenges we need to mitigate as field workers: As it is known widely that in many parts of India the decision regarding women wellbeing, menstrual health and reproductive decisions are mainly decided by the family. Due to safety reasons most of the time girl/women with disability dropout of school/college and the family also keeps them inside the house. There are other aspects connected to this are also lack of information, awareness, stereotyping, gender discrimination, cultural barriers, attitude, environment, accessible transport, accessible toilet, water facility, hygiene in the rural and urban areas.

Any programme working on women's wellbeing, safety and reproductive health should also remember to focus on reproductive healthcare services to women with disabilities or to support development or enforcement of laws to prevent the sexual abuse of people with disabilities especially with intellectual impairments.

Dealing with issues related to reproductive health and sanitation:

As per the UN Declaration to human rights to water and sanitation by India explicitly means that "any person in principle has the right to water and sanitation without non-discrimination.

But the discrimination still require attention, including specific consideration of the situation of disadvantaged and marginalised individuals, persons with disabilities in the society."

Women in our country mainly face challenge related to reproductive health and sanitation especially in rural areas. What are the issues related to reproduction and sanitation? If we look into this as a CBR Worker as there are several issues like no proper and quality medical care, awareness about the rights of women with disabilities, transportation, skilled professionals, medicines, support from the community and system and the list can go on. When we look at Sanitation, in most of the rural area it is not a matter to even give priority but now a day's government schemes are there and sanitation has improved in rural areas. But again awareness on using and keeping it hygienically is still lacking may be due to available of resources or awareness in the rural areas.

When we look at reproductive health and sanitation specifically, most of the time the family decides for women with disabilities in the rural and most part of urban **women** areas. Even for health services the family decides and not the individual.

Needs of women with disabilities:

Although the UN convention has spelt out the need of persons with disabilities, and many programmes have shown how inclusive designs can be cost effective and benefit persons with disabilities, pregnant women, older people and the chronically ill.

In spite of all this there are still certain areas which need to be focused on like lack of adequate facilities, Lack of inclusive facilities which force disabled people to practice in unhygienic and improper practices; for example, wheelchair users and persons who are not able to walk without calipers and crutches are forced to crawl on the floor to use the bathroom or latrines. Persons with disabilities especially, with physical disability may also restrict their intake of food and water to avoid using the toilet which leads to health issues.

It would be good to focus on the needs of women at various stages and at various society (urban and rural). As the need of a women in the rural may be different than the need of the women in urban areas.

As every individual has different needs with regard to wellbeing, safety, reproductive health and sanitation there should be involvement of various stakeholders such as family members, medical professionals, teachers in school and college, rehabilitation professionals, employers, NGOs in the field.

First, the CBID workers needs to understand the risks and needs of women with disability with whom they are going to work with or interact.

To do this you have to explore and understand the needs of the individual women with disability and interact with family members or care givers and then plan for the individual person. In this context awareness is most important for the women with disabilities to make a decision on their reproductive health and life.

If there needs to be any change in the community like in the school, office, field work than the CBID worker needs to encourage women with disabilities to speak up for themselves and their needs.

Women safety is one of the main areas that need to be tackled to empower women with disabilities to be an equal participant in all the activities of the society.

If the CBID worker is a male than he needs to be aware and understand the needs of women with regard to health, sanitation, culture, safety and the community as they are the people who are in the process of empowering people. They will act as a bridge between the people, family and the professionals.

If the CBID worker is women with disabilities who has overcome all the barriers will be an inspiration by herself to another woman in the community.

There are various studies and handbooks talking about women's safety and reproductive health. Can refer to the references given at the end.

CBID workers have to look at the following:

- Individual self esteem
- Family situation and acceptance of the women with disability
- Awareness about women's health needs, safety and wellbeing by the family and community.
- Available resources in the community
- Present issues in the community
- Safety measures like sexual abuse prevention and HIV/AIDS.
- Caste, culture, religion
- Income of the family
- Available opportunities

The above points to be looked by keeping women with disabilities at the centre of the team and any planning or decision making concerning them.

The CBID Worker also needs to collaborate with the local leaders and panchayat authorities, police, government officials, lawyers, teachers, public transport, medical professionals, or community members before finalising the rehabilitation plan.

CBID workers need to co-ordinate in comprehensive and holistic way in the community.

The CBID worker also needs to be aware and needs to network with the local panchayat office for proper toilets, water and the safety of a CBID worker. As in few cases women who work as CBID workers can be abused physically, verbally and also with regard to position in the organisation. The CBID worker needs to be aware and prepared to handle and manage the situation in an appropriate way.

This also links to other sessions in this training which talks about sexual harassment and safety.

References:

https://www.un.org/development/desa/disabilities/resources/women-with-disabilities-fact-sheet.html

http://www.vikalpdesign.com/sadhvi_thukral.html

https://www.mitkatadvisory.com/InsightPdf/Women-Safety-Handbook-Jan-20

https://nhrc.nic.in/sites/default/files/sexual_health_reproductive_health_rights_SAMA_PLD_2018_01012019_1.pdf - Status of human rights in the context of SEXUAL HEALTH AND REPRODUCTIVE HEALTH RIGHTS IN INDIA April 2018

and

https://www.ncbi.nlm.nih.gov/books/NBK361913/ Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities, Third Edition (Volume 2).

Topic 11 Redressal Mechanisms

Content:

- Knowledge of Child protection cells
- Commissions for Persons With Disabilities
- Other Grievance mechanisms

Introduction:

Redressal Mechanisms

The term 'Rights' means "what the other must do". 'Other' can be individual; Institution, Department and Government.

'Other' becomes a responsibility because of an agreement or of citizenship.

To make 'other' effective and responsible we need redressal mechanisms for the proper implementation of Rights.

Differentiating:

- Dissatisfaction - Not satisfaction with surroundings /situation
- Complaint- non-formal allegation/ accusation / charge may be oral or written due to dissatisfaction.
- Grievances- Formal complaint given/ raised when infringement of Rights or dissatisfaction.

Definitions

Forms of grievances- Factual grievances (arises due to non-solution of problem or grievance) Imaginary grievances (arises due to wrong information and attitude in work place or any issue) Disguised grievances (arises due to other problem not concern with major issue/problem)

Types of grievances- Individual, Group, Policy level.

Effects of grievances- Loss Interest in work, Dissatisfaction, High Turnover, Wastage of Resources.

What are the grievance handling systems in India?

- **Grievance redressal procedure in India?**

  Every Institution has grievance redressal procedure in India based on following features:

  1. Acknowledge Dissatisfaction
  2. Define problem/ Issues

3. Get the facts

4. Analyse and Decide

- **E-Courts Mission Mode Project and District legal service authority**

  Under National e-Governance Project High court and District Courts and subordinate courts are computerised for smooth and effective functioning of Courts, which include tracking of records and cases.

- **Free legal aid**

  Under Indian constitution, it is fundamental right of every citizen to secure Justice of social political and economic nature irrespective of caste/ class or religion. Under free legal aid person belonging to Schedule cast, Schedule Tribe, Disable , Women , Poor category can avail services/ costs related to cost of Lawyer, drafting, decree charges and other typing or paper work.

Office of the Chief and State Commissioners for Persons with Disabilities – What are their roles, responsibilities?

- Office of the Chief and state Commissioners for persons with Disability is a statutory independent authority made with Purpose of promoting Rights and issues of Persons with Disability. It can be termed as statutory Authority for grievance redressal.

What does the District Child Protection Units do?

Under Integrated child protection, scheme (ICPS) District Child protection Units are introduced main function is to promote National legislation / Laws related to children it is a primary unit in district and also take care of homes related to children and create environment promoting enabling environment for children growth they work on Principle of best interest of child.

What are the Committees at the District, Block and Village level for Child Protection?

In District there will District child welfare committee headed by Zila parishid chairperson with members from Health, women and child, social welfare and education. In Block, we have Child protection committee headed by Block representative (Panchayat Samiti chairperson). Chief Development Project officer (CDPO) as nominated member secretary of committee also all the representatives, which are concern with children. In village, there will be Village level child protection committee headed by elected PRI member and represented by School Management committee, Asha worker, Aganwadi worker.

Note every state will have notification for guidelines for the strengthen of child protection committee.

Other redressal systems:

- **Child line India**

  Child line is a service for assistance and aid for children in need and protection.it is run by ministry of women and child with number 1098.

- **Grievance redressal with the National Trust**

  National trust also have Grievance redressal mechanism to increase its efficiency and minimise dissatisfaction and complaints the number 011-43187804

- **Women's Commission – complaints and legal cell**

  Under the women commission complaints related to Bigamy/ Polygamy, cyber-crime, Dowry harassment, Work and education.

References:

Childline: https://childlineindia.org.in/

Free legal aid: https://districts.ecourts.gov.in/mahendragarh/legal-aid

National Trust: http://thenationaltrust.gov.in/content/innerpage/grievance-redressal.php

Legal rights of persons with disabilities in India: http://vikaspedia.in/education/parents-corner/guidelines-for-parents-of-children-with-disabilities/legal-rights-of-the-disabled-in-india

Office of the Commissioner for persons with disabilities: https://www.india.gov.in/official-website-chief-commissioner-persons-disabilities ; http://www.ccdisabilities.nic.in

Women's Commission: http://www.ncw.nic.in/ncw-cells/complaint-investigation-cell

Topic 12 Communication Skills

Content:

- Elements, types and principles of good communication
- Special considerations communicating with persons with disability
- Barriers to communication
- Active listening
- Non-verbal communication
- Public speaking
- Speaking on behalf of others

Introduction to communication:

Communication is exchange of information by any modes such as speaking, writing, or using some other medium.

There are four main categories or communication styles including verbal, nonverbal, written and visual.

Listening is an art, a skill, and a discipline. As in the case of other skills, it needs self-control. The individual needs to understand what is involved in listening and develop the necessary self-control to be silent and listen, keeping down his or her own needs and concentrating attention on the other with a spirit of humility.

Listening obviously is based on hearing and understanding what others say to us.

Hearing becomes listening only when we pay attention to what is said and follow it very closely.

Some do's and don'ts of listening

In listening, try to do the following:	In listening, do not do the following:
• Show interest • Be understanding of the other person • Express empathy • Single out the problem if there is one • Listen for causes of the problem • Help the speaker associate the problem with the cause • Encourage the speaker to develop competence and motivation to solve his or her own problems • Cultivate the ability to be silent when silence is needed.	• Argue • Interrupt • Pass judgement too quickly or in advance • Give advice unless it is requested by the other • Jump to conclusions • Let the speaker's emotions react too directly on your own

Communication is important:

- Within team
- With clients / families
- With community leaders
- To mobilise community
- To speak up for clients

With various stakeholders you style and approach needs to be changed depending on the subject and occasion.

What are the components involved in communication?

Communication involves:

- Communicator
- Recipient/s
- Message
- Channel
- Feedback

Alter the components said above depending on the audience and occasion.

Types of Communication:

One–way / 2-way communication: In one-way communication, information is transferred in one direction only, from the sender to the receiver. There isn't any opportunity for the receiver to give feedback to the sender. Eg: Newspaper, weather report on television etc. Where as Two-way communication is when one person is the sender and they transmit a message to another person, who is the receiver. When the receiver gets the message, they send back a response, acknowledging the message was received. So this cycle has to be complete.

Communication can be in any form face to face, written, spoken, electronic Verbal, or non-verbal etc.

Principles of good Communication: This is normally called as 7c's in communication. For a good communication, it should be:

- Complete
- Clear
- Concise (short and to the point)
- Courteous (respectful)
- Correct

- Concrete (specific not vague)
- Consideration (for the emotional responses of the receiver/s)

Use appropriate language and most importantly wait for feedback.

Special considerations when communicating with persons with disability: (from CBM)

- A warm Smile.
- Touch is a very effective communicator of love, concern and understanding.
- Use "people-first" language when referring to someone with a disability. "He is a boy with autism, rather than he's an autistic boy".
- Always speak directly to the person with the disability. Do not speak to the interpreter or aid as a 'go-between'.
- Don't be afraid to use the words "see", "look", "walk" or "listen". People with disabilities are comfortable with these words. Don't assume that people with speech, sight or hearing impairments have intellectual impairments.
- Raising your voice to a blind person or someone in a wheelchair or who has Down syndrome is unnecessary. Only a person with a hearing loss has a hearing loss!
- Avoid words that are judgmental or that lead to pity or sympathy; rather use words that reflect respect and acceptance.
- Talk to people with disabilities as equals. After all, they are like you.
- Do not have a conversation with others as if the person with a disability were not present. Allow opportunity for mutual interaction.
- Do not give excessive praise or attention to a person with a disability. It feels patronizing and makes them uncomfortable.

Barriers to Communication

- The use of jargon.
- Emotional barriers and taboos.
- Lack of attention, interest, distractions, or irrelevance to the receiver.
- Differences in perception and viewpoint.
- Physical disabilities such as hearing problems or speech difficulties.
- Physical barriers to non-verbal communication.
- Language differences and the difficulty in understanding unfamiliar accents.
- Expectations and prejudices which may lead to incorrect conclusions.
- Cultural differences.
- Environmental – too hot, too cold, too much noise

What is active listening

Listening to whole body:

- Brain- concentrate
- Eyes- watch body language
- Ears – both ears paying attention
- Mouth – quiet/ re-phrase
- Heart – empathy
- Back – sit straight or slightly leaning forward
- Hands & Feet – relaxed - no fidgeting

Non-verbal communication

Actions speak louder than words

- Gestures
- Tone of voice
- Facial expressions

Non-formal communication focusses away depending on spoken and/or written communication to a culture where gestures, body language, signs, symbols, photographs, objects of reference and electronic aids to support speech or as an alternative to speech.

Non-verbal: including body movements, breathing patterns and eye pointing. Textures, smells, temperature, etc can also support in communication.

Language-based communication: including speech, lip reading, giving and receiving information in large print, braille and block alphabet and sign language.

Lip-reading: Lip-reading involves watching the lip shapes, gestures and facial movements of the person you're talking to so that you get a better understanding of what they are saying. It's used mostly by people with hearing loss or deaf.

Types of non-verbal communication: There are a range of non-formal techniques and approaches that people use to receive information and express feelings, wants and choices.

Some people with complex disabilities, including many individuals who are congenitally deafblind or have additional learning disabilities, will use non-verbal improvised forms of communication. These can include:

- Gestures
- Vocalisation

- Pointing
- Eye pointing
- Facial expression
- Body language

Symbol systems: including using objects of reference, such as line drawings, pictures and photographs. Picture or graphic symbols can be used to support the development of communication, either instead of, or alongside, text, speech, sign language or objects of reference.

The symbols can look like the object they are representing, e.g. a house shape for home, or they can be an abstract representation that needs to be learnt in order to make the connection, e.g. an arrow meaning go, open door symbol for exit, etc.

We can use any combination of communication with a motive to improve understanding and expression.

Things to keep in mind when preparing to communicate publicly:

- Know your audience
- Know your purpose
- Know your topic
- Anticipate objections
- Communicate a little at a time
- Achieve credibility with your audience
- Present the information in several ways.
- Follow through with what you say.

Speaking On Behalf of others:

While speaking on behalf of others, few things need to be taken care. Communication has to be clear that you are speaking on someone's behalf. Difference scenarios may change while speaking on someone's behalf.

Eg: Knowing when to report an issue to a superior; when to work things out between peers; knowing what situations to speak up for the clients etc.

While you are speaking out there might be some challenges you would face. First of all, you need courage; need to know the right channel to use; not be emotional, etc.

Topic 13 Team Interactions

Content:

- Importance of all members of the team and skills required to work well with them
- Giving and receiving feedback positively

INTRODUCTION

It is very necessary that during the team work, the CBID members communicate effectively honestly, respectfully and focusing on the solution with constructive feedback.

This will help the CBID members to build confidence among themselves which will further strengthened the bond among team members and they can approach the community through right communication.

LEARNING OBJECTIVES:

At the end of this lesson, the learner should be able to:

1. Explain the need for good interpersonal communication skills.
2. List the requirement of good interpersonal communication skills.
3. Develop the learner to work effectively with the team.
4. Accept feedback and demonstrate way to give positive feedback.
5. Discuss ways to interact well with the team.

What is interpersonal communication?

Interpersonal Communication is the interaction and communication between the two people or group. It includes wide range of skills but particularly includes the listening and verbal communication with ability to control and manage emotions.

Need for good interpersonal Communication:

Interpersonal communication is the foundation of the success. In CBID work it has significant importance considering the fact that CBID work involves team work and people with good interpersonal communication highlight the needs of the community that helps to bring the solution to the problem that community faces. When there is good interpersonal communication within the team, the CBID team members are good in communicating to the community about the help and services they can render.

Requirement for good interpersonal communication:

- Good listening to the other team members
- Managing emotions like anger, fear effectively while communicating
- Avoiding criticism and personal remarks
- Working with the team to find mutually acceptable solutions
- Moderate tone, body language and voice
- Focusing on the positive side and the solutions

Working with the team effectively:

- When there is good interpersonal communication between the team, the team members know each other's strength and weaknesses that help them to work effective help them to right thing at right time in CBID
- It helps them to reduce interpersonal conflicts

Take feedback and provide positive feedback.

- If there is good interpersonal communication among team members, they can provide each other feedback about their work, their response to disability issue in the community and how to address community based problems.
- Similarly, it helps to provide feedback which must never be criticism or personal anger against the team member. It must help the team member to improve his work.

Topic 14 Team Dynamics

Content:

- Principles and importance of team dynamics
- Conflict management
- Facilitating active participation of team members

Introduction:

Work effectively in a team a group: Working in a group require effectiveness; which means every individual member in a group should and must focus on achieving the objectives of the group. Utilizing the time, skills, resources from already available from all group members will encourage effectiveness and belonging to the group.

What is a group/ team?

A collection of people who interact with one another, accept rights & obligations as members & share a common identity for achieving a common objective

Definition of team dynamics:

Team dynamics is a system of behaviors and psychological processes occurring within a social group or between social groups.

There are four stages in group formation: Forming, Storming, Norming and performing stage. *(Ref: Tuckman model of team lifecyce in Wikipedia)*

Why people join groups/ teams?

People join groups / teams to achieve goals that cannot be achieved by them alone.

Principles of group/ team dynamics:

1. We feeling or sense of belongingness
2. Status & position
3. Coordination, common direction
4. Group norms
5. Change as per the goals
6. Prepared for re-adjustments
7. Common goals / motives for achievement

8. Goal oriented
9. Power to influence decisions
10. Group continuation

Definition of conflict:

Conflict is a clash of interest. The basis of conflict may vary but, it is always a part of society.

Difference of opinion among members on a matter within the group on which decision is to be made *is not a conflict*.

Conflicts are most likely to arise in any group like project teams, self-help groups, disabled people's organisations, federations, cooperatives, etc. The CBID workers should learn the techniques to resolve such conflicts to enable the group to continue to function in order to arrive at its objectives.

Role of CBID worker in conflict Management:

CBID worker should have knowledge & skill to observe behaviors of group members, understand conflicts situation and to bring in a collective resolution of the conflict.

CBR worker should provide inputs on importance of group cooperation, coordination, collaboration & provide guidance to build inner confidence of group members on unity, solidarity, importance of coming together as a group for achieving a common purpose.

The CBID worker should facilitate the group members to discuss different opinions within the group and the decision of majority of members should be final and settled amicably. However, conflicts which have raised due to differences in values are difficult to resolve. They may apparently get resolved for the time being, but are likely to surface again. The CBID or group facilitator should be able to identify the cause of the conflict and be prepared to face it again. He/she should try to work out a long term strategy to resolve this. You should try to facilitate / create a situation in which everyone wins and no one is left unhappy.

Behaviors that make or break groups:

Conflicts arise when people's needs are ignored or not met. These Needs include physical ones such as food and money; psychological needs like the need to be respected as an individual; and esteem needs refer to the respect or importance that the person thinks is her/his due. People also have emotional and spiritual needs.

For more details please refer to Maslow's hierarchy of needs

Some tips to CBID worker to resolve conflicts:

- Facilitate the group members to identify their own needs, fears, & resolve their own conflicts within / among themselves.

- Do not give judgement. Give good examples, narrate instances where groups have made good settlements of the problems which is a win-win situation for members.
- Facilitate games, stories, skits, riddles, songs on unity & solidarity, use IEC materials on improving communication, semi-structured & structured group exercises like passing the marbles, construction of paper bridge, etc to help group understand the functioning in a group.
- Do not show withdrawal, anger, avoidance, etc in conflict. Instead change your behavior for a more creative and helpful response, if needed.
- If we are creative and sensitive, we can create a situation where both or all parties in the conflict can win and no one loses.

Topic 15 Managing Negative Responses

Content:

- Reinforce getting positive response – inform, consult, involve, collaborate, shared leadership
- Negative, passive and active responses.

Introduction:

CBID worker should work and follow principle of community development of consult, inform, empower and ensure participation with his team and community and sincerely inculcate the value system which recognizes inner worth, dignity, diversity of all individual group and community. CBID worker should take decision on principles mentioned above which will bring equality/equity and gender sensitivity in society.

Concept of response – Response is reply or reaction to something it may be discussion, agreement or situation.

Positive response – Reaction or reply that affirm to discussion, agreement and situation.

Negative response – Reaction or reply that reflects dissatisfaction, non-agreement with situation or circumstances.

Getting positive response from community, colleagues and seniors- CBID worker should do his / her work in consultation through informed consent, involve every concern stakeholder, and strictly adhere to the principles and value system of community development this will help him/her to do the following:

1. Promotion of cross culture collaboration
2. Conflict resolution through democratic values and principle of equality and gender sensitivity
3. More participation of community at across level
4. More opportunity for reflection, restructuring and collaboration
5. Creating good case studies based on participatory problem solution
6. More access to community resources and mobilsation

Responses

- **Passive** – Response or reply, which is dependent upon external force.
- **Active response**- Response that is positive in nature and have exuberance of active action.

In community CBID worker will get above mention responses through shared consent and participatory approaches, she/he can influence responses for social change and development. It is not necessary to give reply to each response however, response need careful review of repercussions and its effects.

- Do not response to degrading or one-off comments
- Respond to comments, remarks, and queries, questions, which ask for solution, Information, correction or reply to queries.
- In the responses, the acknowledgement of the any stakeholder feeling, perception even it is not positive.
- It is important to correct erroneous information or false information that may confuse or mislead others.
- When response is result of negative experience with the organization or community stakeholder providing a solution can positively influence the opinion of that individual and others.

Topic 16 Reflective Planning

Content:

- Methods and techniques that support the CBID workers to reflect on their experiences and actions and engage in a process of continuous learning

Introduction

In order to improve our performance, it is always advisable to slow down enough to reflect on what we have done, what we have achieved and how are we going to do in future. Such actions can be a rich source of insight and continuous learning.

Reflection can be done through reflective practices are methods and techniques that help individuals and groups reflect on their experiences and actions.

The basic purpose of reflective planning is to:

- Carry out CBID Work
- Self-assess the effect that CBID work has on people with disabilities.
- Consider new ways of which can improve the quality of life of people with disabilities
- Try these ideas in practice
- Repeat the process

Methods for the reflective practices:

a) **Documentation:** Documenting the ideas, feeling, observations and visions.

b) **Peer group:** Peer group meeting on regular basis to learn and reflect together and supporting and provide suggestions to individual reflective practice.

c) **Co-operative inquiry:** It is a method of research where two or more CBID participants will research on the problem through their own experience of it, move between their experience and reflecting together on it. Each person will be the co-subject during experience phase and co-researcher in reflection phase.

d) **Brainstorming**: It is a meeting where new ideas are generated in group, where all members contribute, discussed the ideas extensively and find a conclusion for specific problem. It is better more the number better will be ideas, new ideas never thought about are welcome, no criticism is made and combine and improve the ideas.

Gibbs Reflective Cycle:

Topic 17 Time Management and Timely Reporting

Content:

- What and Why of time management
- Strategies for effective time management
- Effects of poor time management
- Timely reporting

Manage your Time; let not time manage you!

Introduction and definition:

Time management is the managing of your time so that time is used to your advantage and it gives you a chance to spend your most valuable resource in the way you choose.

Time management is a skill that can be learned which involves techniques for prioritizing activities and using time effectively while eliminating disruptions and time wasters.

Why time management:

- Mange your work. Don't let your work manage you. You need better planning work with time management to complete the tasks.
- Time Management is an endless series of decisions, small and large, that gradually change the shape of your life.

Strategies for time management

- The secret to effective time management lies in organizing and planning.
- No one has total control over a daily schedule. Someone or something always will always make demands. However, everyone has some control and probably more than they realize. Even within structured time, there are opportunities to select which tasks or activities to handle and what priority to assign to that task. It is through the exercise of these choices that allow you control over your time.
- Always be familiar with your work, develop macro and micro plan and work out monthly weekly plan and with sufficient time for complete the work
- Always make your plan with your team and negotiate what time frame needed to complete the tasks.
- Fix time and duration for each and every task in the field this way helps to complete the task and control the participants may be group meeting on fixed time, date and duration.

- Understand the community timing farming, school, leisure, festival ,holidays and monsoon knowing this you know what is available time frame to complete the target of the year

Effect of poor time management and importance of time reporting:

- If the time is not managed well it affect your coordination, and performance in the field, eg. people can join and leave community meeting any time convenient and you may not achieve the desired out com of the work when no fixed time and duration.
- If the field work, report and other data is not submitted on time before deadline this might badly affect your work and lead to organizational level performance issues and even lead to reputation loss, loss of funding and sustaining the programme.

Topic 18 Disaster Preparedness

Content:

- Introduction to natural and manmade disasters, social unrest
- Vulnerability of persons with disabilities during disasters
- Need for disability inclusive disaster risk reduction

Introduction to natural and manmade disasters, social unrest

Definition: A disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's ability to cope using its own resources. Though often caused by nature, disasters can have human origins.

Disasters two types: Natural and Human induced disasters, further these disasters are divided in to different types such as Natural disasters are divided in to following types,earthquakes, landslides, tsunamis , volcanic activity, avalanches & floods, cyclone ,extreme temperatures, drought and wildfires.

Know disability and disasters:

- Disability is a complex, dynamic and multidimensional issue that encompasses physical barriers, social and economic exclusion and institutional indifference.
- India, according to Census 2011, has around 2.68 crore people who live with disabilities and constitute around 2.21 percent of the nation's population.
- Disasters affect the persons with disabilities inordinately by aggravating the existing conditions for the disabled persons.
- The mortality rate of people with disabilities is two times higher than the general population in disasters. Poor planning of disaster response and recovery measures leads to exclusion of disabled victims due to inaccessibility.
- With the increasing number of disasters, there is a need to incorporate inclusivity in the process of disaster risk reduction (DRR).

The need to incorporate disability-inclusivity from the planning to the execution stage of disaster risk reduction process has been realized at the global as well as national level.

Disability-inclusion has been a guiding principle in DRR process as reflected in the Sendai Framework for Disaster Risk Reduction (SFDRR).

Both the UNCRPD and RPwD Act have provisions for equal protection and safety for Persons with Disabilities (PwDs) in situations of disasters, conflict and emergencies.

The Act further enjoins the National Disaster Management Authority(NDMA) and State Disaster Management (DM) Authorities to ensure that PwDs are included in all activities listed in DM Act 2005. The NDMA has also issued National Disaster Management Guidelines on Disability Inclusive Disaster Risk Reduction (DiDRR) in September 2019 with an aim to implement disability-inclusion in DRR activities of India.

Reference:

NDMA India resource website

Topic 19 Meeting Reports

Content:

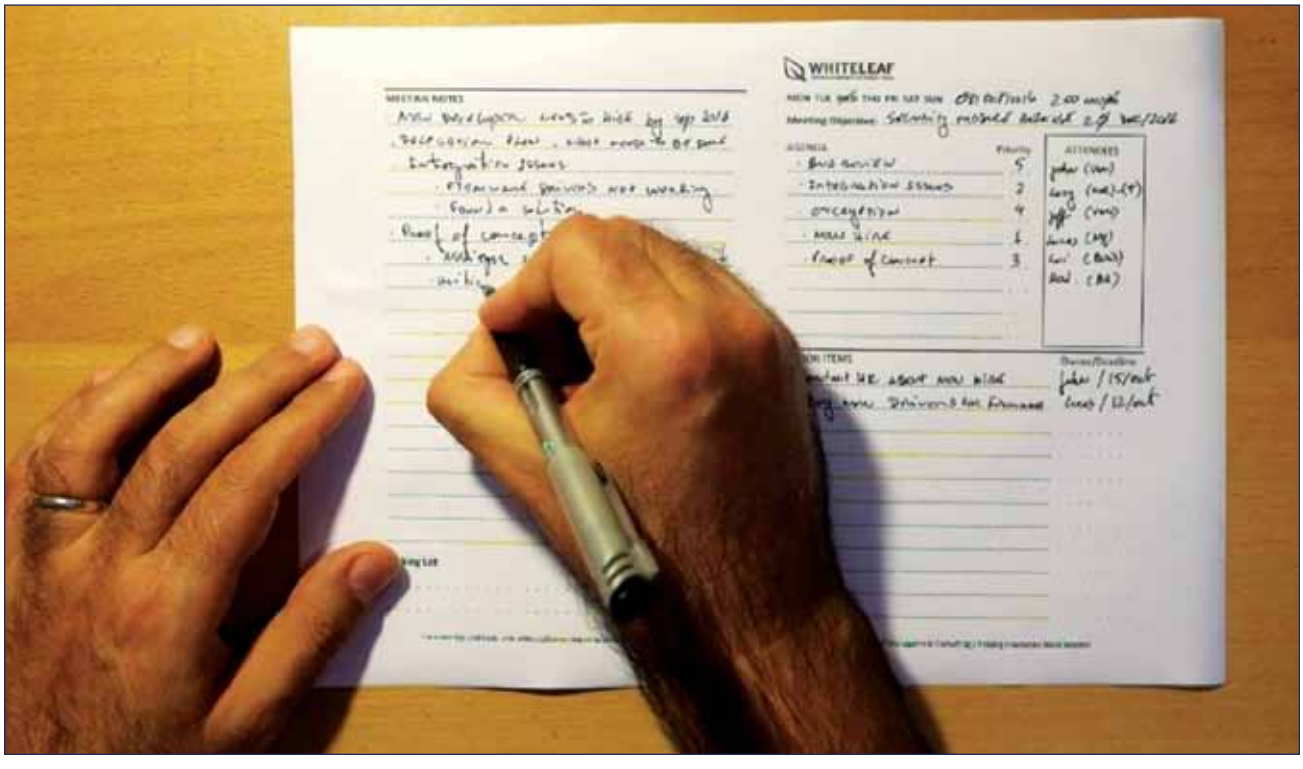
- Meeting minute writing
- Key reporting needs

Introduction:

Reports of meetings are very important because it gives an overview of the discussions, it serves as a reference guide for points discussed and plan accordingly. The report also reminds of the timing to implement a particular activity, it reflects the responsibilities and assignments given and taken by people. It also serves the purpose of updating the discussions to those who were absent during the meeting.

Definition:

When you write whatever is said /spoken in a meeting it is called minutes.



As a CBID worker it is important to document details in order to plan and follow up (attend internal meetings, discussions at the community, families, clients, health workers, NGOs, etc.)

1. Why should you record a meeting?

- Some people may not attend the meeting so this will tell them what happened in a meeting

- It is a document to track the decisions taken during the meeting. You can look back at the document to view the decisions taken
- This again helps in future decision making
- It also helps in planning the future course of activities
- If some people are assigned a particular job during the meeting, the minutes help in assigning the jobs to the respective person

2. Options for recording a meeting

Planning before the meeting:

- Person taking the minutes to be identified within the team
- Have an agenda for the meeting which will serve as a guide while taking minutes
- The agenda will provide the details of participants/attendees, guests etc.,
- Decide, discuss and clarify with the management/director/Manager/Team leader, on what is required

Options for recording:

- Depending on the nature of the meeting discuss on whether it is a detailed minutes or only important points to be recorded
- Also decide if the minutes is to be written or only audio/video recording or both.
- Conference call facility with recording is also available

3. When should you record a meeting?

- If all are not present at the meeting and would require the details for future.
- If an important decision has to be taken
- If there is an important communication/announcements to be conveyed to staff
- If there are roles and responsibilities to be assigned for the staff
- If there is a future planning
- If there are new initiatives to be introduced
- If there are any major changes in operations

4. Who should record the meeting?

Anyone can record a meeting if given an opportunity – but keep the following in mind:

- The persons speaks, understands and writes the language in which the meeting is conducted.
- The person recording the minutes should have some experience in writing the minutes

- Knowledge of the topics being discussed
- Good hand writing or good typing skills to record directly on system
- Should be able to have a good understanding with the facilitator.
- Sometimes the person can be both facilitator and the recorder of minutes, however if some major decisions are to be taken then it is preferable that another person is delegated the responsibility of recording the minutes.

5. How do you record a meeting?

Points to remember before recording minutes:

- Write down the agenda items and leave a space under each agenda item in order to write
- Do not record as a verbatim since it will consume time, so just record major decisions, assignments, roles and responsibilities and plan of action
- Record the decisions under each agenda item as they are discussed
- Ask for clarifications if any decision is not taken in an agenda item
- Record the next steps involved

Format for recording minutes (generic)

- Date and time of the meeting
- Names of the participants and those unable to attend
- Decisions on each of the agenda items
- Action taken or agreed
- Way forward with each of the agenda items
- Agenda items which have not been discussed or postponed
- Any additional agenda item decided on the spot
- Date/time of the next meeting

Meeting & Date					
Attended by:					
Chaired by					
Minutes prepared by:					
Particulars	Key Points Presented	Action Point	Responsibility	Task completion date	Follow-up done/ Comments
Date of next meeting					

Some tips to be a good recorder of the meeting

- Listen carefully and write a gist of the discussions or paraphrase the discussions
- Revisit and see if you have missed any information or covered the content of the discussion.
- Never worry about spelling mistakes and reduce prepositions
- Place the decisions in order of the agenda
- Highlight important decisions

6. Following up: What to do with what you have recorded?

- Once the meeting is recorded, ensure that all decisions have been included.
- Distribute/share the minutes to all participants one to two weeks after the meeting
- While sharing the minutes of the meeting with others, invite feedback or request to include any information which has been omitted by oversight.
- Minutes to be filed in a separate folder for future reference on decisions taken
- It is important also to see that action is being taken on the notes of the decision.

Key reporting needs

- Title of the report to be clear with proper sub-heading
- Content: The content of the report should reflect accuracy with facts as discussed
- Date of preparation and date of submission and date of next meeting
- There should be a logical sequence and consistency in the report & avoid irrelevant information
- Report should be in clear and simple language, because the person reading the report should find it easy to understand.
- Promptness in submitting the report on time will help quicker decision making, because information delayed is information denied.
- Reports should be sent/shared with persons involved in decision making in order to expedite the process of decision making
- The report should be well planned and presented with
    - Objective of the report
    - Summary of conclusions
    - Issues and solutions
    - Recommendations and annexure if any.
    - Duly signed and dated

Reference:

https://www.wildapricot.com/articles/how-to-write-meeting-minutes

Topic 20 Developing Case Studies

Content:

- Introduction to case studies
- Storytelling and human interest narrative
- Ethical considerations in writing case studies

Introducing to case studies:

Case studies are real life example to describe how the efforts taken brought the change needed in the individual, group or the community. Case studies are like story telling which gives positive hope and inspiration to supporters of the project, families and people with disabilities. Case studies are different than case stories or success stories as case studies are in depth, detailed description of a situation, problem and the process by which the problem was solved while success stories focuses on success or outcome.

A good case study must highlight the problem that individual or community face, the situation that time, solutions found and what solution was adopted, the process of intervention, what were the challenges faces and how is the current situation and what lessons were drawn.

Storytelling and human interest narrative.

Storytelling is the process of using fact and narrative to communicate something to community. Storytelling creates a empathy for the challenges that people with disabilities face. Storytelling is a narrative which motivates team, mentions about what disability is, inform about people with disabilities, creates an emotional and engaging bond and facilitates interaction between people with disabilities and community.

Stories bring people together as sharing the story provides a sense of commonality and community. Eg. Narrating a story of a child with disabilities who aspire to become a doctor and how he overcome the challenge. It creates a sense that a child with disability also has the same inspiration.

Stories inspire and motivate specially for the other people who face similar challenges.

A good story must be simple, easy to understand, show common features between individual and community, must identify the problem and highlight the success.

Ethical considerations in writing case studies

Case studies must be published of those individuals who has agreed for publishing it. It must not reveal personal details other than name and location, avoid mentioning personal life. Photographs must not be taken without consent, inform the person what will be case study used for, even if the person don't agree for the case study support must not be withdrawn.

Example of a case study format

Case study Criteria
Include Vidya Campaign - CBM SARO

Outline for Case Studies: Collection of case studies: short stories from fifteen year old (for GCE activities) and also those younger, to highlight cases related to education (challenges & achievements)

1. PROFILE : Include a brief profile of the child in focus – age/background/location/type of disability/reasons for choosing this person
2. Focusing on the Person's Life Cycle of the child: Capture the person's life (say for e.g. her/his life 0-5; 6-12; 14-16 years – whatever age is applicable for the person in focus) and correspondingly highlight the challenges faced at each stage of life, especially related to education.
3. **Highlighting any Form of Support/ Institutional Linkages/Parent's/ guardian's efforts to address/overcome her/his Situation:** Capture any form of support/initiative/intervention that has helped the person overcome/address her/his situation, related to education. What was this support/linkage/initiative/effort - how did it actually help. Give concrete examples.
4. Highlight the Positive or Negative aspect of this Story : For example, if this is a success story then pin-point why is this a success/positive story – what made it successful. If this is a negative or not-so-successful story, state clearly why this is not so!
5. **LESSONS LEARNED:** Highlight a few yet strong lessons learnt from the case study, which also has a policy/advocacy implication/s after the Include Vidya Campaign.
6. **Identifying the Key Challenges:** Based on the child's story, identify the key challenges that children with similar disabilities are likely to face, related to education.
7. **Suggestions that would help facilitate them to overcome/address their Situations**

Again, based on the child's story, suggest either in terms of support requirement/specific interventions, initiatives, assistance (government /non-government) to facilitate children overcome/ address their situations

Note: Consent form is to be signed and is mandatory for every case study*. Each Case study should carry a clear citation of source/location. Each Case Study to have a consent from the child or parent or caregiver being interviewed for documentation as all the cases will be put in public domain or used for various PR material. Case Studies chosen should be reflective of a) different age groups; b) different types of disabilities; c) rural-urban background; d) different class background; e) most important: each must focus on a life-cycle approach (that also enables us to capture clearly the issues of rights, exclusion, accessibility of children with disabilities in different phases of their lives).*

References:

Consent forms:

https://cbmindia.org.in/e-update-files/CBM-Child-Safeguarding-Policy.pdf Appendix 5 (Pg 20,21)

https://www.cbm.org/fileadmin/user_upload/CBM_Safeguarding_Policy_2018.pdf Appendix 6 (Pg 22,23)

Topic 21 Managing Negative Outcomes

Content :

- Reinforce getting positive response – inform, consult, involve, collaborate, shared leadership
- Negative, passive and active responses

Introduction:

Since rehabilitation is long process, requires proper planning, sustained and regular efforts in the community based therapeutic services.

However in spite of the efforts, many a times the results are not in accordance to desired outcome which was expected.

Learning Objectives:

- Understand the reasons for negative outcomes.
- Dealing with the disappointment

The reasons for the negative outcomes can be for many reasons:

1. Negative attitude towards people with disability in the community.
2. Lack of cooperation from stakeholders like people with disability, community members, family members in CBID Process.
3. Lack of description of task that has been assigned to CBID worker by the supervisor or organization.
4. Less job satisfaction.

Dealing with disappointment and failures positively in CBID Work

Understanding different type of responses:

- Negative response which means our response toward ths solution is negative and we are in denial.
- **Passive response-** we acknowledge the problem, however we do it passively without any enthusiasm.
- **Active response-** Ensuring that we are proactively dealing with the issue.

Following are the important aspect while dealing with disappointment and failures in CBID work:

1. Acknowledge that outcomes were not as expected.

2. Do not blame yourself or put blame one person as rehabilitation is a team effort and require equal efforts from all the team members.

3. Take ownership and empower yourself to take control of how you respond to the situation since it is necessary that a positive attitude can boost the enthusiasm of the person with disability and family members.

4. Find out the reasons for not getting the desired outcome was it due to less efforts from the team or not getting adequate response from the family or community members for the rehabilitation or was it due to bad timing, or unrealistic expectations or absence of knowledge or experience of team members.

5. Learn from your experience and utilize this learning in next task.

6. Speak to the community members, family members seek their opinion on how things can be different.

Topic 22 Emotional Health and Managing Negative Emotions

Content:

- Maintaining one's emotional health (Building emotional health and avoiding burnout)
- Fostering healthy relationships (including avoiding entanglements)
- Response to harassments

Introduction:

When we are working in a profession that involves caring for people who are marginalised, vulnerable, sick or disadvantaged in any way, we will come across many situations that can affect us. We may be facing suffering and pain on a daily basis and this can drain us emotionally. It is important to learn how to remain positive and maintain our own emotional health so that we can continue to serve our clients. This lesson will give you some ideas of how to do this and avoid burning out.

Relationships are an important part of any good work setup. Healthcare professionals always work in teams. Healthy relationships will help you to cope better and manage negative situations. Unhealthy relationships will decrease your efficiency and cause stress.

What is emotional health?

It is a state of positive emotional and mental functioning. Emotional health deals with the areas of thoughts, feelings and the consequent behaviours. When all these are balanced we can say the person is healthy emotionally. Emotional health contributes to our overall wellbeing in what we think, feel and do through all the good and bad times of life. Being healthy emotionally means that we can recover from setbacks and continue to function well despite the problems.

What can cause emotional setbacks for a CBID Worker?

Being aware of the situations that could cause you to become discouraged or struggle emotionally is the first step to being healthy emotionally. Of course, we do not all respond in the same way to the same situations. And even the same individual may respond differently at different times.

- *Disappointments*: Often when things don't go according to the plan, we can become discouraged. When this happens often, we can easily become depressed or feel low.
- *Failure*: Similar to disappointments, our own failures and the failure of the system which is supposed to support us can lead to discouragement
- *Lack of social support:* We all need a team to function well. So when we work on our own without adequate support from others we can become drained.
- *Fatigue:* is a state of extreme tiredness. Working too hard and too long is detrimental and one should take time for rest and recreation. Most people, who choose caring professions, naturally

respond to the needs around them. When the needs are many we can often keep going without getting enough rest. This can lead to emotional problems and difficulty coping due to the exhaustion.

- *Working in the face of injustice*: Injustice towards ourselves or our clients can also be draining.

What is burnout and how can we prevent it?

Burnout is a state of exhaustion especially emotional exhaustion. There is also often physical and mental weariness. It is result of continued stress which has not been managed well. A person who reaches burnout is overwhelmed and unable to function normally and respond to the normal day to day pressures. There are also physical symptoms that accompany the emotional and mental fatigue.

It is important for us to understand that failure and setbacks are a part of life for all of us.

So what can the CBID worker do to prevent becoming burnt out?

THINGS TO DO	THINGS TO AVOID
1. Pay attention to physical health: - get enough exercise - get enough sleep - have a healthy diet - take time to Meditate 2. Have seniors who can be mentors and encouragers. Find people whom you trust and frequently debrief with them about how you are doing. 3. Take breaks when required. It is best to have planned holidays and days off rather than wait until you are really tired to take a break. 4. Develop or make time for hobbies that you enjoy. 5. Social interaction and integration is a necessary part of daily life. 6. Maintain spiritual disciplines if this is something that gives you strength. 7. Plan work realistically. Very often we try to do way more than we have the capacity and time for. So being realistic in our planning is important.	1. Overwork. 2. Too much social media. 3. Substance abuse. 4. Blaming yourself. Constant introspection and blaming ourselves for everything that goes wrong can lead to burnout. Learn from your mistakes, then move on.

Ways to handle negative circumstances:

Since negative outcomes, disappointments and failure are part of our lives, we need to have strategies in place to pro-actively handle such situations. We will also face opposition sometimes from others as well as apathy in the community about inclusive development.

Here are a few suggestions, which may be adopted:

1. Self-awareness is a characteristic of emotional health.
2. Build your resilience and make a personal strategy for enhancing resilience despite challenging situations and experiences.
3. Recognise that not everything will go according to our plans.
4. Look at negative outcomes objectively and learn from them.
5. Debrief critical incidents with your superiors and peers.
6. Avoid blame of oneself and others.
7. Recognise the stages of grief and allow oneself time to grieve well.
8. Be assertive and speak up for yourself.
9. Seek social connection to improve your emotional health. Reach out to the people in your life who have made a difference for you. Send them a note, or phone them if it's impossible to meet with them in person. Cultivate your friendships and social connections with loving-kindness.

Fostering Healthy Relationships

Healthy Relationships in the Workplace:

We will only be covering some basics about healthy relationships which will help to prevent problems. Your colleagues will be your best encouragement and help, so it is worth taking time to cultivate good relationships.

Remember that in any given situation we have the ability to choose our response. Every day we face situations relating to people in real life, that we need to respond to. We can call these "Relationship Stimuli (RS)." A stimulus is something that we need to respond to. In relating to people we can either respond well, building the relationship, or poorly, creating a barrier. Showing no response is also a negative way of responding.

Between the Relationship Stimulus and the **Relationship Response** there is short time which we can call an **Opportunity Space**. We are often not aware of this space. But recognising that we can make a decision to respond well is an important way of building a relationship. For example, people suggest counting to ten before responding angrily. That in effect is using the opportunity space to control our emotions and respond well. Not using the Opportunity Space wisely will lead to angry words, blame, etc.

Some people get angry or offended easily. They may believe that 'this is just the way I am' and make no effort to change. Then there is no scope for growth for that person. If you think you are an angry

person, then you will not do anything to change. When we recognise that we can choose to respond angrily or kindly, then we are able to accept the responsibility for our responses, thereby healing relationships and preventing problems.

Similarly, if someone is angry with you, you can choose how to respond to that, rather than getting angry, or upset or feeling inferior.

Healthy Boundaries in Relationships with clients:

As CBID workers we need to be careful about our relationship and behaviour towards our clients and their families and do our best to maintain a professional standard. In order to maintain a professional attitude, it is important to always have a chaperone whenever you are caring for a client of the opposite gender. Either ask a colleague of the same gender as the client or one of the relatives of the client to also be in the room with you and the client.

As much as it is important to empathize with our clients and offer compassionate care, it is important to avoid becoming emotionally involved with them. Recognising this as a danger will help to avoid entanglements and also to take appropriate action if emotional attachment starts to creep in. When dealing with relationships it is wise to have a good form of accountability. Approach a senior person that you can be in touch with to discuss any relationship struggles before they go too far.

Healthy Boundaries in Relationships with superiors:

Harmony in the workplace requires superiors and subordinates to have good communication and a healthy way of relating to each other. However, we do not live in an ideal world and struggles are bound to come up. Here are some suggestions of how to relate to your seniors and superiors.

- Respect those in authority.
- Know and keep boundaries with your peers. If working on a team a clear line of communication and job descriptions help to make sure we all work together well.
- If you do come across any harassment or bullying in spite of the above, first check your own attitude and behaviour and make sure it has not contributed to the issue. Develop a healthy sense of self-worth. Bullying only succeeds if we doubt our own abilities, contribution and intrinsic value. So, you need to learn about your strengths and use those and work on overcoming your weaknesses. It is also important to develop a firmness which is respectful. If these measures do not help, find a neutral senior person or mentor whom you can discuss with and get advice from them as to how to proceed.

Healthy Boundaries in Relationships with peers and juniors:

- Mutual respect towards your peers as well as your juniors is very important to maintain harmony.
- Be willing to apologize if you have done something wrong or offended anyone. And be willing to forgive them when they have offended you.
- Reach out to help your juniors with their tasks. Remember you were once in their place.

The organisation responsibility:

It is important to know that every organisation should have its Mission, Vision and Values linking to the systems, procedures and work culture. Policies, manuals and code of Conduct is the integral part to support and protect its employees including reducing the risks of stress and burnouts. The list below gives the minimum standards and policies which are mandatory for organisation to have.

- Code of Conduct
- Human Resources Manual
- Inclusion Policy Framework
- Staff engagement, Team building, Mentoring and Counselling programmes formal and informal.
- Policy Preventing Corruption and Fraud
- Safety and Security Policy
- Performance and appraisal, performance recognition systems
- Dispute Resolution process
- Anti-Harassment policy
- Anti- Sexual Harassment policy as per the country regulations

Response to harassments:

Please refer to Unit1-Module2-Prevention of Sexual Harassment at Work Place for more information on this topic.

Each employee has the right to a respectful workplace. Sexual /other harassment of any kind at workplace prevents the individual from work at his/her best abilities. It affects the person physically, emotionally and socially. Some of them may experience trauma in the form of stress, anxiety, headache, sleep disorders, lose confidence, low self-esteem, and may have far reaching consequences. Therefore, every employee can approach the internal complaints committee of an organization or the local complaints committee to take support and confide, in case of any sexual harassment at workplace or for any harassment/dispute resolution.

There is a lot more we can say about relationships and response, but if you start practising these tips, you will be able to manage most of the situations that come your way.

References:

WHO Psychological First Aid Guide for Fieldworkers; http://tinyurl.com/PFA-Eb

http://www.who.int/mental_health/publications/QualityRights_toolkit/en/

www.mhpss.net

An introduction to mental health, Facilitator's Manual for Training Community Health Workers in India, 2009

Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 - http://legislative.gov.in/actsofparliamentfromtheyear/sexual-harassment-women-workplace-prevention-prohibition-and-redressal

Topic 23 Safe Travel

General Travel Safety and Security (CBM reference)

Contents

- □ Introduction
- □ Preparation
- □ Basic DO's and DON'Ts
- □ Considerations for persons with disabilities
- □ Traffic and transport
- □ Accommodation, food and water
- □ Health and wellbeing
- □ Accidents
- □ Packing well
- □ Female travellers
- □ Reporting abuse

Introduction

Please read through this sheet and study it carefully. This sheet provides you with basic information about what you can do to make your travel as safe and secure as possible. Familiarise yourself with the content so that in a case of an emergency, you are well prepared and, where needed, your first reaction will be the right one. CBM takes the security and safety of its staff very seriously, and also expects staff to participate in ensuring their own safety and that of a team. Each country context that CBM works in is different, and the safety and security requirements of each programme will need to be contextualised. Always check for local procedures when you arrive in a country. Remember that being a well informed and aware individual will offer you the best sort of protection and by following the basic principles and 'Dos and Don'ts' listed in this factsheet CBM hopes to reduce any risks to you.

Preparation

Whether you are a seasoned traveller or not, always remember that each new journey should start with a thorough preparation and a (renewed) familiarisation with the country you will be travelling to. Even though previous travelling experience is most valuable, there is always a risk that a lot of travel (without incidents) can make you slack and good routines and vigilance become too relaxed. Events might than catch you off-guard in situations where you need to remain alert and react firmly and quickly.

Basic Do's and Don'ts

- Ensure that CBM knows your exact whereabouts and how it can reach you.
- Ensure you get a good briefing before departure and on arrival.
- Keep your passport with you at all times or lock it in a safe. If your passport is in a safe, travel with a photocopy of the passport.
- Ensure you always have a means of communication with you. Test it on arrival and if not working, consider buying a local SIM. Pass on the new number to CBM! Make sure your phone is well charged. Have a spare battery.
- Have emergency numbers plugged into your phone memory as well as a written copy of these numbers elsewhere in your luggage.
- Keep copies of important documents at the bottom of a bag with non-valuable items.
- Ensure you have an amount of cash with you (in different pockets) but avoid having more than the equivalent of $300.
- Ensure you change some money into local currency and always have some small denomination bills.
- Avoid carrying objects of high value.
- Where feasible, pre-arrange reliable pick-up from airports and hotels.
- When possible take a day to 'acclimatise'.

Considerations for persons with disabilities

Much of the advice in this security factsheet will be the same for persons with disabilities. However due to mobility and communication challenges, certain issues will need to be specifically highlighted if you yourself are a person with a disability or when you work or travel with persons with disabilities. In advance and on arrival carefully consider the accessibility challenges you might face regarding accommodation, transport, visits etc. When visiting projects /partners, ensure that people are aware of your needs. Assess your requirements for assistance or specific devices you might need if confronted with a crisis scenario. When reading through this sheet assess and discuss what can be done or planned to ensure your safety and security. Although planned for a fairly Western setting you might find some helpful ideas and advice at http://www.disabilitypreparedness.gov/ppp/index.htm

For further travel advice also have a look at the following web links:

- http://www.lonelyplanet.com/thorntree/forum.jspa?forumID=38 - Lonely Planet's online forum has a branch dedicated to disabled travellers
- http://www.e-bility.com - Australian general disability site with lots of travel-related resources
- http://www.rollingrains.com - Advocating inclusive travel and design
- www.able-travel.com

Traffic and transport

The most common cause of death and injury among expatriates and development workers is traffic accidents. Following the advice below will give you some basic guidance to ensure your safety.

- If at all possible, insist on travelling only in vehicles with safety belts. Be firm on this issue and emphasize it in advance when arranging transport.
- Be willing to pay a bit more for a safe vehicle / means of transport.
- When you feel a driver is driving carelessly (taking into account local 'style'!), point it out and be firm.
- Avoid travelling in the dark, if possible.
- Keep doors locked.
- Try to ensure you always know where you are and where you are going. Acting confidently will help you to not attract unwanted attention.
- Avoid travelling with motor bikes. If you are travelling on a motorbike you must wear a helmet.
- When travelling by ship or ferries, be extra vigilant. Try to avoid overcrowded ferries or ships especially the ones travelling in the dark.
- Always ensure you have enough bottled water with you.
- Bring some small snacks in your backpack. Ensure you have something salty to eat in places with high heat and humidity.
- When (preparing to be) based in a place for a longer period of time, ensure you have access to a well maintained and reliable vehicle.
- Ensure CBM vehicles have emergency equipment and an up-to-date First Aid kit. Check this especially for long trips on rough roads.
- Ensure you acquire some basic knowledge on what to do if your vehicle breaks down in a deserted place.
- Avoid letting the fuel tank drop below half full.
- Keep a spare key.
- When you are travelling in a place with present or past conflicts, be aware of landmines and unexploded ordinance (UXO). We strongly recommend you attend a local mine awareness course.

Accommodation, food and water

- Do not stay in overly cheap hotels (if possible). Keep your room locked at all times. Keep your key away from view so people cannot see which room you are in.
- On arrival in a hotel, familiarize yourself with emergency exits, escape routes etc.

- Use the hotel safe if available to store valuables.
- Drink only bottled water/drinks with original seals.
- Eat only well cooked food. Avoid the salads.
- When offered local food or drinks e.g. when on a field trip, politely accept a little but do not feel obliged to eat/drink it (all) if you feel it might cause you health issues. A bit of humour about your weak foreign stomach will give you an acceptable 'escape'.

Health and wellbeing

- Ensure you have your vaccinations up to date and bring along the 'medical passport' where these are registered.
- Check in advance which local medical issues you need to be aware of.
- Drink more than usual: e.g. air-conditioning and plane travel dehydrates your body.
- Treat even small wounds/injuries immediately. In hot climates a small, untreated wound can quickly get infected.
- Basic first aid knowledge is a very useful knowledge; consider taking a course and ask CBM to assist you in this if required.
- A degree of anxiety before or during travel is natural. However when you feel overly or regularly anxious or depressed before/during travel or on return, contact your line manager. Do not feel ashamed; it is wise and important to share this so you can be adequately advised and assisted.

Accidents

- Always ensure that CBM vehicles are insured for accidents and that the vehicle papers are up-to-date.
- Unless based somewhere, we recommend that you do not drive yourself.
- Check whether you are allowed to drive in the country you work in and/or whether your foreign license is locally accepted. Getting a local license is recommended for long term stay.
- When you see a (traffic) accident, it might be wisest to leave as soon as possible. There have been occasions where foreigners that happened to be nearby or even came to help, were blamed and ended up in big trouble.
- When you or the vehicle you are travelling in is involved in a traffic accident observe the following:
    - Stop, unless you feel at risk of being attacked.
    - When a local person is driving let him/her handle the situation. Try to ensure that the foreigners leave the scene as soon as possible.
    - When you yourself have caused an accident/are involved in (small) accident while driving, assess the situation. Especially when somebody got hurt, angry crowds will naturally assume you are to blame and could become very hostile, consider whether it is safest to

drive on to a nearby police post and there report what happened Check local advice on arrival!

- o Immediately report the incident to your local office / partner and ask them to come to the scene as soon as possible. Let them handle the situation and consider leaving to a safe location.
- o When possible, try to get a photograph of the accident situation.
- o Under no circumstances lose your temper!

- If travelling on a bus, the safest seats are on the curb side, away from the traffic and in the mid-section of the bus.

Packing well

- Bring a small rucksack which you can use on field visits and short trips.
- Bring good shoes for field visits. Bring shirts with long sleeves, long pants and a light jacket.
- Keep a change of clothes in your hand luggage in case your luggage does not arrive. Bring one set of more formal clothing for official events.
- Take a set of recent passport photographs.
- Bring a small torch, spare batteries, pocket knife and matches/lighter.
- Bring a small First Aid kit; (consider the most common travel problems like diarrhoea, malaria, fever etc)
- Bring along a universal adaptor e.g. to charge your phone or laptop.
- Bring sun cream, insect repellent and where needed, a mosquito net.
- If you take medicine or need other medical supplies, bring some extra. Your trip might be delayed, and it is likely you will not easily find reliable medication locally.
- In insecure environments, ensure you have the key items below ready in a 'grab bag' in case you have to evacuate. The contents of a grab bag need to be contextualised so check local security recommendations.

Female travellers

- Avoid travelling alone. Adopt a low profile.
- Only use your first initial and no title ('Miss', 'Ms' or 'Mrs') when checking into a hotel. Keep your keys out of sight so nobody can note your room number. Check you are not being followed to your room.
- On checking into your room, check whether the telephone works and note the number of the reception.
- Always meet visitors in the lobby of your hotel.
- If you feel vulnerable, take a room close to the reception or in a busy part of the hotel, not at the end of a long, empty corridor.

- Give consideration to local customs and dress code; dress conservatively, avoid revealing, tight clothing (this is to increase your own safety).
- Stay alert, especially if you feel you are being watched or stalked by men.
- If someone suspicious is behind or ahead of you, cross the street. Repeat the action if necessary and prepare yourself to use whatever means you have to call for help.
- Consider carrying a whistle to attract attention.
- If travelling on a quiet bus, sit near the driver. When needed ask the driver to assist you finding a seat next to another (local) woman. Check you are not being followed when getting off a bus.
- Consider reading the UN guideline: *Security Guidelines for Women 2006: http://www.ilo.org/gender/Informationresources/Publications/lang--en/docName--WCMS_083929/index.htm*
- Travel guides like *Lonely Planet* have a section for female travellers. This advice can be very useful in outlining the local risks and places to avoid.
- If you feel uncomfortable with a situation or with a person, trust your instinct and act firmly – leave immediately. You will find more advice also in the CBM fact sheet on crime.
- If you do not feel safe or secure with a person that is assigned to travel with you, report this to your line manager. In case he/she is not reachable consider cancelling the trip or take arrangements to have an additional person involved.
- If you do not feel safe in an accommodation that is arranged for you, insist on getting a room in a safer hotel or safer part of the hotel (see above).
- When you yourself suffer abuse (improper and disrespectful treatment, threats, unwanted intimacy, violation or rape):
    - Seek immediate contact with a trusted (female) colleague/person or call the CBM HR hotline and / or line manager. Always talk to somebody that can support you.
    - In the worst case scenario – finding yourself in a lonely place without money, phone or contact information - ask a local woman for her help.
    - Inform your contact person / line manager, CBM (external) resource person for psychological support or someone internally you feel comfortable with for further follow up and support.
- Together decide on next steps. Your personal wellbeing is of the highest importance, the formalities only follow later. These could include reporting to the embassy and police (the latter you should always do together with a trusted person).
- Always seek post-incident care. Talk to a professional. CBM will facilitate finding one.

Reporting abuse

When you see a suspected case of abuse of a child or vulnerable adult, report this to your line manager immediately and seek advice. More information you will also find in CBMs Child Protection document.

Topic 24 Self-assessment and Continuous Learning

Content:

- What is self-assessment
- Johari window
- Continuous learning

Introduction:

Learning is a process of acquiring new knowledge, skills, values or even influencing preferences and behaviours. Self-assessment provides insights to one's own progress and learning through self-monitoring.

These are essential for everyone both for personal life and also in career development. As food and supply of nutrition to the body, learning provides nutrition to our minds.

Learning Objectives:

At the end of this lesson, the learner should be able to truthfully assess him/herself and address gaps in their knowledge and competence by seeking the relevant help required.

What is Johari Window?

A Johari window is a psychological tool created by Joseph Luft and Harry Ingham in 1955, for understanding on:

- self-awareness
- personal development
- improving communications
- interpersonal relationships
- group dynamics
- team development; and
- inter group relationships

It is a simple tool which can be applied in different situation and environments.

Overview of the Johari window model

Table 1

Open **(Known to self and known to others)**	**Blind** **(Unknown to self but known to others)**
Facade **(Known to self but unknown to others)**	**Unknown** **(Unknown to self and unknown to others)**

Table 1 illustrates the diagrammatic representation of the Johari Window process (Source: https://richtopia.com/effective-leadership/johari-window)

From the Johari window model shown above, we can see for an example how an individual works within a team. Here, there are two factors at work within the Johari window. **The first factor is what you know about yourself. The second factor relates to what other people know about you.**

The model works using **four area quadrants**. Anything you know about yourself and are willing to share is part of **your open area**. Individuals can build trust between themselves by disclosing information to others and learning about others from the information they in turn disclose about themselves.

Any aspect that you do not know about yourself, but others within the group have become aware of, is in your blind area. With the help of feedback from others you can become aware of some of your positive and negative traits as perceived by others and overcome some of the personal issues that may be inhibiting your personal or group dynamics within the team. There are also aspects about yourself that you are aware of but might not want others to know, this quadrant is known as **your hidden area**. This leaves just one area and is the area that is unknown to you or anyone else – the **unknown area**. For example, this can be an ability that is under-estimated or un-tried through lack of opportunity, encouragement, confidence or training; or a natural ability or aptitude that a person doesn't realise they possess. *Source:https://www.selfawareness.org.uk/news/understanding-the-johari-window-model.* Check this link, which may have copyright.

Johari window is a tool/technique which helps people to understand one's capabilities and relationship with oneself and others. The purpose of using the Johari window is to create an environment conducive for growth and change.

Self-Assessment

Self-assessment is self-evaluation of one's own action, performance, attitude and perception. It supports to identify gaps and enhance learning. It helps learners to evaluate one's own work, understand his/her learning progress or level. It identifies the areas of improvement for an individual.

Importance of continuous learning

Learning is a process of acquiring new knowledge, skills, techniques, cultural values and practices. It even influences preferences and behaviours. Continuous learning is important for an individual

to further expand his/her skill-set in relation to the changing environment, demands and trends. Continuous learning is important to stay relevant, function effectively, being confident and creating opportunities for boosting and building personal profile and also career growth.

Everyone has his/her own learning styles:

Visual learners: learn by exposure or seeing, reading, learning from demonstrations, pictorial representation, flowcharts, etc.

Auditory learners: learn best when information is reinforced through sound. This can be through lectures, music, attending conferences or workshops.

Kinaesthetic learners: learn best by doing. They remember information through performing a task/ activity. This is tactile style of learning, which can be through doing experiments, mock drills and role plays.

How can you learn continuously/learn every day?

- Reading newspapers, books, magazines
- Enrolling for online courses or degrees
- Taking membership/subscribe/join networks/social groups of interest or a library
- Attending workshops, seminars, conferences
- Being more observative and explorative
- Learning by reflection
- Learning by teaching
- Conducting own research/experiments
- Practicing new skills; exercise till you get better
- Reviewing articles, videos, case studies
- Listening to interviews, critics, make your own reviews
- Taking support of mentors both for feedback and also to confide

"Learning gives creativity
Creativity leads to thinking
Thinking leads to knowledge
Knowledge makes you great."
- Dr. APJ Abdul Kalam

References:

https://www.selfawareness.org.uk/news/understanding-the-johari-window-model
https://www.youtube.com/watch?v=9TUTc3h01oA
https://www.youtube.com/watch?v=BWii4Tx3GJk
https://www.bookwidgets.com/blog/2017/06/stimulate-your-students-with-these-10-creative-self-assessment-ideas
https://innovationmanagement.se/imtool-articles/continuous-learning-an-essential-strategy-for-your-personal-success/

भारतीय पुनर्वास परिषद्

REHABILITATION COUNCIL OF INDIA

(A Statutory body of the Ministry of Social Justice & Empowerment)
Department of Empowerment of Persons with Disabilities (Divyangjan)
B-22, Qutab Institutional Area, New Delhi-110016
Ph. : +91-11-26532408, 26534287, Fax : +91-11-26534291
E-mail : rci-depwd@gov.in
Website : www.rehabcouncil.nic.in

Community Based Inclusive Development (CBID)