A Study of

Community Development Programmes

In India

Relevant to Sightsavers Programme

Cover

Back Cover page

3rd Page (back)

Community Development Schemes Relevant to Sightsavers Program

India Country Strategy

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Content

Charpai- cot made of wood/bamboo and ropes

Sahyogi: assistant

Acronyms

AA-ActionAid
ABL- Activity Based Learning
AIDS - Acquired Immune Deficiency Syndrome
ANC – Antenatal care
ANM – Auxiliary Nurse Midwife
APL- Above Poverty Line
APRLP- Andhra Pradesh Rural Livelihoods Project
ARC -Administrative Reforms Commission
ASHA- Accredited Social Health Activists
AWC-Angan Wadi Centre
AWW- Angan Wadi Worker
BPL- Below Poverty Line
BRC/CRC- Block Resource Centre
BRGF - Backward Region Grant Fund
CBOs – Community Based organizations
CBR- Community Based rehabilitation
CHC – Community Health Centres
CII - Confederation of Indian Industries
CIVE-Central Institute of Vocational Education
CMO- Chief Medical Officer
CSOs – Civil Society Organizations
CSR- Corporate social Responsibility
CWSN- Children with special needs
DBCS-District Blindness Control Society
DDM -District Development Manager
DFID- Department for International Development
DH- district Hospital
DIET-District Institutes of *Education* and Training
DPT - Diphtheria, Pertussis (Whooping Cough) and Tetanus
ECE- Early Child Education
EDUSAT- Education satellite
EGS&AIE- Education Guarantee Scheme and Alternative & Innovative Education
EMIS- Educational Management Information System
EPA- Environmental Promotional Assistance Scheme
FRU- First Referral Unit
GHGs – Green House Gases
GoI- Government of India
HIV – Human Immuno Virus
ICDS- Integrated Child Development Services
ICT- Information and Communication Technology
IEC- Information, Education and Communication

IECYD -Inclusion in Education of Children and Youth with Disabilities
IEDC - Integrated Education for Disabled Children
IGNDPS - Indira Gandhi National Disability Pension Scheme
IHHL - Individual household latrines
IOL-Intra-ocular Lens
IPCC - Intergovernmental Panel on Climate Change
ITDA- Integrated Tribal Development Agency
IU-Vitamin A Dose
IWDP- Integrated Wastelands Development Programme
JEI- Jordan Education Initiative
JFM - Joint Forest Management
JSY- Janani Surakhya Yojana
KGBVs -Kasturba Gandhi Balika Vidyalayas
KVIC- Khadi and village Industries Corporation
KVKs - Krishi Vigyan Kendras
L.C.I -Leonard Cheshire International
MADA-Modified Area Development Agency
MDG- Millennium Development Goal
MFIs -Microfinance institutions
MGML -Multi Grade Multi Learning
MGNREGS/ NREGS - Mahatma Gandhi National Rural employment Guarantee Scheme
MHRD- Ministry of Human Resources Development
MoUs -Memorandums of Understanding
MTA- Mother Teacher association
NABARD- National Bank of Agriculture and Rural Development
NBMMP - National Biogas & Manure Management Program
NCPEDP-National Centre for Promotion of Employment for Disabled People
NCF- National Creche Fund
NHFDC -National Handicapped Finance and Development Corporation
NIOS- National Institute of Open School
NGO – Non Government Organization
NPCB – National Program for Control of Blindness
NREGA- National Rural Employment Guarantee Act
NREGS- National Rural Employment Guarantee Scheme
NRHM- National Rural Health Mission
NSSO- National Sample Survey Organization
OPV- *Oral polio vaccine*
ORS – oral Re-hydration Solution
OT- Occupational therapy
PACS- Poorest Areas Civil Society (PACS) Programme of DFID
PDS- Public Distribution System
PHC – Public Health Centre
PNC- Post natal care
PRIs - Panchayati Raj Institutions
PT- Physiotherapy
PTA- Parent Teacher Association

PWD- Person with disability
RCH – Reproductive Child health
REI -Rajasthan Education Initiative
RIF - Rural Innovation Fund
RSBY - Rashtriya Swasthya Bheema Yojana
RSMs- Rural Sanitary Marts
RTI- Reproductive Tract Infection
RTI- Right to Information
SBCS -State Blindness Control Society
SC- Scheduled Caste
SHG- Self Help Group
SGSY- Swaranjayanti Gram Swarojgar Yojana
SIEMAT - State Institutes of Education Management and Training
SIERT- State Institute of Educational Research and Training
SL- Sustainable Livelihoods
SMC- School Management Committee
SPO -State Programme Officer
SREDA - State Renewable Energy Development Agency
SRG -State Resource Group
SSA- Sarva Sikhya Aviyan
SSI-Sightsavers International
SSDC-Sunderban Social Development Centre
SSHE - School Sanitation and Hygiene Education
ST- Scheduled Tribe
STI- Sexually transmitted Infections
TB- Tuberculosis
TLM- Teaching and Learning material
TSC- Total Sanitation Campaign
UEE- Universal Elementary Education
UNESCO- United Nations Educational, Scientific, and Cultural Organization
UNICEF- United Nations International Children's Emergency Fund
UP- Uttar Pradesh
VEC- Village Education Committee
VHND -Village Health Nutrition Day
VHSC-Village Health and Sanitation Committee
VO- Voluntary Organization
WHO – World Health Organization

Executive Summary

1.1. The study on "Community Development Programmes in India Relevant to Sightsavers Programme" aims to develop a strategy for the inclusion of the eye care and other needs of stake holders affected by eye health problems with the mainstream community development programmes implemented by the government and other institutions.

1.2. This study is based on the review of secondary data from various sources and collection of primary data from the field by paying visit to selected states in different regions (eastern, western, northern, southern and central parts) of India. The outputs of the study include specific strategies and processes for linking the Sightsavers' Community Eye Health and Social Inclusion (specific strategy and process for each of these two components) interventions with community development programmes; guidelines for training of the programme staff and the staff of the partner agencies on topics related to integration of Sightsavers programme with community development programmes and a suggestive roadmap for Sightsavers and the partner agencies for ensuring the integration of Sightsavers programme with community development programme.

1.3. The analysis and presentation of information is backed by a conceptual framework which broadly defined eye health, social inclusion, gender, rights and role of stakeholders in communities.

1.4. A detail review of available community development schemes in different states in India and their close examination in relation to eye health, disability and social inclusion helped to put the schemes under different development themes and the degree of their relevance to eye health, disability and social inclusion programmes. Meetings with the community level human and institutional stakeholders helped to understand the potential key players and stake holders who can play critical role in the integration and convergence of different community development schemes in order to establish a sustainable community eye health and social inclusion program in the communities.

The study emphasized that the mere provision of extension or outreach services is not in itself sufficiently indicative of an effective community eye health and social inclusion services. Only when these services are related to alleviation of poverty by social inclusion and bring about a perceptible change in community behaviour and eye care parameters, can we say that an effective system of community eye health programme exists. In order to design a successful and sustainable community eye health and social inclusion programme, the schemes on health care, nutrition, water, sanitation and hygiene, education, livelihood, mitigation of climate change impact are to be integrated with the ongoing programmes and the practices.

1.4.1. Relevant Health Sector schemes: The major health sector schemes those address eye health (blindness prevention, restoration of vision, etc) are National Rural Health Mission (NRHM), Schemes for Voluntary Organizations/NGOs under NPCB, the Reproductive and Child

Health Programme, Janani Surakhya Yojana etc. Monthly Village Health Nutrition Day (VHND) observed under NRHM can be used as an important tool for the convergence of all health care activities including eye screening and vitamin A supplementation. The key community level stakeholders in health sector who can play potential role are the service providers like ANM, ASHA, Multi-Purpose Health Worker, Health Officer (PHC), health staff of NGOs, Private Medicine Practitioner/ Traditional Medicine Practitioners, etc.

1.4.2. Schemes on Nutrition and eye Health: Poverty and unequal access to proper and adequate nutrition puts poor people in disadvantage in most of the communities which affects eye-health and quality of life in some stages of life. Children, women and aged are most vulnerable to nutritional deficiency. The schemes like Integrated Child Development Services (ICDS), National Prophylaxis Programme against Nutritional Blindness, etc address the issue of nutrition and its deficiency among women and children leading to eye health problems and poverty. The community level office bearers responsible for community development schemes on nutrition are Anganwadi Staff, mid-day-meal cook in the schools, Public Distribution System dealer, ANM, ASHA, NGO staff looking after nutrition component of their projects. The community institutions supplementing nutrition or improving over all nutrition of the target families/groups are Angan Wadi Centre, Schools, NGOs, community based health facility etc.

1.4.3. Inclusive Education: The schemes on inclusive education are concerned with providing flexible education keeping in view the diverse needs of children. It builds on recognizing diversity and valuing differences and not just tolerating children with special needs (CWSN). The model educational schemes implemented in the communities are Sarva Sikhya Aviyan (SSA), Integrated Child Development Scheme (ICDS), Inclusion in Education of Children and Youth with Disabilities (IECYD), Rajasthan Education Initiative (REI) etc. The community level service providers are school teachers, Angan Wadi staff, Adult Education/Night School Teacher, Early Childhood Intervention Teacher. The institutions directly delivering services are Village School, Anganwadi Centre, the National Institute of Open School (NIOS), EGS&AIE centres, District Rehabilitation Centre, District Disability Rehabilitation Centres and Composite Resource Centres, Central Institute of Vocational Education (CIVE), Public Health Centres, etc.

Project managers can collaborate with the Government's flagship Sarva Siksha Abhiyan (SSA) to achieve universal education targeting the 6-14 age groups. The school teachers can screen and identify children for referrals and surgery if trained by eye health doctors. The fixed cost for treatment and surgery can be reimbursed from the SSA. The collaboration would be immensely useful in reaching out to the remotest of hamlets. Similarly, for the 0-6 age group, eye health project partners may collaborate with the Integrated Child Development Scheme (ICDS) programme implemented by the Department of Women and Child Development.

1.4.4. Livelihood Schemes and Social Inclusion: The economic empowerment of disabled people is the key to independent living and sustainable livelihoods. In line with this thinking, the Tenth Plan advocated the introduction of a Component Plan for the Disabled in the budget of all concerned Ministries/Departments in order to ensure a regular flow of funds for Schemes/Programmes for the empowerment of disabled people. The livelihood schemes available in the communities are Tribal/Rural livelihood Project, MGNREGS, Swarna Jayanti

Gramya Swarojgar Yojana, Rural Innovation Fund (NABARD), livelihood project floated by bi-lateral agencies (DFID Livelihood Project), Grain Bank, income generation schemes by non-government, private and banking and cooperative agencies. The community level service providers in livelihood sector are Village Agriculture worker/Lady Village Agriculture Worker, Livestock Inspector, Milk Union staff, Cooperative Bank Secretary, Commercial Bank Staff, Gramya Rojagar Shayak (MGNREGS), SGSY Resource Person, etc. The institutions directly delivering services to community are Panchayati raj Institution, National Handicapped Finance and Development Corporation (NHFDC), commercial bank, NABARD, KVIC, Cooperative Bank, Milk Union, Insurance Company and government line departments including Rural Development, Panchayati Raj, Forest and environment, Agriculture, Animal Husbandry, Revenue, Civil supply etc.

1.4.5. Water, sanitation and Hygiene and Eye Health: Crowded living conditions, lack of sufficient water and sanitation services, and contact with eye-seeking flies and fly-breeding sites near the homes are some of the many risk factors for trachoma and Conjunctivitis. Trachoma is an indicator of public health and community health issues as well as a pathway to blindness for many individuals.

Trachoma and Conjunctivitis are diseases of marginalized populations living in areas with limited resources and in need of a good water supply near their home as well as proper, well-maintained sanitation facilities. As the education and economic welfare of a community rises, trachoma decreases. Meanwhile, the WHO, along with an alliance of interested parties, Alliance for Global Elimination of Trachoma by the year 2020 has adopted the "SAFE" strategy to combat trachoma. The strategy includes besides surgery – to correct end-stage disease and antibiotic treatment – emphasized on facial cleanliness – frequent face washing and environmental improvement – improved water supply and sanitation facilities.

The schemes safe water, sanitation and hygiene are the Rural Water Supply Scheme, Water-shed Project, Rural Sanitation Mission (TSC), My Tank (Mo Pokhari) (State Government), Indira Awas, etc. Community level service providers in water, sanitation, hygiene and housing include Sarpanch, Ward Members, School Teacher, ANM, Lady Health Visitor, AWW, ASHA, NGO Staff, private agencies etc.

Institutions involved in delivering services are Sanitation Mission, Rural water supply Department, NABARD, etc. The community institutions involved in implementation of the schemes are Village Panchyat, Village Development Committee/Gaon kalian samittee and Village Health and Sanitation Committees (VHSC). The services include supply of safe drinking water, installation of latrines, Hygiene Education, IEC materials on water, sanitation and solid waste disposal.

1.4.6. Schemes on Mitigation of Climate Change Impact on Eye Health: Blinding cataract in certain parts of India is attributable to repeated dehydrational crises resulting from severe life threatening diarrhoeal disease and heatstroke in summer months and cooking fuel pollution. It is reported that such cases are increasing due to extreme climate change impacts which were not so previously. The relevant schemes which may address the issue of mitigation of climate change impact on eye health are NRHM, ICDS, MGNREGA, Social Forestry/Plantation, Wetland Management/Water-shed Management, TSC, National Biogas &

Manure Management Program (NBMMP), Integrated Afforestation & Eco Development Project (Ministry of Environment & Forest, Government of India), National Biogas & Manure Management Program (NBMMP) (Department of Renewable Energy, Government of India), Environmental Promotional Assistance Scheme (EPA of NABARD), etc. The Community Level Service Providers are the Sarpanch, Health Officer, ANM, ASHA (Provide ORS), AWW (IEC), Forest Officer, Agriculture Extension Officer, Water Resource staff, NREGA Staff (NREGA and climate Change mitigation actions), NGO Staff, etc. Institutions directly delivering services to the community are the Village panchayat, PHC, CHC, Sub-centre, Agriculture Department, ITDA, Village School, and the State Renewable Energy Development Agency (SREDA).

1.4.7. Relevance of micro-insurance: In India, low-income people on an average are more prone to illness, work under hazardous conditions and do not have regular health and eye check –ups. Besides risks related to hazardous working conditions often result in disability. The relevant micro-insurance products are comprehensive health and vision insurance, life and disability insurance, Asset Insurance, Farm & Rural Non-Farm Micro-Finance, Livestock insurance, agricultural insurance, etc.

A person's medical insurance may cover a medical eye problem, but not pay for the exam if it is a "routine" eye exam. Many vision plans provide coverage for glasses and contact lenses, or at least give a person some type of discount on the doctor's fees. A person's medical insurance will pay for examinations if s/he has eye health problems. Many people with medical insurance have a separate rider policy to cover routine eye exams. The plan coverage varies among insurance companies. Insurance companies usually separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. Typically, vision insurance policies usually cover both the eye exam and the refraction, while medical policies cover the exam only.

Asset insurance will protect the beneficiaries under rehabilitation and pursuing livelihood activities from loss due to fire, theft etc. The schemes available are Rashtriya Swasthya Bima Yojna, Comprehensive Health Insurance Scheme (CHIS) and Vision Insurance, Aam Admi Bima Yojna (AABY), Janshree Bima Yojna, National Agricultural Insurance Scheme (NAIS), Micro Credit to Self Help Groups, etc

The community level service providers are insurance agents (Micro-insurance), MFI Staff, staff of NGOs working on micro-credit. The institutions directly delivering services to community are Birla Sun Life Insurance, SBI Life Insurance, Oriental Insurance, Royal Sundaram, Alliance Insurance, Reliance General Insurance, IFFCO Tokyo, General Insurance, Life Insurance Corporation, HDFC Chubb, Cholomandalam Ms General Insurance, Tata Aig, etc.

Community institutions involved in implementation of Schemes are Village Panchayat, SHG Committee, etc. Government policies play a key role in promoting health insurance programmes. The Government of Karnataka for example, is running a major heath insurance scheme for farmer's cooperatives named Yashaswani. M. M. Joshi Eye Institute, Hubli, is the lead network hospital for eye care under this scheme in north Karnataka. Taking it

further, the Karnataka Government has now decided to expand this scheme to include all school-going children of both government and private schools in its ambit. This has been the result of sustained advocacy.

1.5. PRI as a Nodal community Institution: Consequent to the 73rd Constitutional Amendment Act, the State Governments are now evolving modalities and institutional arrangements for facilitating the involvement of Panchayati Raj Institutions (PRIs) in implementation of various programmes under 29 subjects including 'Empowerment of Disabled'.

The National Health Policy, 2001, emphasizes implementation of public health programmes through local self-government institutions, especially relating to the national disease control programmes. PRIs are seen as critical to the planning, implementation, and monitoring of the NRHM. The PRIs are given a vantage position to take over full responsibility for implementation of a rights based pro-poor programme of large magnitude like the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS). Government consciously decided to internalize its operationalisation into the Panchayati Raj system to further empower it.

The PRIs can play a pivotal role in 'Empowering People with Disabilities' through awareness building, ensure convergence of the various programmes which are meant to benefit the disabled, ensure that all the children with disabilities are identified in a systematic manner, located in either the community, anganwadi centres, health centre or school at least once in a year; make arrangements for training of personnel who are involved in identification and early detection of disabilities; organize small groups of disabled persons for viable income generating activities with the help of block level panchayats; make arrangements for vocational training programmes of the children with disabilities at their right ages.

1.6. Practices from the Field: A number of practices were documented during visits to the projects of the partners located in different states. Some of the practices of agencies working in eye health sector were also elicited from the secondary sources. These practices provide insight about the linkage of eye health and social inclusion interventions with community development schemes on health, nutrition, education, livelihood, water, sanitation and hygiene, micro-insurance floated by government, non-government, private, bilateral and multilateral agencies.

1.7. Strategy and action plan (SAP): Finally the study report has proposed a strategy and action plan (SAP) for Community Eye Health and Social Inclusion interventions by linking with relevant community development programmes; suggested the mode to involve community level stake holders and community based institutions in the process of convergence and integration of Community Eye Health and Social Inclusion interventions with the community development schemes; proposed the method of building socially inclusive community development programmes by mainstreaming disability, with a view to being on-target with the Millennium Development Goals; proposed to adopt a rights-based approach to disability, with community development organisations oriented to understand disability as a cross-cutting issue; suggested to establish programmes with stronger community base and identified strategic community based institutions for linkage in different mandates of SSI, and recommended to inform and orient partner organisations to broaden their scope of work, especially from pure service delivery to comprehensive community approach.

1. Introduction

Community development programs in India are initiatives designed to promote social, economic, and cultural advancement at the grassroots level, particularly in underserved or marginalized communities. These programs aim to empower communities to address their own development needs through collaboration, capacity building, and the sustainable use of local resources. In the context of the Sightsavers Programme, which focuses on disability inclusion, these community development efforts are crucial in ensuring that people with disabilities (PWDs) are not left behind in development processes.

Relevant community development programs aligned with Sightsavers' mission include:

- Disability Inclusion Programs: These programs work to raise awareness about the rights and needs of people with disabilities, promoting accessibility, inclusion, and participation in all aspects of community life, such as education, healthcare, and employment.

- Healthcare Initiatives: These focus on improving access to essential health services, including eye care, for marginalized populations. Programs like eye screening, cataract surgeries, and vision correction services are critical in tackling avoidable blindness and visual impairments in rural India.

- Educational Support for Children with Disabilities: Efforts to improve the quality of education for children with disabilities, including inclusive education in schools, training teachers on disability awareness, and providing specialized learning materials.

- Livelihood Support and Vocational Training: Vocational programs that provide skill-building opportunities for people with disabilities, enabling them to achieve economic independence and participate actively in the workforce.

- Advocacy and Policy Influence: Sightsavers supports advocacy to influence national and local policies that impact people with disabilities, such as advocating for inclusive legislation and improved social protection systems.

- Empowerment of Disabled People's Organizations (DPOs): These programs aim to strengthen the capacity of DPOs, allowing them to become effective advocates for the rights of people with disabilities at the community, district, and national levels.

These programs contribute to an inclusive society where people with disabilities can lead independent, fulfilling lives with access to quality healthcare, education, and economic opportunities.

1.1. BACKGROUND

In India Sightsavers International has the mandate to combat blindness among people in rural and urban communities. Over the years, its mission has expanded to provide services to the blind and campaign for the eradication of needless blindness through programmes of direct service delivery & social inclusion projects. The services in India are mostly limited to what the implementing local partner agencies deliver from the support of the Sightsavers International. But, in India there is a large scope to tap resources from a number of community development schemes launched by the central government, the state governments, the Panchayati Raj Institutions (PRIs) and a host of bi-lateral, multi-lateral, private and non government agencies to address the needs of the target groups. But no concrete effort and strategy is yet made for accessing the resources of mainstream community development schemes and relevant service delivery agencies operating in the communities. In Sightsavers strategic plan for 2009–13 one of the foci is to "Ensure all eye care and social inclusion programmes are rooted in community development". In this context it becomes important to spell the strategy and to identify the community development initiatives with which the programme of Sightsavers can be linked to ensure inclusive, sustainable and value added benefits to its target stakeholders.

1.2. Purpose:

The purpose of the study is to develop a strategy for the inclusion of the eye care and other needs of stake holders affected by eye health problems with the mainstream community development programmes of the government and other institutions.

1.3. Objectives:

- To identify and examine the community development programmes with which the Sightsavers programme can be linked.
- To know how the selected community development programmes will benefit the Sightsavers' project beneficiaries.
- To identify the process for linking the Sightsavers projects with the community development interventions

1.4. Methodology:

The study is based on review of secondary data and collection of primary data from the field. Field visit was made to selected states in India covering different regions (eastern, western, northern, southern and central parts) of India.

- Secondary information included the review of Sightsavers current programme approach and practice of eye care and social inclusion, community development schemes floated by Government of India,the Sate Governments where the partners of Sightsavers were implementing their programme and the community programmes supported by bilateral, multilateral and other national and international NGOs.
- First hand data were collected on (i) the impact of various community development schemes on people with disability in general and visually impaired segment in particular, (ii) their response towards the programs, (iii) data on best practices (best practices developed in the field/success stories from project partners), (iv) data on human and institutional development at the community level, (v) partners' and duty bearers readiness, their capacity and gaps
- In this connection interface discussions with focus groups of beneficiaries/other local stakeholders were held in the community level including staffs of partner agencies, office bearers of various service delivery institutions in the community level, community based peoples' institutions engaged in ther implementation of different government and other schemes, people with disability, Blind People

Organizations and people with restored vision. Program wise successful community development practices were identified by partners' and stakeholders' consultation.

1.5. Outputs:

- Specific strategies and processes for linking the Sightsavers' Community Eye Health and Social Inclusion (specific strategy and process for each of these two components) interventions with community development programmes

- Guidelines for training of the programme staff and the staff of the partner agencies on topics related to integration of Sightsavers programme with community development programmes.

- A suggestive roadmap for Sightsavers and the partner agencies for ensuring the integration of Sightsavers programme with community development programme.

2. Conceptual Framework

The conceptual framework explains the potential and possibilities of linking community eye health and social inclusion process with different community development schemes.

2.1. Eye-health: Eye care implies the use of appropriate strategies to reduce the burden of eye disease, the promotion of good ocular health, the prevention of ocular morbidity & disability, treatment of curable blindness and rehabilitation of the incurable blind and persons with restored vision in the community.

A multi-state study undertaken in India identified the major causes of severe visual impairment/blindness (SVI/BL) children (SVI/BL) mainly attributable to vitamin A deficiency (Rahi JS, Sripathi S, Gilbert CE, Foster A. 1995). A study states that one of the causes of corneal blindness is malnutrition.

Conjunctivitis known as eye flu which usually affects a large number of people at a time, particularly during monsoon, spreads from person to person. Fingers, flies and fomites (handkerchief, towel, bed linen, etc) spread infection. Local partner in Sunderban shared that proper hygiene and clean water for washing is not available during monsoon in their area. Trachoma, an infectitious disease is found in certain pockets of the states like Haryana, Punjab, Rajsthan, UP, Uttaranchal, Gujarat, etc. Local NGO partners said that personal hygiene, clean environmental sanitation can prevent its spread.

In states like Orissa and Chhattisgarh it was reported by the people and health personnel that blinding cataract is attributable to repeated dehydrational crises resulting from severe life threatening diarrhoeal disease and heatstroke in summer months and cooking fuel pollution. It was also shared by the elderly people that such cases are increasing due to extreme climate change impacts which were not there previously.

People with irreversible blindness need supports like livelihood, health care and nutrition, housing, insurance, education and other community basic services for their rehabilitation.

It is important to remember that the mere provision of extension or outreach services is not in itself sufficiently indicative of an effective community ophthalmology services. Only when these services are related to alleviation of poverty by social inclusion and bring about a perceptible change in community behaviour and eye care parameters, can we say that an effective system of community ophthalmology practices exists.

In order to design successful and sustainable community eye health and social inclusion programmes, the schemes on health care, nutrition, water, sanitation and hygiene, education, livelihood, mitigation of climate change impact are to be integrated with the onging programmes and the practices.

2.2. Social Inclusion:

It is rightly said by Olof Palme, late Prime Minister of Sweden-

'We human beings are all different. We have different needs, and different weaknesses. Therefore, the society in which we live should never be formed on the basis of the special demands by the few. The society must be formed in such a way that it will suit all. The needs of disabled persons must influence the planning of our societies as much as the needs of non-disabled persons, not because we must pay special attention to the disabled, but because they are citizens of the society as everyone else. Therefore, their needs must be included in the building of the society as a matter of course.' (Cited by Janet Seeley, 2001)

Taking a leaf from Olof Palme's message, this report intends to actively ensure people with disabilities to be included and benefit equally from a wide range of community development schemes. Disability inclusion can apply to many different kinds of programmes, for example, health, education, livelihood, micro-credit and micro-insurance and infrastructure programmes. Disability inclusion would occur when programmes are adjusted and strengthened. Small changes are required so that the needs of people with disabilities as well as those who do not have a disability are met. In order to meet the needs of people with disabilities in a country like India, two broad strategies are necessary: disability specific initiatives and disability inclusive projects

There is a need to advocate for equal rights of persons with disabilities in society and seek to support healthcare, educational, rehabilitative and income generation services designed to maximise their quality of life.

2. 3. Gender

Above two-thirds of blind people in India are women and girls. But men are twice as likely to access eye-care services as women. Females of all ages across the states in India have a much higher risk of being visually impaired than males. The reasons are complex and vary from place to place. However, salient factors include longer life expectancy, cultural constraints on the mobility of women, lack of awareness and education about possible treatment and straightforwardly inappropriate services. Equal access to eye care could substantially reduce blindness in poor communities. Women disproportionately bear the burden of health inequalities in the communities and face unique barriers in accessing medical care.

Researchers have conducted a meta-analysis of population-based prevalence studies and found that approximately two out of every three blind people were women, most of whom were over the age 50 years, and ninety percent lived in poverty. In no instances did biological differences explain these gender disparities. Instead, "women of all ages (including children) were more frequently exposed to causative factors, such as infectious diseases and malnutrition, and utilized eye care services less frequently than men".

Not only are women more likely to have higher rates of blindness, they are also less likely to obtain proper eye care. Several studies have documented such disparities. For example, women account for 67% of all

individuals with visual problems, adjusted for age and irrespective of any biological attribute. Also, women were found to utilize eye care services 40% less than men. The difference in gender distribution and low vision is statistically significant in all age groups. In addition, females in South India are less likely to have surgery for cataracts although the cataract blindness burden is higher for women.

Why do these drastic inequalities exist? On the surface, there are proximate factors that contribute to health disparities between men and women, such as lower levels of education, literacy, and socioeconomic status. Yet underlying these proximate factors are the ultimate causes of gender inequality. Socially embedded constructs of masculinity, power differentials, and social status are all fundamental factors that manifest in poor health outcomes for women and constrain their ability to access medical care. There is also poor targeting of women suffering from eye problems in social inclusion process in rural and urban slum communities.

2. 4. Rights-based approach:

Access to eye care services and social inclusion programmes are the rights of affected people. A rights-based approach is the answer to self-help and to reduce dependence on rest of society to decide for disables. It is based on empowerment, equality of entitlement, dignity, justice and respect for all people. It encourages demanding services actively, according to their own priorities, and thereby raises self esteem and promotes autonomy. It implies obligations by society to enable people to enjoy their rights, but requires mechanisms for redress if things go wrong.

2.5. Stakeholders: Human and Institutional

The stake-holders of different community development schemes include the office bearers of different schemes, various community based institutions including the Panchayati raj Institution, NGOs, cooperatives and the government line departments involved in implementing the schemes, various committees in the village level involved in planning and monitoring of activities. The understanding of their role, responsibilities and their potential will help in strategizing community level convergence and integration for effective eye health and social inclusion programmes.

Community & multiple service institutions

Visit to Tentulikhunti GP, Boisinga Block of Bolangir is a wonderful experience. The community people listed a number of office bearers in the community who are paid by GO, NGO, co-operatives or private agencies and work for the community people in different thematic areas. There are a number of committees in the village which look after the implementation of the programs. People of the village including women, men and children listed the services they receive from different agencies those exist in the community. People shared that multiple service institutions, office bearers, committees have ensured greater participation of people in different schemes meant for the people. It has reduced conflict; it has helped in lobbying for services and implementation of schemes; it has ensured transparency and flow of information, to stakeholders.

3. Community Development Schemes with Scope for Linking Eye Health and Social Inclusion Interventions

A detail review of available community development schemes in different states in India and their close examination in relation to eye health, disability and social inclusion helped to put the schemes under different development themes and the degree of their relevance to eye health, disability and social inclusion programmes. Meetings with the community level human and institutional stakeholders helped to understand

the potential key players and stake holders who can play critical role in the integration and convergence of different community development schemes under the array of themes to establish and mainstream a successdul and sustainable community eye health and social inclusion program in the communities.

3.1. 3.1. Health Sector Schemes

Several health sector schemes in India address eye health, focusing on the prevention of blindness, restoration of vision, and management of major eye diseases. Prominent among these are the National Health Mission (NHM), Schemes for Voluntary Organizations/NGOs under the National Programme for Control of Blindness & Visual Impairment (NPCBVI), the Reproductive and Child Health (RCH) Programme, and Janani Suraksha Yojana.

3.1.1. National Health Mission (NHM)

The National Health Mission (NHM), encompassing both the Rural Health Mission (NRHM) and Urban Health Mission (NUHM), aims to provide accessible, affordable, and quality healthcare to the rural and urban populations of India, especially vulnerable groups such as women, children, and the elderly.

The National Programme for Control of Blindness & Visual Impairment (NPCBVI) has been integrated under NHM. As a result:

- The State Blindness Control Societies (SBCS) have been merged with State Health Societies.
- The District Blindness Control Societies (DBCS) have been merged with District Health Societies.
- Funds for the implementation of NPCBVI are now released through State Health Societies in the form of Grant-in-Aid.

Key Initiatives under NPCBVI (Now under NHM):

- Infrastructure Development:
    - Construction of dedicated Eye Wards and Operation Theatres in district and sub-district hospitals, particularly in North-Eastern States, Bihar, Jharkhand, Jammu & Kashmir, Himachal Pradesh, Uttarakhand, and other identified regions.
- Human Resource Strengthening:
    - Appointment of Ophthalmic Surgeons and Ophthalmic Assistants in newly created districts.
    - Deployment of Ophthalmic Assistants in Primary Health Centres (PHCs) and Vision Centres lacking trained personnel.
    - Engagement of Eye Donation Counselors in Eye Banks operated by both government and NGOs on a contractual basis.
- Support to NGOs and Private Sector:
    - Grant-in-Aid for management of eye diseases beyond cataract, including:
        - Diabetic Retinopathy
        - Glaucoma
        - Laser Techniques
        - Corneal Transplantation
        - Vitreoretinal Surgery

        - Treatment of Childhood Blindness
    - Financial support of:
        - ₹750 per case for Cataract/IOL surgery (₹850 for NE, Hilly, Desert Areas)
        - ₹1,000 per case for other major eye diseases (₹1,100 for NE, Hilly, Desert Areas)
    - Involvement of Private Practitioners at sub-district and community levels.
- Technological and Mobile Outreach:
    - Expansion of Tele-Ophthalmology Services (Eye Care Management Information and Communication Network).
    - Development of Mobile Ophthalmic Units (MOUs) equipped with telemedicine tools to reach remote and underserved areas.
- Programmatic Strengthening:
    - Expansion of Intraocular Lens (IOL) Implantation up to Taluka level.
    - Enhanced grants to Eye Banks, Eye Donation Centres, and NGOs for improved service quality.
    - Maintenance support for ophthalmic equipment supplied under the program.
    - Strengthening of the Management Information System (MIS).
    - Intensification of Information, Education & Communication (IEC) activities to raise awareness and promote eye health-seeking behavior.

Budgetary Allocation:

A provision of ₹1,550 crore was earmarked for the implementation of NPCB during the 11th Five Year Plan, reflecting the government's commitment to eliminating avoidable blindness and improving access to comprehensive eye care.

Monthly Village Health Nutrition Day (VHND): a platform for Convergence

Monthly Village Health Nutrition Day (VHND) is an important tool under NRHM for the convergence of all activities including eye screening and vitamin A supplementation. Village Health and Nutrition Day (VHND) or Health Day is observed every month in every village of a state to provide health care services to women, adolescents and children. ASHA, AWW & ANM organized Health day and mobilized the women, adolescents and children. On this day, health related issues like nutrition, personal hygiene; care during pregnancy, importance of antenatal & post natal care, institutional deliveries, immunization, etc are discussed.

The Angan Wadi Centre (AWC) is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for intersectoral convergence. VHND is also a platform for interfacing between the community and the health system.

VHND if organized regularly and effectively can bring about the much needed behavioral changes in the community, and can also induce health-seeking behavior in the community leading to better health outcomes. On the appointed day, ASHAs, AWWs, and others mobilize the villagers, especially women and children, to assemble at the nearest AWC. The ANM and other health personnel remain present on time; On the VHND, the villagers can interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities. Health services will be provided at their doorstep. The VHSC comprising the ASHA, the AWW, the ANM, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practices.

Primary Health Care:

The rural poor are most vulnerable to disability. Nutritional deficiencies, inadequate sanitation, insufficient or inaccessible health care services, accidents and injuries from poorly-designed equipment and implements, and practices like consanguineous marriages, have all contributed to a high prevalence of disabilities. Immunisation programmes have not yet achieved 100% coverage, due partly to inadequate infrastructure, logistical problems and difficulties in maintaining the cold chain, and partly to the lack of public education on the subject. It has been estimated that an effective primary health programme can prevent about half of all disabilities. Early detection of impairment, combined with early and effective curative care can make a significant impact in minimizing or compensating for impairment and its consequence.

3.1.2. Schemes for Voluntary Organizations/NGOs under NPCB:

VOs/NGOs can play an important role in implementing various activities under the programme. Under the scheme a non-recurring grant a maximum of Rs.25.00 lakhs is granted for expansion/up gradation of Eye Care Units for tribal and backward rural areas. Also Rs. 10 lakh is granted for up gradation of Eye Banks as non-recurring assistance and Rs. 1000 are provided per pair of eyes as recurring assistance. The schemes are available under NPCB. The purpose of the schemes is to develop eye care infrastructure and to provide appropriate eye care services to reduce the prevalence of blindness.

NGOs establish and manage Vision Centres. The Vision Centre in a village set-up becomes the hub of all promotion and preventive activities. As a one point source, it also serves as the centre for screening, referrals and spectacle disbursement.

Schemes for Voluntary Organizations/NGOs under NPCB are annexed-1

3.1.3. The Reproductive and Child Health (RCH) Programme

SSDC does eye check of both Mother and Child

Sunderban Social Development Centre, Sunder Ban, West Bengal is not only running a Vision Centre in a PHC, it has also mobilized INR 13.7 lakh from MP fund for a Maternity Hospital and INR 50,000 from MLA Fund for the vision centre to procure equipments. Subsequently it also received Rs 5 lakh for Eye Hospital from MP fund. Japan High Commission extended Rs 30 lakh for hospital building. SSDC is active in eye check up of both mother and child those come for delivery to the Maternity Hospital.

The programme aims to universalize the immunization, ante-natal care, skilled attendance during delivery as well as for common childhood elements. Greater stress on improving neonatal care in at all levels, hospital, homes and community is paid so as to substantially reduce the infant mortality. This programme aims at eradication of polio virus while selectively introducing Hepatitis B. The scheme is accessed through local healthcare centres. Non Government Organizations also adopt Public Health Centres (PHCs) where they run Vision Centre and create facilirty like Maternity Hospital. Sunderban Social Development Centre, West Bengal is not only running a Vision Centre in a PHC, but also created a facilirt like Maternity Hospital. SSDC is active in eye check up of both mother and child those come for delivery to the Maternity Hospital. SSDC's initiative is a case that provides a scope for integration of eye care with RCH programme in Public Private Partnership (PPP) mode and attracted support from various agencies.

(Annexure-2: Relevant Health Sector Schemes implemented in different states in India)

3.1.4. Community level Stakeholders in Health Sector Schemes:

- Across the states in India the key community level stakeholders in health sector include the community level service providers like ANM, ASHA, Multi-Purpose Health Worker, Health Officer (PHC), health staff of NGOs, Private Medicine Practitioner/ Traditional Medicine Practitioners etc.
- The health institutions directly engaged in providing services in the communities are Sub-centre, Primary Health Centre (PHC), Community Health Centre (CHC), health facility created by NGOs and private agencies.
- Community based institutions those facilitate the implementation of health schemes include, Gaon Kalyan Samittee, Eye Care Committee/ Blindness Prevention Committee (Andhata Nivaran Committee) (SSI Partner), Matru Mangal committee, Rogi Kalyan samitee (PHC/CHC), Link Workers Committee (ActionAid), Village Health and Sanitation Committee (VHSC), etc.
- The health provisions/Services at Community level include health services from Sub Centre, Public Health Centre, and Community Health Centre and in the apex the District Hospital, Ambulance Service (private and public) and in some places Mobile Health Clinic (some have also facility for eye screening, etc). (* Based on field data from Orissa, West Bengal, Uttar Pradesh, Rajasthan, Andhra Pradesh, Tamilnadu)

3.2. Nutrition & Eye Health

Nutrition and eye health appear to be strongly correlated and there are many foods, vitamins and minerals that may make a significant difference in the quality of vision and eye health. Nutrition for the eyes includes more than sufficient vitamin A. Other nutrients are equally important for maintaining eye health and to prevent age-related disease. The first step to ensuring eye health is to maintain good overall nutrition through out life cycle, because a balance is necessary to support biochemical processes. Poverty and unequal access to proper and adequate nutrition puts poor people in disadvantage in most of the communities which affects eye-health and quality of life in some stages of life. Children, women and aged are most vulnerable to nutritional deficiency. There are community development schemes like Integrated Child Development Services (ICDS), National Prophylaxis Programme against Nutritional Blindness, etc that address the issue of nutrition and its deficiency among women and children.

3.2.1. Integrated Child Development Services-IV (ICDS-IV)

World Bank assisted Integrated Child Development Services-IV (ICDS-IV) is under implementation for the period 2008/09 to 2012/13 by the Ministry of Women and Child Development (MWCD) in selected States (identified on the basis of malnutrition parameters). ICDS aims to reduce child malnutrition among children in the age group of 0-6 years, with special focus on children below three years, through expanded utilization of nutrition services and awareness and adoption of appropriate feeding and caring behaviors by households; and improve early child development outcomes and school

Nutrition from Nutrition Garden

Minakhi Gayan is a staff of local NGO partner of SSI. She works in Durbachoti GP. The population of the GP is 6300 having 1235 families. She had motivated about 50 percent of the families to have a Nutrition Garden in their backyard after demonstration in a couple of villages. They grow a variety of vegetables using organic farmimg practices. They feed green vegetables to their children and sell the surplus in the market.

It is shared by the Sarpanch that the people of Durbachoti GP link eating organic vegetables with reduced eye problem and improved household nutrition. Mamata, a member of the Adolescent Group said that they grow carrots in their backyard. "Carrots contain vitamin A and certain carotenoids, essential nutrients for the health of our eyes", she shared. Sujata, another girl said that the nutrient keeps the eyes healthy by preventing night blindness, and is probably the most important ingredient for healthy eyes. A deficiency in vitamin A could lead to night blindness, which may in turn lead to dry eyes, corneal ulcers and swollen eyelids. Muna Khan, a member of the Adolescent Group reported that eggs are beneficial to the health of our eyes because they are a surprisingly rich source of lutein. "Vitamin B deficiency, especially vitamin B2, can cause our eyes to look bloodshot, feel gritty and even sensitive to light. Vitamin B can be found in wholegrain cereals".

readiness among children 3-6 years of age in selected high burden districts/States, and special focus is given to girls and children from disadvantaged sections.

The revised implementation framework has restructured the ICDS program with the objective of hastening 'universalisation with quality' by intensifying efforts to decrease malnutrition, infant mortality rate and improve early child development outcomes. ICDS programmes comprise (i) supplementary nutrition, (ii) Pre-school service, (iii) Dissemination of health and nutrition awareness, (iv) Health check-up, (v) Immunization, and (vi) Referral services. Whilst services (i) to (iii) are key tasks of ICDS functionaries, services (iv) to (vi) are provided jointly through a coordinated effort of Health Department and ICDS.

These services are given to targeted beneficiaries at Anganwadi centre, established for a cluster of 1000 persons. Targeted beneficiaries are: pregnant women, nursing mothers, adolescent girls, children 0-3 and 3-6 age groups. Thus, the bouquet of services seeks to extend a protective shield from the time a woman conceives to birth, growth of the infant, pre-school services through to the level the child starts school, and then to adolescents and nursing mothers. In accordance with the programme objectives, ICDS has the structure to pull rural population out of the scourge of malnutrition.

The key institutions those play role in ICDS are Anganwadi centre (AWC), Gram Panchayat and sub-centre and the office bearers are Anganwadi Worker, Sahyogini, "Sahayika", ANM, The village sarpanch, up-sarpanch, and ward members.

Anganwadi Worker

The main concern of AWW is to ensure that children, adolescent girls and women get proper SN, medicines, and information to break the cycle of malnutrition.

Sahyogini

The Sahyogini's responsibility is to ensure that (a) adolescent females and beneficiary women take SN and micronutrient doses in their presence, (b) every potential target is included in ICDS. They are further supposed to contact ten households every day and advise every pregnant, nursing mother and adolescent girls on best practices for healthcare and nutrition.

"Sahayika"

She is a helper. Her job is to help the AWW maintain cleanliness, distribute SN and medicines, and look after the children.

ANM

AWWs and their Sahyoginies are supposed to be in touch with pregnant women and nursing mothers and keep the ANM updated. When information comes to ANM she arranges for ANCs, PNCs, immunisation, or referral. If she observes any major health problems, she refers the case to a PHC or CHC or First Referral Unit (FRU). She arranges vaccinations through the **Sub-centres** (cold chain equipment and vaccines are kept here). Data and information given by AWWs are aggregated at sub-centre level and collated at PHCs and CHCs. **Annual healthcare, family welfare, and immunisation plans are prepared at CHC level based on this data**. Thus, the AWW provides information to ANM that helps formulate block-level health plan. Based on assessment of health of the population, the CM&HO advises appropriate intervention. ICDS acts accordingly.

Thus, the ANM is responsible for ANCs, PNCs, all vaccinations, health check-up, special camps, and co-ordination with AWWs to ensure that no woman or child is left out. An ANM is responsible for early

detection of serious health problems among children (RTIs, growth faltering, etc) and recommends appropriate action.

On the other hand, the main task of AWW, a volunteer, is to run pre-school and monitor growth of pre-school children. They are *also* responsible for maintaining records- of anaemia among women and children, vaccinations, children's growth- based on which they distribute supplies and discuss remedial actions with ANM. Effective ANM-AWW coordination is necessary at the community level.

The village sarpanch, up-sarpanch, and ward members:

The village sarpanch, up-sarpanch, and ward members have a role in the development of their village, including provision of basic services such as AWCs, Sub-centres, water, sanitation, construction and maintenance of community assets such as roads, village pathways, water storage system, Panchayat Bhavans, Mahila Mandal Bhavans, sarai, etc. They are actively involved in selection of Anganwadi worker, Sahyogini, Sathin, and helper. It has been observed that village headmen are taking keen interest in these appointments and some have even taken steps to get an AWC started in their village.

3.2.2. National Prophylaxis Programme against Nutritional Blindness

Blindness due to Vitamin A deficiency is one of the major causes of blindness in children below five years. Vitamin and mineral deficiencies are common in India. In 2006-07, a policy decision has been taken to cover all children in the 9 month to 6 yr age group under the massive dose vitamin A programme. Clinical Vitamin A deficiency often coexists with other micronutrient deficiencies and hence, there is a need for broad-based dietary diversification programmes aimed at improving the overall micronutrient nutritional status of children.

In view of the serious nature of the problem of blindness due to Vitamin A deficiency, the National Prophylaxis Programme against Nutritional Blindness was initiated as a centrally sponsored scheme. Under this scheme, all children between ages of one and three years were to be administered 200,000 IU of Vitamin A orally once in six months.

Data on coverage under massive dose Vitamin A programme in different states reported in different surveys indicate that while coverage in a few states was satisfactory, coverage in majority of states was low. In an attempt to improve the coverage, especially of the first two doses, Vitamin A administration was linked to the ongoing immunization programme during the Eighth Plan period. Under the revised regimen a dose of 100,000 IU of Vitamin A was administered to all infants at nine months along with measles vaccine and a second dose of 200,000 IU was administered at 18 months of age along with booster dose of DPT and OPV. Subsequently, the children were to receive three reported coverage figures under the modified regimen indicate that there has been some improvement in coverage with the first dose (50 –75 per cent). However, the coverage for subsequent doses is low.

(Annexure-3: Relevant Schemes on Nutrition)

3.2.3. Community level Stakeholders:

The community level office bearers responsible for community development schemes on nutrition are Anganwadi Staff, mid-day-meal cook in the schools, Public Distribution System dealer, ANM, ASHA, NGO staff looking after nutrition component of their projects.

The community institutions supplementing nutrition or improving over all nutrition of the target families/groups are Angan Wadi Centre, Schools, NGOs, community based health facility etc. In some communities Food Security Committees are formed either by the panchayats or by NGOs to organize grain-banks or facilitate community nutrition programs, PDS provisions to prevent starvation and malnutrition. NGOs, community health facility, schools and AW Centres also implement IEC programs, demonstration programs to address malnutrition in communities.

The services provided by different agencies operating in communities are PDS provisions, mid-day meal, demonstration of nutrition gardens in backyards, supplementary nutrition in AW centres and information and education programs, observation of Village Health and nutrition day organized by all community stakeholders including ANM, AWW, Panchayat etc, Vitamin-A administration by ANM and AW centres.

The schemes on nutrition include Integrated Child Development Services (ICDS) covering AW centres and Schools. Some State Governments like Tamilnadu have also floated nutritious mid-day meal programs in schools along with ICDS program. People can seek information about non-availability of grains from PDS, their food entitlement through ration card and their rights for food and nutrition through RTI Act.

3.3. Inclusive Education

Inclusion is not just being physically in schools. It means that all children study, work, play and grow up together. The Sarva Shiksha Abhiyan program and plan for inclusive education is path-breaking. It has been a boon for all children who earlier had faced a barrier to schooling, particularly for children with disabilities. The number of children with disabilities in mainstream schools has been on the rise every year. Inclusive Education has grown from the belief that education is a basic human right and that it provides the foundation for a more just society (UNESCO). With the 86th amendment of the Indian Constitution in 2002, elementary education is no more a privilege, but a legally recognized fundamental right of all children in India. The idea of inclusion is based on respect for the fundamental human rights and dignity of each individual and it envisions an entire education system becoming more responsive to the needs of all. Inclusive education is concerned with providing flexible education keeping in view the diverse needs of children. It builds on recognizing diversity and valuing differences and not just tolerating children with special needs (CWSN).

The model educational schemes implemented in the communities are Sarva Sikhya Aviyan (SSA), Integrated Child Development Scheme (ICDS), Inclusion in Education of Children and Youth with Disabilities (IECYD), Rajasthan Education Initiative (REI) etc

3.3.1. Sarva Shiksha Abhiyan (SSA)

The Government of India has launched Sarva Shiksha Abhiyan (SSA) for Universalization of Elementary Education in the age group of 6-14 years. SSA has adopted a pragmatic approach in implementing the programme of inclusive education. SSA framework clearly states that "SSA will ensure that every child with special needs, irrespective of the kind, category and degree of disability, is provided education in an appropriate environment". SSA adopts a zero rejection policy so that no child is left out of the education system. It supports a wide range of approaches, options and strategies for education of children with special needs.

Inclusive Education in SSA is a more expansive concept, wherein the stress is to provide education to children with special needs (CWSN) in an environment most appropriate to their learning needs. These

options vary from a regular school to Education Guarantee Scheme (EGS) Centres, bridge courses to prepare CWSN for schools and home-based education aimed mainly to either prepare CWSN for schools or for life.

The interventions suggested under SSA for inclusive education of disabled children are identification of CWSN, awareness to demolish attitudinal barriers preventing children with special needs from coming to schools, necessary infrastructure for planning and management, early detection and identification, functional and formal assessment, educational placement, preparation of Individualized Educational Plan, aids and appliances, teacher training, resource support, strengthening of special schools, removal of architectural barriers and monitoring and evaluation.

3.3.2. Inclusion in Education of Children and Youth with Disabilities (IECYD):

The National Action Plan for Inclusion in Education of Children and Youth with Disabilities (IECYD) developed by the MHRD (November -2005) emphasizes the inclusion of children and young persons with disability in all general educational settings from Early Childhood to Higher Education. The goal of the Action Plan is –"to ensure the inclusion of children and youth with disabilities in all available general educational settings, by providing them with a learning environment that is available, accessible, affordable and appropriate." As SSA supports inclusion of children with special needs at the early childhood education and elementary education level, it is desirable to introduce a scheme for the disabled children at secondary stage.

Then let not, what I can not have: Educate Me Higher

Manisha, aged 14 belongs to Swarapiya ka Tala village (Hindustan ka last village) of Chohatan Block in Barmer District. Born blind, she studies in Class 8 of a local school. Manisha has good understanding about her subject of studies particularly geography, history and civics. The integrated education teacher placed in the village and the school teachers have helped Manisha learn Braille very fast.

Manisha is fond of listening radio programmes. She is interested to attend a course in music. She shared that evaluation and comparison between able and disable often de-motivates her. "If some one tells, you can do it, it motivates me", Manisha shared. She never wants people telling her that she can not do what others can. She often confronts people saying what she would do after her study! It sometimes hurts Manisha.

Manisha desires to interact with the models of animals- camel, deer, Neel gai, etc. She wants to visit historical places, museums, Zoos with audio facility. When asked about what is her aim to become in life, she promptly replied to pursue higher education to become either a teacher or to make a career in music and she expressed her desire to work for disables. Manisha said, given the opportunity, she would volunteer to help and prepare other disables with life skills.

The scheme for IEDSS is therefore envisaged to enable all children and young persons with disabilities to have access to secondary education and to improve their enrolment, retention and achievement in the general education system. Under the scheme every school is proposed to be made disabled-friendly. The scheme aims to enable all students, with disabilities completing eight years of elementary schooling, get an opportunity to complete four years of secondary schooling (classes IX to XII) in an inclusive and enabling environment, provide educational opportunities and facilities to students with disabilities in the general education system at the secondary level (classes IX to XII) and support the training of general school teachers to meet the needs of children with disabilities at the secondary level.

The scheme covers all children of age 14+ passing out of elementary schools and studying in secondary stage in Government, local body and Government-aided schools, with one or more disabilities as defined under the Persons with Disabilities Act (1995) and the National Trust Act (1999) in the age group 14+ to 18+ (classes

IX to XII), namely Blindness, Low vision, Leprosy cured, Hearing impairment, Locomotor disabilities, Mental retardation, Mental Illness, Autism, Cerebral Palsy and it may eventually cover (i) Speech impairment and (ii) Learning Disabilities, etc. Girls with disabilities will receive special focus and efforts would be made under the scheme to help them gain access to secondary schools, as also to information and guidance for developing their potential.

The scheme is to ensure that every child with disability will be identified at the secondary level and his educational need assessed. Every student in need is provided aids and appliances, assistive devices. All architectural barriers in schools are removed so that students with disability have access to classrooms, laboratories, libraries and toilets in the school. Each student with disability is supplied learning material as per his/ her requirement. All general school teachers at the secondary level are provided basic training to teach students with disabilities within a time frame.

It makes provision of support services to students with disabilities like the appointment of special educators, establishment of resource rooms in every block and establishment of model schools in every state to develop good replicable practices in inclusive education. It ensures access to learning material as per his/ her requirement like Braille textbooks, audiotapes, talking books, textbooks in large prints and any other material needed.

It also has provision for facilities like transport facilities, hostel facilities, scholarships, books, uniforms, assistive devices, support staff (readers, amanuensis), stipend for Girl Students with disability, the use of ICT and provision for the purchase of appropriate technology by way of special software such as Screen Reading software like JAWS, SAFA, etc. for the visually impaired and speech recognition software for the hearing impaired to develop computer vocabulary for the hearing impaired and modified hardware like adapted keyboards, financial assistance for purchase/production of instructional materials for the disabled and also for purchase of equipment required. There is provision for external support from an interdisciplinary team of experts such as educational psychologists, speech and occupational therapists, physiotherapists, mobility instructors and medical experts at the local level.

Partnerships and Linkages include formation of Parents / Guardians Groups at community/ village level for sharing of information regarding benefits available from the scheme for their wards. Implementing Agencies include the Education Departments of State Governments / UT Administrations directly, Non Governmental Organizations (NGOs) having experience in the field of education of the disabled in the implementation of the scheme, autonomous organizations of stature having experience in the field of education and / or rehabilitation of the disabled.

3.3.3. Rajasthan Education Initiative (REI): A Public-Private Partnership Model

The Rajasthan Education Initiative (REI), launched in 2005, has evolved as an inspiring model of Public-Private Partnership in the field of education. The REI transcends the boundaries of technology in an attempt to improve learning skills on the one hand, while assisting the community and society at large as they achieve holistic development of the children of the state of Rajasthan.

The REI, driven by the State Government and supported by the activities of the core partners, namely the Confederation of Indian Industries (CII), the Global e-Schools and Communities Initiative (GeSCI) and the World Economic Forum (WEF), focuses on girls, rural children, urban underprivileged children, and children with special needs, through various ICT and non-ICT track interventions.

The REI has significantly contributed to the fulfillment of SSA goals and different facets of educational development in Rajasthan, including widening access, promoting efficiency, enhancing the quality of learning and teaching and improving infrastructure and management systems.

The REI has engaged with global and national partners from the private sector, foundations and NGOs by signing 26 Memorandums of Understanding (MoUs) with various organisations since the launch of the REI.

REI Strategies

The REI seeks to bring a new educational paradigm to the State, based on the following strategies:

- Evolving innovative and locally appropriate models of Public-Private-Partnership with scale-up potential;
- Adopting and adapting best practices from both the public and private sector while ensuring community participation;
- Deploying new technologies, particularly ICTs, for modernizing educational service delivery, skill development and quality learning;
- Creating systems for enabling greater community participation in the State's educational programmes;
- Enhancing the flow of resources into the educational sector in Rajasthan by structuring suitable projects and creating incentives for increased participation of different stakeholders;
- Focus efforts on serving underprivileged communities in urban and rural areas as well as on the girl children and children with special needs;
- Demonstrating the success of such public-private partnership interventions, by evaluating their impact on students with reference to the overall objectives of the Sarva Shiksha Abhiyan;
- Disseminating the outcomes and learnings from the REI for replication in other parts of the State, other states in India, as well as in other developing countries.

REI Priority Areas

The REI is inspired by the philosophy, approach and results of the Jordan Education Initiative (JEI). However, unlike the Jordan Education Initiative, which focused on technology interventions only, REI has both ICT as well non-ICT based projects as a part of the programme. The scale of REI operation is much wider, impacting larger number of schools, teachers and students. The REI framework comprises need based and multi-dimensional approaches and activities.

The REI promotes the State's educational objectives by focusing on improving the delivery of educational services, in particular on promoting equitable access, enrolment and retention of children in school, reducing gender disparities, promoting skill development and enhancing learning levels. The REI also focuses on strengthening hard and soft infrastructure including quality of teaching and learning.

The focus remains on girls, rural children, urban underprivileged children, and children with special needs. The Government of Rajasthan is of the opinion that, the project period of the REI should be co-terminus with the tenth plan period i.e. 2011.

Partnership Themes

- Large scale partnerships with private sector and civil society in priority districts to address gender, social and regional gaps.

- Priority to Model cluster schools (4,710 in 186 educationally backward blocks) and Kasturba Gandhi Balika Vidyalayas (KGBVs) in the State.
- Partnerships required for initiatives to improve quality of teaching and learning, MGML and teachers training, computer based teaching-learning, reading corners, sports kits, health and sanitation activities in model schools and KGBVs.
- Partnerships invited for Computer Aided Learning Programmes in Primary and Upper Primary Schools in the State on BOOT basis.
- Partnerships invited for training of teachers in three subjects, viz., Maths, English and Science, in order to improve the competence and skills of teachers.
- Partnerships for developing reading habits and skills of children in classes I and II through innovative teaching-learning methodologies.
- Partnerships for using Multi Grade Multi Learning (MGML) teaching-learning methodologies in classes IV and V in the schools of one block at least in each district.
- Partnerships for starting new schools (100) in remote and tribal areas of the State. State Government to provide free land and funds for construction of building.
- Partnerships for using existing facilities of EDUSAT in the state by establishing and maintaining ROTs (Receiving Terminals) in the schools for imparting education and special courses for the children and adults.
- Partnerships for adopting the Mobile Computer labs and/or meeting the recurring operational and maintenance expenses of existing Mobile labs.
- Partnerships for establishing Tele-Centers in the schools, to educate children free of cost during school hours and provide access post hours for community members to use internet, e-mail and other integrated services for a fee
- Partnerships for establishing Resource Hubs at the block level in Block Resource Centers to provide ICT based education and services, including Internet and Voice connectivity, to the children and adults in the rural areas for a fee
- Innovative partnerships for instituting Chairs in educational institutions like SIERT, SIEMAT, DIET and colleges of education for mentoring, capacity building and integration of ICTs in school education.
- Award of Fellowships for deserving and interested teachers to pursue advance education or training courses in various thematic areas/subjects.
- Partnerships for organizing conferences, seminars, workshops for the educationists in the state in various thematic areas of education

3.3.4. Stakeholder analysis

- The community level service providers are school teachers, Angan Wadi staff, Adult Education/Night School Teacher, Early Childhood Intervention Teacher.
- The institutions directly delivering services are Village School, Anganwadi Centre, the National Institute of Open School (NIOS), EGS&AIE centres, District Rehabilitation Centre, District Disability Rehabilitation Centres and Composite Resource Centres, Central Institute of Vocational Education (CIVE), Public Health Centres, etc.
- Community Institutions involved in implementation of Schemes are Matru Sikhya Committee, Sikhya Committee/Village Education Committee (VEC), Parent Teacher Association (PTA), and School Management Committee (SMC). In SSA grass root structures like the Village Education Committee (VEC) or a School Management Committee (SMC) or similar forum is constituted at village/school level. The SSA State Mission Societies considers parent of a child with special needs as the member of the VEC or the SMC. The 2-day training of community leaders have an essential component on issues related to CWSN.
- The range of services are Education for CWSN, Bridge Course, Physiotherapy, education loan/stipend/scholarship, home-based education, occupational therapy and speech therapy, distance

leaning facility, Aids and Appliances; books, dress, stationary, transport allowance, escort allowance, hostel allowance, reader allowance, equipment allowance, resource room facility, helper and an assistant for locomotor impaired children.

Inclusive Education of CWSN-Some Observations

- Central and state governments have taken a number of initiatives to improve the enrolment, retention and achievement of children with disabilities. There is a need to establish interlinks and collaborations among various organizations to prevent overlapping, duplication and contradictions in programme implementation.
- Most services for children with disabilities are concentrated in big cities or close to district headquarters. The majority of children with disabilities who live in rural areas do not benefit from these services.
- There is an absence of consistent data on the magnitude and educational status of children with disabilities, and the disparities between regions and types of disability. This makes it difficult to understand the nature of the problem, and to make realistic interventions.
- Many schools have a large number of children in each classroom and few teachers. As a consequence of this, many teachers are reluctant to work with children with disabilities. They consider it an additional workload.
- Training for sensitization towards disability and inclusion issues, and how to converge efforts for effective implementation of programmes, are important concerns.
- Different disabilities require different supports. The number of skilled and trained personnel for supporting inclusive practices is not adequate to meet the needs of different types of disability.
- The curriculum lacks the required flexibility to cater to the needs of children with disabilities.
- There are limited developmentally appropriate teaching–learning materials for children both with and without disabilities. The teaching–learning process addresses the individual learning needs of children in a limited way.
- Families do not have enough information about their child's particular disability, its effects and its impact on their child's capacity. This often leads to a sense of hopelessness. Early identification and intervention initiatives sensitize parents and community members about the education of children with disabilities. Bearing in mind this scenario, the following recommendations need to be considered in order to move towards education of children with disabilities in inclusive settings..
- Links and bridges need to be built between special schools and inclusive education practices. Linkages also need to be established between community-based rehabilitation programmes and inclusive education.
- Public policies, supportive legislation and budgetary allocations should not be based on incidence, but on prevalence of special education needs, and take into consideration the backlog created as a result of decades of neglect.
- The existing dual ministry responsibilities should be changed. Education of children with disabilities should be the responsibility of the Department of Education. The Ministry of Welfare should confine itself to support activities only.
- Inclusion without 'adequate' preparation of general schools will not yield satisfactory results. It is essential that issues related to infrastructural facilities, curriculum modification and educational materials should be addressed.
- Regular evaluation should be based on performance indicators specified in the implementation programme, and accountability for effective implementation at all levels should be ensured.
- There should be emphasis on bottom-up, school-based interventions as part of regular education programmes following inclusive strategies. The programme should be based on stakeholder participation, community mobilization, and mobilization of NGO, private and government resources.
- The training of general teachers at pre-service and in-service levels should address the issue of education of children with disabilities, so that teachers are better equipped to work in an inclusive environment.

(Annexure-4: Relevant Schemes on Education)

3.4. Inclusive Livelihood

Poor people with disabilities are caught in a vicious cycle of poverty and disability, each being a cause and a consequence of the other. Disability limits access to education and employment, and leads to economic and social exclusion. But perhaps the greatest obstacle to participation and equity is the prevalence of deep-rooted negative attitudes on the part of non-disabled people in the family and community, as well as in Government and in the voluntary sector. The goal of poverty eradication cannot be achieved if disabled people who constitute 5-6 per cent of the total population of India are ignored or left out. If figures are indicative of the status of any section of society, then disabled people constitute 20 per cent of the poorest of the poor, and over 80 per cent of the 70 million disabled people live in rural India - well below the poverty line.

The economic empowerment of disabled people is the key to independent living and sustainable livelihoods. People with Disability need their rights as guaranteed by the Indian Disability Act. More than a decade after the Persons with Disability Act passed in India, mainstreaming disability into critical areas such as livelihood and employment remains at the bottom level. Therefore, mainstreaming of disability into development projects is crucial. It is now an accepted position that disability has to be a component of all development programmes. In line with this thinking, the Tenth Plan advocated the introduction of a Component Plan for the Disabled in the budget of all concerned Ministries/Departments in order to ensure a regular flow of funds for Schemes/Programmes for the empowerment of disabled people.

Moreover, the Disability Act mandates a three per cent reservation in all areas of activity, it clearly states: "The appropriate Governments and local authorities shall reserve not less than three per cent in all poverty alleviation schemes for the benefit of persons with disabilities." While over the past one decade, disability has emerged as an important issue of public policy discourse in India, the implementation of legislation and institutional mechanisms, both government and non-government has been poor.

The schemes available in the communities are Tribal/Rural livelihood Project, MGNREGS, Swarna Jayanti Gramya Swarojgar Yojana, Rural Innovation Fund (NABARD), livelihood project floated by bi-lateral agencies (DFID Livelihood Project), Grain Bank, income generation schemes by non-government, private and banking and cooperative agencies.

3.4.2. Mahatma Gandhi National Rural Employment Guarantee Act

The Government of India passed the National Rural Employment Guarantee Act (N.R.E.G.A.), in September 2005. It provides legal guarantee of a hundred days of employment in a financial year to adult members of a rural household. N.R.E.G.A. aims to end food insecurity, empower village communities, and create useful assets in rural areas. The approach is rights-based as the assumption here is that every adult has a right to basic employment opportunities at the statutory minimum wage. Under this scheme, one member of every rural household is guaranteed 100 days of work at the minimum wage per day. All rural poor, whether below the poverty line or not, are eligible to apply. One-third of the beneficiaries should be women. This scheme has the potential to go a long way in alleviating rural poverty.

While appreciating the genuine concerns and efforts of the Government to ensure employment, food and livelihood security for its rural citizens with the enactment of N.R.E.G.A., it is distressing to see that people with disabilities, who constitute the most vulnerable and poorest of the poor segment of society, have been left out of the scheme of things.

But the Government (under Chapter 4 on Registration & Employment Section 4.6; Sub-section 4.6.10 in its Operational Guidelines for the implementation of the N.R.E.G.S) states that, "If a rural disabled person applies for work, work suitable to his/her ability and qualifications will have to be given. This may also be in the form of services that are identified as integral to the programme. Provisions of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, will be kept in view and implemented." This guideline, if understood in the right spirit and perspective, can facilitate assured employment for the rural disabled people. While the onus, in the first instance, is on disabled people to apply for jobs, the responsibility to provide the right kind of employment lies with the implementing agency at the grass root level. But whether these guidelines will be followed by the implementing agencies in all states, or how far they will be binding to hold the Government legally responsible for providing employment to disabled people in rural areas, is yet unknown.

A look at the funding pattern of N.R.E.G.S. will give a picture of the magnitude of this programme. The project has been conceived with an annual budget of Rs. 40000 crores. If the component on disability is truly included, and the three per cent quota is implemented, the funds for disabled people under the scheme

would be a whopping Rs. 1200 crores per annum! Unquestionably, N.R.E.G.S. has the potential to go a long way in mitigating poverty among the rural disabled.

A study points out that from a sample of 499 visually impaired and blind respondents about 43.5 percent had NREGA job-cards and only 21 percent job-card holders had worked under the scheme which ranged a maximum of 5-15 days in a year against their right to be engaged for 100 days. Community and village Panchayat perceive that disable persons can not be engaged in productive works and they are not considered as a target group. PWD are never engaged in planning processes for NREGA at panchayat level. (ADHAR Study, 2010)

To initiate the process of including disability in N.R.E.G.S., Leonard Cheshire International (L.C.I.), Handicap International, Poorest Areas Civil Society Programme and Department for International Development (D.F.I.D.) joined a two day 'National Consultation on N.R.E.G.S. & Inclusion of Persons with Disabilities' organised by the Administrative Reforms Commission (A.R.C.). The objective of the Consultation was to strengthen accountability, transparency and monitoring of N.R.E.G.S. The A.R.C. has come up with some major path-breaking recommendations such as earmarking not less than three per cent of the resources at the block level for disabled people; ensuring that widows, disabled siblings and each disabled adult are counted as "single family household" so that they get an additional 100 days of employment guarantee; including disabled people in administrative and supervisory roles at district, panchayat and block level; and conducting social audits to measure and evaluate inclusion of different classes of people on a periodic basis.

Now the onus is on the disability sector and other stakeholders to ensure that the three per cent quota is implemented in N.R.E.G.S. The disability sector also needs to actively ensure that all this information is properly disseminated amongst the rural disabled population. The right kind of projects and jobs need to be identified within the scheme. Further, there is an urgent need for sensitisation of key officials at the district, block as well as panchayat level, on issues related to disability, poverty and rural development.

It has been experienced that the inclusion of people with disability in NREGA is an issue of mindset of the officials at the local level. It is a common mindset that disables people can not do physical labour and therefore not allowed to work by the local officials and representatives. A high number of disable persons having job cards in different states indicates that they are interested to be engaged in the work. In order to ensure their inclusion, the typical mindset of the ground level officials needs to be changed.

No doubt that NREGA is the first act in its type which is more inclusive in nature. The act has the provision for giving preference to 30% of women in each works. There are provisions for land development of SCs, STs and PWD beneficiaries. The central portal also maintains a data base, where it indicates person days created by the scheduled caste, scheduled tribe, and persons with disability and women laborers. Even though the data generated under NREGA views a bright picture in terms of inclusion issues but the state and region wise data says that some states performing well and have successfully included these socially excluded groups where as many other states are lacking behind. Only ensuring the participation of the deprived in NREGA is not the solution. The government has to ensure that the wage goes to them in time and as per their days of work. Along with that their participation in the process of planning, monitoring and evaluation of the scheme needs to be ensured very strictly.

3.4.3. **Rural Innovation Fund (NABARD)**

Rural Innovation Fund (RIF) of NABARD is a fund designed to support innovative, risk friendly, unconventional experiments in Farm, Non-Farm and micro-Finance sectors that would have the potential to promote livelihood opportunities and employment in rural areas. Individuals, NGOs, Community Based Organisations, SHGs, Farmer's Club, Panchayati Raj Institutions and Corporates who have the expertise and willingness to implement innovative ideas for improving the quality of life in rural areas may apply. They can

approach the District Development Manager (DDM) of NABARD in the district or the Regional Office of NABARD at State Capitals.

Guiding principles:

- The activities must have the rural poor in their focus and must be innovative, experimental and demonstrative in nature leading to replicability and commercial viability.
- The activities funded may involve development of new products, processes, prototypes, technology, patenting and extension support.
- Appropriate action research and studies contributing to better understanding of rural development issues, policy and process implementation may be undertaken.

Type of projects supported under RIF:

- All innovations and related activities in the Farm, Rural Non-Farm and Micro-Finance sectors can have access to the RIF. Assistance from RIF will be available for all activities which are in keeping with the guiding principles of RIF and specifically those which
- Provide technology and skill up gradation, inputs supply and market support leading to promotion of viable enterprises, sustainable employment, infrastructure development, improved flow and access of credit to rural entrepreneurs.
- Undertake innovations so as to improve efficiency of credit delivery and other support services to the rural resource poor. Patenting innovations leading to commercialisation of the idea through licensing or otherwise.

These would include innovative proposals which aim at increasing productivity and profitability of operations of the farmers, artisans, handicraft persons and rural people in general, projects that help in reducing drudgery, improving access to market, projects that help better sanitation, health and hygienic conditions and environment in rural areas, proposals, which improve rural credit, outreach, proposals, which help in creating sustainable employment opportunities in rural India, proposals, which improve, farm practices, and help in conserving the land fertility and research studies for documenting the innovations already taking place in rural areas and examining issues concerned with rural cottage & village industries /farm sector / farming practices.

Campaigning for the rights of the disabled: ORRC Project

ORRC Project is a federation of visually impaired peope who agitate through Satyagraha for access to Government employment, income generation, housing, education and health programmes. They also protest against injustice and atrocities committed against the PWDs. Since a decade ORRC has been working with disabled people in several Mandals (a cluster of up to 100 villages) in Andhra Pradesh. Their objective is to facilitate the formation of self-help groups of disabled people who can support each other and campaign for their rights. They not only encourage the disabled to join self-employment activities in work-sheds but also help disabled people to access bank loans, education, housing, transport, land and drinking water.

ORRC also supports savings, credit and income generation for people with disabilities. There are a number of small initiatives. It also provides vocational training. Self-help groups for the disabled which bring people together with the purpose of promoting their development have shown some success, and merit support from donors and governments. They need to be linked to other development initiatives if the disabled are to influence and contribute to the policy and practice of development in their communities.

3.4.4. DFID Livelihood Project (inclusion of disabled people)

The DFID-supported Andhra Pradesh Rural Livelihoods Project (APRLP) covers five districts in Andhra Pradesh, with a total population of over 15 million. The target groups for the project are the rural poor in those districts, estimated to be up to 40% of the population. There are likely to be at least 150,000 profoundly disabled people in the project's target population, and probably many more affected by some un-enumerated form of disability.

In this project, DFID advocates a twin-track approach (Needs-based and rights-based approaches) to equality for the disabled: combining attempts to account for the needs and rights of the disabled in mainstream development cooperation work as well as supporting specific initiatives aimed at the empowerment of the disabled. The livelihoods approach can accommodate both strands by including the disabled in participatory development initiatives in the community as a whole and providing particular opportunities, perhaps income earning opportunities, for specific groups of the disabled so that there is a chance for the whole community to benefit from development.

Blind and partially sighted people are no different from sighted people. They too want to develop skills, take on responsibility and earn a living. Preparing blind and partially sighted people for the world of work can take some time. Much of the ground work involves confidence building and the development of new skills. The challenge is capacitating visually impaired people for an appropriate trade at a pace that they are comfortable with and to suit their particular needs. The critical first step is aptitude assessment of target persons and exposure to work experience opportunities to prepare visually impaired people for entry into employment. NGOs can provide self employment support for blind and partially sighted entrepreneurs. They can provide professional support to blind and partially sighted entrepreneurs who are looking to establish new businesses or developing business. Partners may try to give them that chance.

There are suggestions that the livelihoods of the disabled can be seriously addressed if development initiatives embrace a variety of schemes including farm, non farm, artistic and intellectual trades. There is no limit on the extent to which *rural* development schemes can improve the livelihoods of the disabled. There is lot of scope for creating options for the physically disabled to use their intellectual and artistic skills:

- First, affirmative action can be taken to reserve some positions in the community/panchyat level (e.g. in services such as the post office, ICDS, SSA, NREGS, PRI, primary Health Facility) for the disabled;
- Second, tax concessions and other incentives can be provided to promote the employment of the disabled or business start-up on their own account in such fields as long-distance telephone booths, internet cafes and other information communication technologies;
- Third, there is also an important requirement for providing the disabled with the kinds of technical skill appropriate to such lines of work.

Haryana Government enhances unemployment allowance for the disabled

The Haryana Government has decided to raise the unemployment allowance by almost three times, for educated people with not less than 70 per cent physical disability. Thus, the earlier unemployment monthly allowance of Rs. 400 for those who have studied up to middle level would be increased to Rs. 1000; matriculates would get Rs. 1,500 instead of Rs. 500; and those with higher educational qualifications or diploma would get Rs. 2000 in place of the earlier amount of Rs. 600. The revised rates were effective from 1 April 2006.

The disabled must be able to build new social networks. This is where initiatives such as support to self help groups for disabled people in rural communities can help to make their voice heard. Within such groups people may also press for access to literacy and numeracy to learn more about their rights. It is important for the disabled to be recognised as full members of the community. At root,

disability is a human rights issue. Sustainable livelihoods approaches need to embrace a 'rights-based approach to development' rather than just a 'needs-based approach' for the disabled.

PWDs require conscious inclusion by others in the community and by government and NGO staff working with communities. The overall task is to develop replicable approaches and interventions for enabling poor rural people with disabilities to gain greater access to rehabilitation services, opportunities for learning skills and for economic development, infrastructural support for employment and self-employment and opportunities for acquiring their own productive assets.

3.4.5. Vocational Rehabilitation Centre

The Government of India has set up the Vocational Rehabilitation Centre for disabled at Bangalore and the same has been functioning from 1991. The Centre is providing vocational training in Computers, Carpentry, Welding, Fitter, Electrical, Embroidery, Book Binding and Tailoring etc. The Vocational Rehabilitation Centre has provided 100% placement for all the trainees who have undergone training. The Vocational Training Centre also provides counseling services for children / persons with intellectual disabilities.

3.4.6. **Incentives to Private Sector Employers for providing employment to persons with Disabilities**

Under the scheme Gonernment of India gives incentives to employers for providing employment to persons with disabilities in the private sector. Employees with disabilities with monthly wage up to Rs.25000/ per month working in the private sector are covered. Government pays the employer's contribution to the Employees Provident Fund and Employees State Insurance for the first three years. The administrative charges of 1.1% of the wages of the employees covered under the Employees Provident Fund & Miscellaneous Provisions (EPF&MP) Act are paid by the employer.

The scheme is applicable to the employees with disabilities. The Ministry Social Justice and Empowerment makes available to the employees provident fund organization and employees State Insurance Corporation lump-sum funds by way of advance. These are used for the purpose of adjustment of individual clients received from the employers under the scheme. The amount with the organizations is replenished periodically. Initially both the organizations would be provided Rs.5.00 crores each and considering the requirement, the amount would be subsequently enhanced. The advance amount would be subject to quarterly review by the high level Committee to be set up. A High Level Committee co-chaired by the Ministries of Labor and Employment and Social Justice and Empowerment is constituted to monitor the implementation of the scheme.

Policy Perspectives

- For poverty-focused development to follow the core principles of livelihoods approaches, ways must be found of adapting development activity to incorporate the diversity of people
- Livelihood approaches must be sensitive to the existence of persons with disabilities within any target group so that their needs are automatically included in the planning, financing and implementation of mainstream development cooperation activities
- Given funding constraints in many states in India, together with widespread insensitivity towards disability, support should be given within livelihoods programmes and projects for piloting opportunities for the disabled in community development activities, even in a small number of activities initially
- If inclusion of the disabled is to be sustained within mainstream programmes, policy guidelines will need to establish concrete mechanisms and practices for implementing agencies, including adequate monitoring and follow-up

- Action to allow the rural disabled priority access to employment opportunities and to new business start-up where they can exercise their intellectual skills may be especially appropriate
- However, in rural areas there is limited scope for the physically disabled to exercise their intellectual capabilities.
- Self-help groups among the disabled have had some success in influencing policy and practice and merit support

Annexure-5: Relevant Schemes on Livelihood

3.4.7. Stakeholder Analysis

The community level service providers in livelihood sector are Village Agriculture worker/Lady Village Agriculture Worker, Livestock Inspector, Milk Union staff, Cooperative Bank Secretary, Commercial Bank Staff, Gramya Rojagar Shayak (MGNREGS), SGSY Resource Person, etc. The institutions directly delivering services to community are Panchayati raj Institution, National Handicapped Finance and Development Corporation (NHFDC), commercial bank, NABARD, KVIC, Cooperative Bank, Milk Union, Insurance Company and government line departments including Rural Development, Panchayati Raj, Forest and environment, Agriculture, Animal Husbandry, Revenue, Civil supply etc.

Community institutions involved in implementation of livelihood schemes of government are the village Panchayat, Forest Management Committee, SHG Committees, Youth Club, Mahila Mandal/ Narisangh, Food Security Committee, Village Development Committee, Farmers Club, Social Audit Committee-Panchayat Work, committees formed by the NGOs like Pasupalak Samittee, Sambal sangathan (Resource for blind people), etc.

The range of services at Community level are rice etc from PDS, procurement of Milk, Livestock, small ruminants, Kisan Credit Card, NREGS Job Card, Life Insurance (Janasri Bima), Farm, Rural Non-Farm and Micro-Finance, Bank Loan, Cooperative Loan, handicap/disable pension, Old age Pension , Pension for Widows, income generation activities supported by Government, Non-government, private and banking agencies.

3.5. Water, Sanitation & Hygiene

Poor environmental sanitation affects human health, and many diseases are associated with lack of water and sanitation. Eye problems are often caused by other health concerns such as child malnutrition, malaria, water-borne disease, and lack of sanitation. The eye disorders associated with facial cleanliness are mostly minor irritations and infections. Poor facial hygiene is associated with the development of trachoma, an eye infection which is the world's leading cause of blindness.

Trachoma is the world's leading cause of preventable blindness and the second cause of blindness after cataract. Blindness from trachoma occurs after years and years of repeated infection with the microorganism, Chlamydia trachomatis. Women have two-to-three times the rate of advanced trachoma and blindness than men, because as mothers, grandmothers and older sisters who care for children (the main source of active trachoma infection), they are excessively and continually exposed to the bacterium.

Crowded living conditions, lack of sufficient water and sanitation services, and contact with eye-seeking flies and fly-breeding sites near the homes are some of the many risk factors for trachoma. Trachoma is an indicator of public health and community health issues as well as a pathway to blindness for many individuals. Trachoma is a disease of marginalized populations living in areas with limited resources and in need of a good water supply near their home as well as proper, well-maintained sanitation facilities. As the education and economic welfare of a community rises, trachoma decreases. Meanwhile, the WHO, along with an alliance of interested parties, Alliance for Global Elimination of Trachoma by the year 2020 has adopted the "SAFE"

strategy to combat trachoma. The strategy includes besides surgery – to correct end-stage disease and antibiotic treatment – emphasized on facial cleanliness – frequent face washing and **e**nvironmental improvement – improved water supply and sanitation facilities.

Numerous environmental improvement interventions have been implemented in India as an attempt to prevent trachoma infection. These include the provision of water and sanitation facilities (in particular pit latrines to control fly populations) and insecticide spraying to eradicate infection carrying flies. Studies also suggest that broad environmental health interventions (e.g. combined provision of pit latrines and clean water alongside insecticide spraying) can reduce trachoma prevalence.

According to a recent World Bank report there are 450,000 deaths out of 575 million cases of diarrhoea in every year in India, where millions of people in both rural and urban areas still have to defecate in the open, do not wash their hands and cope with poor drainage systems.The premature deaths, treatment of the sick for illnesses like diarrhoea, malaria, trachoma and intestinal worms, as well as the time lost due to illness is costing $38.5 billion alone. A further $10.7 million is lost in 'access time', the report said - time spent looking to access a shared toilet or open defecation site compared to having a toilet in one's own home. Inadequate toilets in schools and work places also incurred losses as women and girls are often absent or refuse to attend due to the indignity of lack of privacy.

The community schemes are the Rural Water Supply, Water-shed Project, Rural Sanitation Mission (TSC), My Tank (Mo Pokhari) (State Government), Indira Awas, etc.

3.5.1. Total Sanitation Campaign (TSC)

The Government of India have restructured the Comprehensive Rural Sanitation Programme with effect from 1.4.1999 and launched the Total Sanitation Campaign (TSC). The main objectives of the TSC are to bring about an improvement in the general quality of life in the rural areas and to accelerate sanitation coverage in rural areas to access to toilets to all by 2012 by motivating communities and Panchayati Raj Institutions in promoting sustainable sanitation facilities through awareness creation and health education. Individual Household Latrines, School Toilets, Anganwaadi Toilets, Sanitary Complexes and Rural Sanitary Marts are taken up under the scheme.

The project envisages a demand-driven approach with increased stress on awareness building and meeting the demand with alternate delivery mechanisms. TSC aims to bring about an improvement in the general quality of life of people in the rural areas, ccelerate sanitation coverage in the rural areas, generate a felt and informed demand for sanitation facilities through awareness creation and health education, cover school in the rural areas with sanitation facilities and promote sanitary habits among students, encourage cost effective and appropriate technologies in sanitation, bring about a reduction in the water and sanitation related diseases. The maintenance of sanitation and hygiene in the villages are the mandatory duties of Village Panchayats.

TSC gives strong emphasis on Information, Education and Communication (IEC), Capacity Building and Hygiene Education for effective behaviour change with involvement of PRIs, CBOs, and NGOs etc. The key intervention areas are Individual household latrines (IHHL), School Sanitation and Hygiene Education (SSHE), Community Sanitary Complex, Anganwadi toilets supported by Rural Sanitary Marts (RSMs) and Production Centers (PCs). The main goal of the GOI is to eradicate the practice of open defecation by 2010. To give fillip to this endeavor, GOI has launched Nirmal Gram Puraskar to recognize the efforts in terms of cash awards for fully covered PRIs and those individuals and institutions who have contributed significantly in ensuring full sanitation coverage in their area of operation. The project is being implemented in rural areas taking district as a unit of implementation.

Under this programme, NGO partners with communities and governments can address issues of pollution, improper waste disposal, and water problems that threaten their daily survival, through advocacy, sensitization and awareness creation programmes aimed at getting both the government, the people and development partners involved in tackling the problems.

(Annexure-6: Schemes on Water, Sanitation and Hygiene)

3.5.2. Accessible & Affordable Housing for people with disabilities:

Accessible, affordable housing is essential for people with disabilities to live independently in the communities. There is the need of information about housing rights, tax credits, making a home accessible, and supportive housing services that can help people with disabilities live independent, self-directed lives. In consequent to the coming into effect of the persons with disabilities (Equal Opportunities Protection of Rights and Full Participation) Act, it has been decided by the Govt. of India to earmark 3% of the funds for the benefit of persons with disabilities under Indira Awas Yojana. This reservation of 3% under IAY for disabled persons below the poverty would be horizontal reservation i.e. disabled persons belonging to sections like SCs, STs and others would fall in their respective categories. In Madhya Pradesh there is 3% reservation for housing for the disabled under the Indira Awas Yojana, and another 4% in other schemes. Around 16,844 disabled-friendly houses have been constructed under the Persons with Disability Act, and another 16,000 under other schemes.

Indira Awas should have provision allowing a person with a disability to install a ramp into a building, lower the entry threshold of a unit, or install grab bars in a bathroom.

Annexure-7: Relevant Housing Schemes

3.5.3. Stakeholder Analysis

Community level service providers in water, sanitation, hygiene and housing include Sarpanch, Ward Members, School Teacher, ANM, Lady Health Visitor, AWW, ASHA, NGO Staff, CSR staff of corporate agencies etc.

Institutions involved in delivering services are Sanitation Mission, Rural water supply Department, NABARD, CSR wing of corporates in some communities, etc. The community institutions involved in implementation of Schemes are Village Panchyat, Village Development Committee/Gaon kalian samittee and Village Health and Sanitation Committee (VHSC)

The services include supply of safe drinking water, installation of latrines, Hygiene Education, IEC materials on water, sanitation and solid waste disposal.

3.6. Climate Change and Eye Health

Climate change is a major problem caused by the increase of human activities leading to several direct and indirect impacts on health. The combustion of fossil fuels, increasing number of industries, and large-scale deforestation are some of the causes for the accumulation of GHGs (greenhouse gases) in the atmosphere. The GHGs have been responsible for the depletion of stratospheric ozone, which protects the earth from the harmful direct rays of the sun. Depletion of stratospheric ozone results in higher exposure to ultra violet rays of the sun lead to an increase in the number of people suffering from eye diseases such as cataract. An estimated 38% of blinding cataract may be attributable to repeated dehydrational crises resulting from severe life threatening diarrhoeal disease and/or heatstroke (Minassian D C, Mehra V, 1989).

The association of fuel use and ocular morbidity in a village in western India investigated wood use as an important factor in the etiology of age dependent cataract. There is evidence-base to link the dietary contribution of biological diversity to improved eye health which is substantiated using existing phyto-chemical, pharmacological, and clinical knowledge (Bélanger J, Johns T. Ecohealth. 2008).

Rising temperature may lead to increase heat exhaustion and heat stroke, cardiovascular diseases, exacerbate existing conditions related to circulatory-, respiratory- and nervous-system problems, dehydration, malnutrition, waterborne diseases like diarrhea, cholera, skin and eye diseases etc. Respiratory disorders, such as asthma, would be affected by changes in average and peak air pollution levels. Airborne particulates have been shown to cause nasal, throat, respiratory and eye problems.

The relevant schemes addressing the issue are NRHM, ICDS, MGNREGA, Social Forestry/Plantation, Wetland Management/Water-shed Management, TSC, National Biogas & Manure Management Program (NBMMP), Integrated Afforestation & Eco Development Project (Ministry of Environment & Forest, Government of India), National Biogas & Manure Management Program (NBMMP) (Department of Renewable Energy, Government of India), Environmental Promotional Assistance Scheme (EPA of NABARD), etc

3.6.1. Environmental Promotional Assistance Scheme (EPA of NABARD)

The scheme is for extending promotional grant assistance for undertaking activities related to environment protection aimed at sustainable and environment friendly agriculture and rural development with a focus on demonstration of replicable eco-friendly technologies. The eligible agencies are NGOs, Universities, Research Institutions, Krishi Vigyan Kendras (KVKs), etc

The activities include components such as training, demonstration, replication of eco-friendly control measures/ technology, awareness campaigns, publicity, capacity building are covered by grant assistance. Some of the activities so far covered are post-watershed development, promotion of bio/organic fertilisers, use of solar energy, village resource management, training on pot/drip irrigation and fodder cultivation, dissemination of information on naturally coloured cotton and organic cotton cultivation, conversion of waste into organic manure, vermicomposting, demonstration on bio-gas plants, plantation for bio-diesel, demonstration of replicable eco-friendly technologies and awareness creation.

3.6.2. Integrated Afforestation & Eco Development Project (Ministry of Environment & Forest, Government of India)

The short-term objectives include regeneration and eco-development of degraded forests and adjoining areas on a watershed basis and employment generation for the neediest sections of society, particularly those belonging to women, people with disability, scheduled castes/scheduled tribes and landless rural labourers, inhabiting the forests and adjoining areas. The long-term objectives are checking forest degradation and loss of bio-diversity and ecological restoration and environmental conservation and eco-development.

The scheme is implemented as a Centrally Sponsored Scheme/Central Sector Scheme for voluntary agencies, cooperatives and other registered institutions to which projects may be sanctioned directly by the NAEB, with 100% central funding. JFM will, be a central and integral part of all plantation projects. The project authorities will be given adequate leverage by way of "entry-point activities" and requisite funds for building up awareness etc. amongst communities. In the selection of the project sites, gram panchayats or other village level bodies would be associated.

The activities include soil and moisture conservation measures like contour furrows, staggered trenches, mulching, box trenches, bench terracing, and vegetative barriers, etc; soil and moisture conservation by

construction of small scale engineering structures like gully plugging, check dams, retaining and breast walls, toe walls, spurs and torrent control measures, small water harvesting structures including ponds, tanks and such vegetative measures as may be necessary; planting and sowing of multi-purpose trees, shrubs, grasses, and legumes, as well as fodder production and pasture land development including seed and seedling production; promotion of agro-forestry and sericulture etc., as appropriate; measures needed to disseminate new technology such as mycorrhizal treatment of soils, tissue culture and bio-technology

3.6.3. National Biogas & Manure Management Program (NBMMP) (Department of Renewable Energy, Government of India)

The project aims to provide fuel for cooking purposes and organic manure to rural households through family type biogas plants and to improve sanitation in villages by linking sanitary toilets with biogas plants. The project promotes indigenously developed models of biogas plants in rural households.

(Annexure-8: Relevant schemes)

3.6.4. Stakeholder Analysis

Community Level Office Bearers/Service Providers are Sarpanch Health Officer, ANM, ASHA (Provide ORS), AWW (IEC), Forest Officer, Agriculture Extension Officer, Water Resource staff, NREGA Staff (NREGA and climate Change mitigation actions), NGO Staff, etc.

Institutions directly delivering services to the community are the Village panchayat, PHC, CHC, Sub-centre, Agriculture Department, ITDA, School, the State Renewable Energy Development Agency (SREDA).

Community Institutions involved in implementation of Schemes are Gramsabha/ Village panchayat, Village water and Sanitation Committee, Village Development Committee/Gaon Kalyan Samittee, Forest Management Committee, Water User Group, Food Security Committee, etc.

The services are IEC on Heat related diseases/preventive measures by NGO and Health facility Prevention of Malaria/Dengue and Eye diseases, ORS in summer, Drinking water, Plantation cover, Health intervention during Flood, Medicines from Sub-centre/ANM & PHCs, Disaster Relief by NGO/GO/Panchayat, Smokeless Chulla, etc.

Role of individuals and communities to mitigate the effects of green house emissions:

The impacts on the more vulnerable groups of the population, including the elderly, the young, the infirm and the poor are of particular concern. Climate change will have disproportionate and most severe impact on poor people who have least contributed to it and are the least equipped to deal with it.

- Adoption of simple measures in daily lives can dramatically reduce green house gases and turn back the clock on climate change. These include buying energy efficient appliances, cleaners and pest repellants and segregating waste. Heaps of garbage left in the open emit methane and contribute to global warming.
- Experts underline the necessity for proper health management in addressing the health risks. CSOs should call for revision of climate change strategies in the national health policy. Mitigation of the impacts and adaptation to climate change should be done simultaneously.
- There is lack of specific data to ascertain the precise consequences of climate change on eye health. We need to generate and collect more reliable data on the matter.

- Adaptation has the potential to significantly reduce health-related vulnerabilities to climate change. Some adaptation initiatives include the development of vaccines against emerging diseases, public education programs aimed at reducing the risk of disease exposure and transmission, and improving disaster management plans so as to enhance emergency preparedness. The implementation of early warning systems for extreme heat and cold is another effective adaptation strategy. Reducing the heat island effect in urban areas would also reduce future climate change impacts.
- Indicators for cooking fuel pollution are needed to determine the extent of fuel-related problems and to assess the success of measures undertaken to reduce such problems. It is proposed that eye irritation in the form of tears or smarting eyes during cooking time is a useful determinant of indoor air pollution from cooking-related sources.
- Reduction in the use of non-renewable sources of energy and increased use of renewable sources will undoubtedly decrease the emission of GHGs substantially. This decrease in the GHGs will have a positive affect on the health and well being of the people.
- Furthermore, switching to cleaner fuels and energy-efficient technologies will reduce local pollutants and therefore, have an added beneficial impact on health.

3.7. Micro-credit and micro-insurance:

Micro-insurance is the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. Low-income people can use micro-insurance, where it is available, as one of several tools to manage their risks. In India, low-income people on an average are more prone to illness, work under hazardous conditions and do not have regular health and eye check –ups. Besides risks related to hazardous working conditions often result in disability.

The micro-insurance and micro-credit services at community level are vision insurance, health insurance, life and disability insurance, Asset Insurance, Farm & Rural Non-Farm Micro-Finance, Livestock insurance, agricultural insurance, etc.

Vision Restored and loan repaid: a big Difference for Hanif Khan

Hanif Ali Khan, aged 50 remained visually impaired person for 6 years. He left the hope to cultivate his three and half acres of land. After a screening test of his eyes by a local NGO volunteer, Haneef was found suffering from Cataract in both the eyes. He was assisted to operate his eyes and his vision was restored. Now Khan not only cultivates his land, but he is plying a motor propelled rickshaw. After spending about Rs 60 in fuel he manages an income of Rs 200 per day. The loan he had made to buy the rickshaw from a local bank is almost paid back. He is able to look after his 12 member large family including children and grand children, Hanif shared.

The schemes available are Micro Credit to Self Help Groups, Rashtriya Swasthya Bima Yojna, Comprehensive Health Insurance Scheme (CHIS) and Vision Insurance, Aam Admi Bima Yojna (AABY), Janshree Bima Yojna, National Agricultural Insurance Scheme (NAIS), Rashtriya Swastya Bima Yojana (RSBY), etc

3.7.1. Vision Insurance and Health Insurance:

Vision insurance is supplemental to regular health insurance, it's difficult to understand which benefits are included and which ones must be purchased.

The type of eye exam is determined by the reason for one's visit or one's chief complaint, as well as one's diagnosis. Routine vision exams usually produce final diagnoses such as nearsightedness or astigmatism while

medical eye exams produce diagnoses such as conjuctivitis. Most insurance companies focus on the reason for one's visit.

Insurance companies sometimes handle routine eye exams differently than medical eye exams. A person's medical insurance may cover a medical eye problem, but not pay for the exam if it is a "routine" eye exam. Many vision plans provide coverage for glasses and contact lenses, or at least give a person some type of discount on the doctor's fees. A person's medical insurance will pay for examinations if s/he has eye health problems.

Many people with medical insurance have a separate rider policy to cover routine eye exams. The plan coverage varies among insurance companies. Insurance companies usually separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. Typically, vision insurance policies usually cover both the eye exam and the refraction, while medical policies cover the exam only.

3.7.2. Life and disability insurance

Life insurance is the most obvious choice for micro-insurance. The consequences of death are always significant for poor households so there is a constant demand. The exclusion of suicide reduces moral hazard problems. By selling to groups that are involved in some activity adverse selection can be reduced. Mortality rates are often easier to obtain than, for example, rates of different types of illnesses. A death certificate or identification of corpse makes claim verification easy. With a one-time payout the system is relatively easy to administrate. For this reason, the vast majority of all micro-insurance products, in India and worldwide, are life products.

Because poor people are frequently involved in hazardous jobs, there is a significant demand in India for disability insurance. Although termed disability insurance, in practice it is often dismemberment insurance because the latter is easier to verify than general disability.

3.7.3. Health insurance

A number of studies have been completed on the demand for health insurance products in India. In one study, Ralf Rademacher mentions that only 10 percent of the entire Indian market is covered by private and public health insurance. He further mentions that secluded castes and secluded tribes often exhibit a strong preference for traditional medicine, making their incorporation into formal health provider systems difficult. Rademacher claims that approximately 80 percent of the financing of the Indian health-care system is done through private payment in spite of the existence of free universal health care and public - sector hospitals in all urban areas.

In his survey of 447 households in Pune, Maharashtra, Ralf Rademacher found that the main reason people used public services was their inability to pay for private health care, although they would prefer it. In urban and semi-urban areas, 57 percent of the low-income respondents in Rademacher's survey used a combination of state and public health-care services: 42 percent only used private services. In rural areas, 70 percent of respondents used only public health care providers. With severe illnesses requiring long -term or expensive care, 86 percent of all respondents, i.e., rural and urban, use d public health care. This figure in part reflects the fact that private hospitals do not exist in rural areas. Twenty-five percent of the patients who enter hospital above the poverty line fall below the poverty line after hospitalization because of their health-care costs. (Rademacher, p. 60)

3.7.4. Asset and Agricultural insurance

There are three broad categories of asset microinsurance: hut, livestock and cattle. A few policies also cover goods within a hut, usually to a certain maximum level.

Most of India's poor population is engaged in some way in agriculture. Agricultural insurance has always been a social priority for the Indian Government, and in theory there should be demand for additional commercial cover. In addition to insurance sold together with agricultural equipment, e.g., water pumps, agricultural insurance tends to cover crops and livestock.

A lot of crop insurance is sold through the National Bank for Agriculture and Rural Development (NABARD). NABARD is an apex institution that primarily wholesales credit to rural retailers. NABARD is promoting the target group, farmers. Borrowers of NABARD funds *must* take insurance; for non-borrowers insurance is an option.

A number of companies sell livestock insurance policies. Public companies include National Insurance Company Ltd., Oriental Insurance Company Ltd., United India Insurance Company, New India Assurance Company. Private companies include Allianz AG and Reliance General Insurance Company.

Many NGOs and MFIs that partner with insurers are in need of capacity-building to help ensure that (a) they get the best deal from the insurer and (b) manage the relationship efficiently. In order to get the best deal from insurers, NGOs and MFIs need to know exactly how much it will cost them to do the agency work. Very few NGOs and MFIs cost their activities effectively, and this adversely affects their sustainability. It would be useful to assist them in costing their activities.

In the 'Concept Paper on Microinsurance' the IRDA envisages a minimum training requirement for MFI and NGO agents. Although most of the work of the agents will be related to the specific product they sell and the specific relationship they have with the insurance company, there will be a minimum core common to all agents, for example, the basic principles of insurance and selling techniques. As such material would benefit all parties, it would be useful to hold a workshop with insurers and MFIs, decide what training would be useful for all, and then develop training materials on the common themes.

3.7.5. NHFDC Schemes for PWDs:

National Handicapped Finance and Development Corporation (NHFDC) has been set up by the Ministry of Social Justice & Empowerment, Government of India on 24th January 1997. NHFDC functions as an apex institution for channelising the funds to persons with disabilities through the State Channelising Agencies (SCAs) nominated by the State Government(s) or through Non Government Organisations (under Micro Credit Scheme). The corporation provides financial assistance for a wide range of income generating activities to disabled persons for setting up small business in Service/Trading sector, for purchase of vehicle for commercial activity, for setting up small industrial unit, for Agricultural activities, for self-employment amongst persons with mental retardation, cerebral palsy and autism.

(Annexure-9A, 9B, 9C & 9D on relevant other schemes)

3.7.6. Stakeholder Analysis

The community level service providers are insurance agents (Micro-insurance), MFI Staff, staff of NGOs working on micro-credit.

The institutions directly delivering services to community are Birla Sun Life Insurance, SBI Life Insurance, Oriental Insurance, Royal Sundaram, Alliance Insurance, Reliance General Insurance, IFFCO Tokyo, General Insurance, Life Insurance Corporation, HDFC Chubb, Cholomandalam Ms General Insurance, Tata Aig, etc.

Community institutions involved in implementation of Schemes are Village Panchayat, SHG Committee, etc.

4. Panchayati Raj Institution and Community Development

Most of the mega schemes in the functional domain of Panchayats in India have largely ignored the Panchayats or given them only a perfunctory role. However, NREGA breaks new ground in this respect. Panchayats have been legally declared as the "principal authorities for planning and implementation" of the scheme made under the Act. Incidentally, NREG Act is the first developmental legislation which assigns a definite and important role to PRIs. Also it is significant to note that National Rural Employment Guarantee Scheme (NREGS) does not entail creation of parallel bodies for implementation; even the ubiquitous DRDA has not been given any functional role. The Act has created the legal framework to enable the political executive to structure effective decentralization. The Guidelines reaffirm this declaring the PRIs as the "key Stakeholders."

Panchayat is the nodal agency of development schemes

Soumendra Nath Das, sarpanch of Durbachoti GP under Patharprotima Block expressed that Panchayat is the nodal agency for channeling and implementing all development schemes in the communities. All stakeholders including local NGOs should contribute to Panchayat Annual Action Plan. Recommendation of stakeholders to include important matters regarding community development can be accommodated in the Action Plan including schemes addressing disability and eye health issues. VHND can be used as a platform to implement the activities relating to health, nutrition, etc. Pritish Samant, the local School Teacher endorsed the view of the Sarpanch. Samant besides a teacher is also active in school based Eye Health program who often take the help of the local ANM Sutapa Das in administering Vitamin-A to the school children and takes a proactive role in organizing VHND with the ANM and the local Sarpanch.

Theoretically, with this powerful legal entitlement backed up by substantial resources in a largely untied form, and, reckoning the potential synergy with other schemes like the Backward Region Grant Fund (BRGF), National Rural Health Mission (NRHM), Rashtriya Swasthya Bheema Yojana (RSBY), the launching pad for PRI empowerment and their transformation into "institutions of self-government" has been put in place. It is a debatable issue whether this potential has been fully realized and given concrete shape in practice. Since NREGS is a programme which combines the economic development and social justice functions in a context of local planning and implementation it is only in the fitness of things that PRIs play the central role as the Constitution itself assigns these two roles to PRIs. Further for realizing entitlements and broadening capabilities of the disadvantaged, democratization and participation are essential and sufficient pre-conditions and only PRI can bring them about.

4.1. Selected PRI Schemes

4.1.1. PRI in Health Sector & NRHM

Panchayats have been assigned 29 rural development activities, including several, which are related to health and population stabilization.

The National Health Policy, 2001, also emphasizes implementation of public health programmes through local self-government institutions, especially relating to the national disease control programmes.

The National Rural Health Mission, (NRHM) aims to provide an integrated package of primary health care services at the village level through intersectoral convergence, decentralization and community action. The reach of the present health and Family Welfare system is extended to the village level in the form of "ASHA"- an Accredited Social Health Activist, who is selected, supervised and supported through the panchayat and its committees. Thus the policy and programme environment for PRI engagement in health is very supportive.

4.1.2. Panchayati Raj Institutions in the success of the NRHM:

PRIs are seen as critical to the planning, implementation, and monitoring of the NRHM. The NRHM is seen as a vehicle to ensure that preventive and promotive interventions reach the vulnerable and marginalized through expanding outreach and linking with local governance institutions.

Key to the success of the NRHM is: intersectoral convergence, community ownership steered through village level health committees at the level of the Gram Panchayat, and a strong public sector health system with support from the private sector. Underlying this is a commitment to systemic reform within the health sector for better regulation of medical establishments, public health oriented medical education, strengthened management capacity, and effective and rational human resource policies. Success of the NRHM in achieving its outcomes is significantly dependent on well functioning gram, block and district level Panchayats.

ASHA, the mechanism to strengthen village level service delivery, is a local resident and selected by the Gram Panchayat or the Village Health Committee (VHC). She is supported in her work by the AWW, school teacher, members of local community based organizations, such as SHGs, and the Village Health committee. ASHA's role is to facilitate care seeking and serve as a depot holder for a package of basic medicines. She is reimbursed on a performance based remuneration plan.

The Village Health Committee (VHC) forms the link between the Gram Panchayat and the community. The VHC is responsible for working with the Gram Panchayat to ensure that the health plan is in harmony with the overall local plan. It is anticipated that this committee will prepare a Village Health Plan and maintain village level data, supervised by the Gram Panchayat. Engaging the Gram Sabha and other groups in planning and monitoring the Village Health Plan will presumably enforce transparency and accountability.

Under the NRHM, untied funds of about Rs. 10,000 are placed with the ANM to meet unanticipated expenditures and to ensure that lack of drugs and other consumables is not an issue. At the sub center level planning and use of these funds will be supported by the appropriate tier of the panchayat.

Effective health care is not within the realm of the health department alone. At the village level convergence is required with agencies providing nutrition, sanitation, education, livelihood/poverty alleviation and empowerment schemes at the very least. Beyond the functionaries of each of the line departments, the only institution at the village level which can coordinate all these functions is the PRI. In reality however there is little convergence at the village level in many states, much less an active role for the PRI in facilitating convergence. At the District level a District Health Mission will coordinate NRHM functions. Sanitation will be aligned with the NRHM.

Table: 4.1. Key Health Programs and Role of Panchayat at various levels:

Key Programmes	Specific Interventions	Role of PRI- various levels
Blindness Control Programme	-Identification of persons with blindness - Enabling access for consultation, diagnosis and treatment in public health systems or NGO managed services - Identification of specialist facilities nearest the residence -Enabling referral and follow-up	- Gram Sabha will work with ANM/Health worker in identifying persons - Panchayat will ensure that the person has access to requisite clinical and diagnostic examination -Panchayat will be responsible for referral - Block Panchayats will be responsible for ensuring availability of doctors, monitor surgical facilities, and ensure compliance with fixed day services

There are enough portents to suggest that PRI engagement in improving key health indicators will become a reality. However in order to expedite the process and to make it more effective, consideration of key issues related to empowerment of Panchayats through funds, human resources and capacity are critical. PRI engagement is perhaps the only existing mechanism to achieve large-scale community participation and reach the marginalized and vulnerable, particularly women, children, and the poor. Locating NRHM functions within the gram panchayat and implementing it through a village health committee/Gram Sabha will facilitate the process and make health for all an achievable reality.

4.1.3. Rural Business Hub

Rural Business Hub aims to eradicate rural poverty and create employment opportunity in rural India. This initiative intends to give a fillip to village enterprises that add value to economic activities in rural areas. The Ministry of Panchayati Raj has adopted the goal of "*Haat to Hypermarket*" as the overarching objective of the Rural Business Hubs (RBH), initiative aimed at moving from more livelihood support to promoting rural prosperity, increasing rural non-farm incomes and augmenting rural employment. RBHs set up in association with Panchayati Raj Institutions (PRIs) could thus constitute the fulcrum of "inclusive growth" - the theme of the Eleventh Plan.

4.2. Socially Inclusive Panchayati Raj in Kerala

Box: In Kerala, 35 to 40 percent of the total budget of the state government is allocated to the local bodies (Gram, Block and District Panchayat). Out of this 40 percent, 30 percent of the budget has to be allocated for planning activities related to social sectors. Plans for such resources are entirely based on locally identified needs. While vertical planning is done by the Centre, the identified target and budget have to be implemented by the local units. The Ninth Five-year Plan in Kerala is considered as the best model for empowering local self-governments. A movement popularly known as "People's Campaign for Decentralized

Planning" was launched, whose main focus was to create pressure from below to bring about necessary institutional reforms corresponding to devolution.

Kerala is the acknowledged pioneer and leader in strengthening Local Governments in the post-Constitutional Amendment phase. Following a "big bang" approach resulting in a series of reversals in the conventional sequence in decentralization – giving responsibilities and then building capacity, giving powers and then structuring administrative systems, giving funds and then putting up accountability mechanisms – Kerala launched its decentralization experiment, following a campaign mode which by itself not only set the agenda but generated expectations and forced the pace.

Paradoxically, though the push was unorthodox, the principles and practices have been classical in their features. They include:

(1) Sharp mapping of functions and responsibilities among different tiers of Panchayats and a rational division of labour between the State and Local Governments – in this scheme of things, poverty reduction, human development, local economic development and provision of minimum needs including housing, sanitation, water, power, and connectivity are all predominantly Panchayat responsibilities.

(2) Devolution of funds matching expenditure responsibilities, in a largely untied manner, facilitating considerable local autonomy in prioritization and allocation of resources - the State gives about a quarter of its Plan Budget in this fashion, with every rupee allocated as per a formula ensuring transparency, fairness, equitability and predictability.

(3) Transferring staff to Local Governments to discharge the transferred functions and in putting in place a dual control system – even while the State Government is the staff-creating and cadre-controlling authority, Local Governments have full freedom in assigning work, supervising its execution, reviewing performance and even imposing minor punishments, if required.

(4) Setting up of independent umpiring institutions like Ombudsman and Appellate Tribunal to reduce executive control over local government functioning.

(5) Enhancing financial and social accountability through due process in budgeting, transparency in decision making, particularly in selection of beneficiaries and in expenditures and mandatory reporting of performance to constituents.

(6) Participatory planning to ensure incorporation of people's priorities.

(7) Creating space for formal people's participation in governance – in priority setting, in implementation and in monitoring.

Approach of Kerala

With more than a decade of experience in local level planning and development, the PRIs of Kerala were in a vantage position to take over full responsibility for implementation of a rights based pro-poor programme of large magnitude like NREGA. Therefore Government consciously decided to internalize its operationalisation into the Panchayati Raj system to further empower it. The salient features of this approach are summed up below:

1) NREGA was perceived as an opportunity for strengthening and institutionalizing decentralization in all respects and therefore a decision was taken that the whole programme would be implemented through PRIs and, by and large, through Grama Panchayats which are closer to people.

2) Right from the beginning an attempt was made at deconstruction and de-schooling vis-à-vis the employment generation schemes of the past so that NREGA does not get contaminated by vestiges of past practice. A clear distinction was drawn between the past schemes and NREGA and communicated to all stakeholders especially the elected leaders of Panchayats.

3) Though it was widely realized that NREGA is not the main solution to the unemployment problem of the poor in Kerala where a large number of the poor seek not manual work but self-employment and wage employment in the formal informal sectors, at the same time, the State was able to foresee a niche for NREGA in reducing poverty of at least half

a million poor agricultural labourer families who are expected to turn up for works under NREGA and get an additional annual cash income of Rs.12,500 per annum.

4) Realizing that the vast majority of the workers is going to be women it was decided to involve the Kudumbashree network of poor women in a big way - for awareness creation, for demand generation, for identification of work; for organization of work and for concurrent social audit (Kudumbashree is a unique programme for poverty reduction and women's empowerment under which every BPL family in the State and a few APL families - families in rural areas are organized into - neighborhood groups (NHGs) at the local level, networked with - Area Development Societies (ADCs) at the Village Panchayat Ward level which are then federated into 999 Community Development Societies (CDSs), at the Village Panchayat level. This large community-based organization works in partnership with the PRIs.

5) In a State which has very little public land, to enhance the quality of environment using NREGA, a policy decision has been taken to focus on natural resource management in forest areas, river basins and watershed areas in agricultural land.

6) To prevent NREGA from being seen as an extraneous Centrally Sponsored Scheme the processes and procedures were designed in such a way that they could be woven seamlessly into the fabric of the administrative operating systems now existing in Panchayats.

7) The potential of NREGA to strengthen good governance at the local level mainly through its consistent and coherent information and accountability systems and transparent and participatory processes was realized right in the beginning and acted on.
8) A carefully focused and planned objective was to achieve zero corruption in the implementation of NREGA – whatever may be the costs in terms of time and resources. Interestingly this approach was articulated in unambiguous terms by the political leadership sending powerful signals both to elected leaders and field level officials. It also gave freedom to senior officers to design systems, procedures and processes to attain this policy priority.

4.3. Kudumbashree in Kerala

Kudumbashree, which means prosperity of the family, is the name of the women oriented, community based, and empowerment programme of the State Poverty Eradication Mission of Government of Kerala. The mission aims at the empowerment of women, by forming self help groups and encouraging their entrepreneurial or other wide range of activities. The purpose of the mission is to ensure that the women should no longer remain as passive recipients of public assistance, but active leaders in women involved development initiatives.

The Mission

The mission of Kudumbashree aims "to eradicate absolute poverty in ten years through concerted community action under the leadership of local governments, by facilitating organization of the poor for combining self-help with demand-led convergence of available public services|services and resources to tackle the multiple dimensions and manifestations of poverty, holistically".

Specific Objectives:

The specific objectives are:

- Identification of the poor families through risk indices based surveys, with the active participation of the poor and the communities to which they belong.
- Empowering the poor women to improve the productivity and managerial capabilities of the community by organizing them into CBOs.
- Encouraging thrift and investment through credit by developing CDSs to work as informal bank of the poor.

- Improving incomes of the poor through improved skills and investment for self -employment.
- Ensuring better health and nutrition for all.
- Ensuring basic amenities like safe drinking water, sanitary latrines improved shelter and healthy environment.
- Ensuring a minimum of 5 years of primary education for all children, belonging to risk families.
- Enabling the poor to participate in the decentralization process through the CDS, as it is a subsystem of the local government, under which it works.

In order to achieve the specific objectives of the Mission, several auxiliary objectives are pursued methodically.

Organizational Structure

The following are the community structures existing for the rural areas:

- Kudumbashree Ayalkoottam (NHG)
- Kudumbashree Ward Samithy (ADS)
- Kudumbashree Panchayat Samithy (CDS)

The paradigm shift in the approach is that any women who is residing in the Grama Panchayat can become a member of the Kudumbashree Ayalkoottam irrespective of the fact that she belong to a below poverty line (BPL) Family. Since this aspect gives an opening for the APL families to enter into the community structures envisaged by Kudumbashree, it is further ensured that majority of the office bearers should belong to BPL families. These structures give added importance to women empowerment both social and economic.

Strategies

The activities charted out for Kudumbashree are: -

Formation of women collectives

The poor women from families identified will be organised into Neighbourhood Groups (NHG) representing 15 to 40 families. A five-member team elected from the NHGs will be the cutting edge of the programme. NHGs will be federated democratically into Area Development Societies (ADS) at the Panchayat/Municipality Ward level and then into Community Development Societies (CDS) at the Panchayat/Municipal level. Their organizational structures will provide opportunities for collective public action.

More information/training

Weekly meetings of NHGs, sharing of experiences, discussions, organised/unorganized trainings etc., will broaden their outlook on better health, better education, better social and economic status.

Skill up gradation training

To facilitate economic development, suitable skill upgradation trainings will be given to women.

Thrift-credit operations and 24 hour banking system

Enabling women to realize their latent potential, strengthening them through self-help are the main objectives of Kudumbashree. Small savings generated at the families are pooled at various levels as thrift

and used to attract credit from banks, which will operate as 24-hour bank for the poor, acting as a sub-system of the formal banks.

Better living conditions - Infrastructural facilities

The needs identified at NHG level are shaped as micro plans which are integrated into mini plans at ADS level and action plan at CDS level. This will be the anti-poverty sub plan of the local body and this will facilitate convergent delivery of Government programmes meant for the poor. Rather than the traditional system of heavily subsidized approach, Kudumbashree promote self-help approach for building houses, latrines, access to drinking water, sanitary facilities etc., availing the minimum support from Government. Common infrastructural facilities in the community strengthen them further.

Micro-enterprises for sustainable economic development

Providing skill up-gradation trainings, self-employment opportunities and infrastructural development through wage employment schemes are the preparing grounds for further development of successful micro enterprises. Kudumbashree is bent on giving necessary resource support and facilitate forward/backward linkages etc., to promote micro-entrepreneurship among poor women.

Power to the people especially the poor women

The skill for identification of needs, fixing priorities, availing resources, bridging gap between needs and resources in a cost effective manner etc., are taught to the poor women groups in various phases. In the decentralization of power to the local bodies and common man, Kudumbashree can act as a healthy sub-system facilitating participation of poor women in the planning, implementation and monitoring of the programme.

Leadership - decision making power

Interaction in women collectives will help them to have a better understanding, which will lead to the emergence of leadership. This will help to ensure efficient women leadership to elected governments in future.

The ultimate goal

Reaching out family through women, and community through family, is the ultimate target of Kudumbashree.

Informal banking system

The three-tier community based CDS system, envisaged for poverty alleviation in Kudumbashree approach, will take up the informal banking responsibility also.The poor women should be able to approach the informal banks whenever necessity occurs. The doors of the banks should be open for 24 hours a day, 7 days a week and 365 days a year. The informal banks are formed with the active involvement of every member belonging to the Self Help Group. An Informal Bank doesn't need an office building, furniture and other paraphernalia we normally relate with a formal bank.

The strength of an informal bank is the intimate relationship between the members of the Self Help Group. The members know each other's potentials weaknesses and problems. The members can deposit even trifle amount in the thrift scheme of the banks. Informal bank always tried to encourage saving habit among poor women. An informal bank can provide collateral free loans with the terms and conditions decided by the group. The Self Help Group behind the informal bank is free to fix market driven rates of interest for

advances. Every operation of an informal bank takes place in the group level, including depositing of thrift amounts and sanctioning of thrift loans. The groups itself decides the eligibility of a member to get assistance from the bank after discussions and assessment of the need and repayment capacity.

The very existence of an Informal Bank brings about the homogeneity and affinity among members of the poor. Thrift savings of the members serve as the main bondage among members. The bank promote regularity in savings and assures sufficient frequency for group meetings. The informal banks will instill collective decision-making capability among the poor women. This sublime quality will be of great assistance to them for their fight against poverty and their participation in planning process and economic development activities. Informal banks will slowly do away with the subsidy syndrome prevailing in the lowest stratum of the society. The poor women will begin to enjoy the unique pleasure of doing things with their own money. The financial empowerment of women achieved through thrift and bank accessibility will improve their status in their own families and society. Naturally, their confidence will increase. Above all Informal Banks provide loans to the poor women at their own doorsteps without any hassle.

Once the informal banks of the NHGs, ADSs and CDS reach a certain level of maturity, they can grant loans to the members for genuine needs. Poor need financial assistance for several purposes, falling under four major categories.

Micro-enterprise development

Kudumbashree views Micro Enterprise development as an important tool for poverty reduction. When the concept of developing Business|enterprises by poor women was planned in 1999, the response from various stakeholders including banks was far from encouraging. The previous experience of failures in group enterprises under various government programmes, perceived lack of entrepreneual abilities of poor and apathy of banks in associating with ventures of the poor were the prime reasons for this unfavourable environment.

But the most crucial factor was the lack of any successful enterprises model, which was worth emulating. The task for Kudumbashree was simple and challenging, to create a model for enterprise development. Kudumbashree went about creating a model, and the results are for everyone to see. 18969 enterprises across the state covering urban and rural areas, ranging from "traditional" enterprises like Goat rearing and Dairy, Catering units, Multi Purpose job clubs, Health care enterprises, Computer hardware and data entry units, innovative enterprises like Clean Kerala Business in solid waste collection are a testimony to the resolve of women to succeed in enterprises.

The definition of Micro Enterprise according to Kudumbashree is that, any enterprise that has:

- Investment ranging from Rs 5000 to Rs 2.5 lakhs
- Turnover ranging from over of Rs 1 lakh to Rs 10 lakhs.
- Potential to generate a net income of at least Rs 1,500 per member per month.
- Fully owned, managed and operated by members themselves.

There are some common features in the funding of the various enterprise programmes. All Kudumbashree enterprises are bank linked and a minimum of 50 % of the project cost has to be through bank loans. The subsidy component is limited to 50% of the total project cost and the entrepreneurs' share is to the tune of 5% of the total project cost.

The emphasis in the Kudumbashree enterprise programme was to encourage innovative business ideas rather than on the "tried and tested" ones. A simple and practical way for identifying enterprises was devised; any idea that could solve a problem existing in the society (Problem Solving), fill the gap that existed (Gap

Filling) or cater to new opportunity (Emerging Opportunities) was converted into an enterprise. The fact that most of the entrepreneurs were first generation entrepreneurs from their families was kept in mind while implementing the RME programme. The micro enterprise development was seen as an emerging process, which will start with low capital low risk and low profit in the initial stage that will gain momentum and later scale up to greater capital, risk and profit (accounting).

Milestones at a glance

In contrast with the previous poverty eradication programmes there are no specific financial and physical targets set for Kudumbashree. Kudumbashree practices a process approach and not a project approach. Milestones of the Mission at a glance, as per 2009 data, are as follows:-

- The largest women movement in Asia with a membership of 36 lakhs representing equal number of families.
- 36 lakh poor families brought under the community based organisations (CBO)s consisting of 1.87 lakh Neighbourhood Groups (NHG), 17,000 Area Development Societies (ADSs) and 1,058 Community Development Societies (CDSs)- rural & urban.
- mobilised a sum of Rs. 1,105 crores as thrift and disbursed loans amounting to Rs.2,818 crores to the members of Neighbourhood Groups.
- 1,14,761 NHGs graded under Linkage Banking Programme, out of which 96,330 NHGs linked with banks and an amount of Rs.645 crores mobilised as credit.
- 25,050 individual enterprises and 1,,757 group (with minimum 10 members) enterprises of women developed in urban areas.
- 1,430 individual enterprises and 4,578 group (with minimum 10 members) enterprises of poor women formed in rural areas.
- 2,55,270 families participated in lease land farming and {{convert|63560|acre|km2}} of land brought under cultivation.
- 376 group enterprises and 319 individual enterprises started under the Special Employment Programme (Yuvashree).
- Ashraya-Destitute identification and Rehabilitation Project implemented in 745 Local Self Governments and 58,389 destitutes identified.
- 44,586 houses constructed under the Bhavanashree housing loan scheme (without subsidy) for the poor in rural areas.
- 235 enterprneur groups (Thelima) formed for the municipal solid waste management in urban areas.
- 'Buds'-10 special schools for physically and mentally challenged children set up under the leadership of the Local Self Government.
- 45,262 Balasabhas (Children's) Neighbourhood Groups) with 7.9 lakh children formed in urban and rural areas.

5. Practices from the Field

A number of practices were documented during visits to the projects of the partners located in different states. Some of the practices of agencies working in eye health sector were also elicited from the secondary sources. These practices provide insight about the linkage of eye health and social inclusion interventions with community development schemes on health, nutrition, education, livelihood, water, sanitation and hygiene, micro-insurance floated by government, non-government, private, bilateral and multilateral agencies.

5.1. SSDC does eye check up of both Mother and Child

Sunderban Social Development Centre (SSDC) works in South 24 Parganas District of West Bengal. SSDC runs an Eye Hospital in its campus. It provides service to the vulnerable & underprivileged people of remote villages of Sundarban and needy people from other areas those suffer from various eye related problems. The eye care services include primary eye screening and treatment, pathological tests, cataract surgery, refraction services, spectacles provision, referral services, post operative follow up, medicine shop, ambulance and mobile van facilities, counseling and health education through the Eye Hospital, Vision Centres and Outreach Eye Camps.

There are facilities like canteen, waiting room for patients & their relatives, PCO etc in the Hospital campus. Eye care and treatment are provided by qualified & experienced specialist doctors, nurses, technical persons and other administrative staff. SSDC has an out-reach team working in collaboration with local youth clubs, Village Committees, market committees, schools authorities, PRI members of project areas. Screening Camps are organized regularly at different Panchayats and Municipal areas to establish easy referral linkage with base hospital.

SSDC runs four Vision Centres in different locations of South 24 Parganas district including one in a public health centre (PHC). The Vision Centres identify cataract patients and refer them to SSDC Eye Hospital for a detail screening, treatment and operation. These Vision centres offered doorstep services on primary eye care to the communities.

SSDC is running one Maternity Centre in its premise since a decade. The centre, equipped with advanced facilities, provides services to pregnant & lactating mothers, children and adolescents. Nature of facilities available are AN & PN checks up, treatment & care to children and adolescents, institutional delivery for both normal & complicated cases, advice & guidance for immunization, counseling on family planning, nutrition and referral services. Government schemes like 'Ayusmati', 'Janani Suraksha Yojana' are implemented through the Maternity Centre. The mothers from below poverty line (BPL) families are provided facility for institutional delivery with post delivery follow up. The patients from the distant places availed opportunity of Ambulance service of the centre.

Children's health check up is done by child specialist(s) and the services include general health screening, growth monitoring, and treatment of common ailments, vitamin A and nutritional supplementation and eye screening.

SSDC has mobilized INR 13.7 lakh from MP fund for the Maternity Hospital and INR 50,000 from MLA Fund for the vision centre to procure equipments. Subsequently it also received Rs 5 lakh for Eye Hospital from MP fund. Japan High Commission extended Rs 30 lakh for hospital building. SSDC in campus facilities ensure eye check up of both mother and child those come for delivery to the Maternity Hospital.

Observations:

The case of SSDC (West Bengal) is a successful integration of eye health facility with maternity centre. The approach of eye testing in the eye hospital of mother and children those visit maternity centre appear innovative and it is replicable else where through convergence with available health schemes like NRHM, Ayusmati', 'Janani Suraksha Yojana' and also mobilizing resource from MP/MLA fund and other donors. . SSDC has mobilized resources from a variety of schemes and agencies which includes government and bilateral agencies that exclusively target grass-root initiatives.

SSDC has further enriched its eye health and social inclusion interventions by working in collaboration with local youth clubs, Village Committees, market committees, schools authorities, PRI members of project areas. This approach has made its programme cost effective and created a scope to scale up the services in a wider geographical area.

5.2. Working with the Government frontline functionaries

Schools play a very important role in the early initiation and formation of health seeking behaviour in children. Some partners (ADHAR, ORRC, JKS, Sunderban Social Development Centre, Shramik Bharati, SURE, SEVA Rural, etc)have strategically collaborated with the Government's flagship Sarva Siksha Abhiyan (SSA), a programme coordinated by the Department of Education to achieve universal education targeting the 6-14 age groups. This strategy was found to be very effective for those engaged in Childhood Blindness Project. After receiving training from the doctors, the school teachers screened and identified children for referrals and surgery. The fixed cost for treatment and surgery was reimbursed from the SSA. The collaboration was immensely useful in reaching out to the remotest of hamlets.

Similarly, for the 0-6 age group, partners have collaborated with the Integrated Child Development Scheme (ICDS) programme implemented by the Department of Women and Child Development. Several partners have been strategic in using this approach to identify and reach out to this critical age group. In Kanpur, UP, every month the meetings of the ICDS department takes place in the conference hall of the partner, where all anganwadi workers (AWWs) responsible for running a small centre in the village for meeting the nutritional and pre school educational needs of all children (0-6) and sector supervisors of one block participate. The first half is utilized by the doctors in orienting the AWWs in early symptoms and identification of childhood diseases. The second half is reserved for the departmental meeting. In the next month the trained AWWs bring the children identified with eye problems along with their parents for referral. The key learning here is to identify like-minded officers in the Government and then work out a mutually beneficial arrangement.

Observations:

Working with the government frontline functionaries has helped the partners in brining expertise and man power support, training support from the government schemes (teachers trained in eye screening), sharing of resource, space and provisions (reimbursement of costs) from the government schemes like SSA, ICDS etc.

From the sustainability angle, working with the Government frontline functionaries like primary school teachers and anganwadi shows high returns. Not only is the strategy cost effective but also ensures a

steady source of counseling and referrals long after the project period. Significantly, this is perhaps the only strategy that can achieve the scale and magnitude at a fraction of the cost otherwise.

5.3. Developing inclusive practices and methods

Bijapur is one of the largest districts of Karnataka. 80% of the population lives in rural area against state average of 69%. The district has taken keen interest in developing curriculum adaptations for children with special needs keeping in view the retention of these children, especially at higher classes as there is a tendency of CWSN dropping out. The expertise of IERTs has been utilized in developing a hand book for Class V language called TUDITA. IERT volunteers and few professionals in Bijapur came together to find solutions of developing inclusive practices and methods of how inclusive education could really be adopted in the classroom by using the existing curriculum. The curriculum is adapted for language keeping in view the special educational needs. The hand book is in Kannada. Every learning objective of class V language text is provided in the adapted curriculum format for three disabilities (VI/HI/Intellectual disability) to assist the teachers to develop inclusive practices. The approach in inclusive practice is a twin track approach while making necessary changes in the education system. There is a need to look into the specific needs also and the support required to nurture the potential of CWSN. Firstly at the classroom level, available instruction time, the attitude, knowledge and skills of teachers and teaching methods and materials can be distinguished as important prerequisites for special needs teaching in mainstream settings. Secondly issues involved in organizing inclusive education at the school level are structure for providing special support within schools, the role of special education services, other support systems finally decide as to how the child with special needs is able to learn and participate in the learning and achieve the desired goal of education.

5.4. Activity Based Learning (ABL) for CWSN (Tamilnadu)

ABL is an innovative effort in developing knowledge, skills and positive attitude within the children with special needs. ABL classroom provides a child friendly environment for learning with necessary need based support services. Under this ABL method, language cards and maths kits have immense utility in enhancing the teaching learning levels and in attracting the differently abled children towards the school. By doing so, ABL has attracted a large number of CWSN to schools. It is a process towards access, participation and achievement for all in education and that's what SSA-Tamil Nadu has successfully achieved in the past few years.

Towards the successful implementation of ABL concept for CWSNs and also to motivate the school teachers and special teachers towards to adapt the ABL methodology for CWSNs, a well equipped training was conducted. The children with special needs are to be specially taken care of, as each child coming under the broad category of CWSN has a disability in some area. Each child has to be understood and guided and included in the activities of the classroom, based on his /her disability level.

In the District/Block levels training programmes, the logos were segregated in accordance with the capacity of different disabilities. Following it, Teaching and Learning material (TLM) was prepared for the respective logos. The TLMs were prepared keeping in mind the capacity of CWSN. These learning materials have their sound logical base to make the children to have deep involvement in enriching their abilities relating to the aspects of reading, writing and calculations.

The experience of the last two years in ABL with the disabled children covered under inclusive education is that the CWSN enjoy being in an ABL classroom. They feel free and active and show keen participation in the ABL activities. They like to sit in groups with other children and read; they write on the low- level blackboard by using chalk piece and even interact with the teacher and peers.

The pictures in the ABL cards are very effective with the disabled children. They learn a lot from looking at the pictures than by explanation. The same ABL cards can be modified and made specific for different categories of disability, along with the required TLM.

Activity Based Learning provides lots of opportunity for the different kinds of CWSNs. Visually Impaired Colorful ABL cards is very helpful for the low vision children. These cards increase the rapid recognition. Various TLM related to the ABL cards are prepared for these children. Bold letters are used in the ABL cards. The letters used are written in attractive colors. Tactile flash cards are used for these children. Beads are used for these children for introducing basic arithmetic skills.

5.5. Haryana, a role model for inclusive education

Haryana aims to start a model inclusive school in each and every block in the state so that children with special needs do not have to travel long distances to study. It has already set an example for other states by including 28,445 children with special needs into the Integrated Education Programme under the Sarva Siksha Abhiyan.

The State has started Home Based Education programmes to meet the learning requirements of the 31,907 children identified so far. This programme is being implemented through model inclusive schools, an example that is now being considered worth replicating.

The model inclusive schools already set up in Gurgaon, Panchkula, Hisar and Rohtak have now been extended to Sirsa, Yamunanagar, Faridabad, Bhiwani, Fatehabad and Kaithal districts of Haryana. These schools are inclusive because they have on their rolls a large number of non-disabled students. The Government has made available facilities such as transport, special learning material and equipment, trained staff, and incentives such as books, uniforms and special furniture.

5.6. Space for NGOs in Inclusive Education

A number of NGOs have adopted innovative philosophies and strategies for educating children with disabilities, primarily through encouraging the use of an integrated and inclusive approach. The National Association for the Blind working in various states, Ramakrishna Vidyalaya in Tamil Nadu, and the Blind People Association in Ahemedabad have developed teacher training programmes and learning materials. Large-scale programmes using a cross-disability approach were initiated by organizations promoting community-based rehabilitation such as the CBR Network. These programmes are run in close collaboration with state and central governments. As a broad policy, the government is promoting the role of NGOs at all levels with a view to achieving participatory development, and supporting the administration in implementing its programme. It proposes that the programme be implemented in a manner that will provide adequate opportunities for NGOs. The private sector can contribute towards the achievement of programme goals by developing community-owned initiatives for UEE. It is recognized that NGOs have the potential to contribute to innovating and implementing education programmes. At present, the involvement of NGOs is generally limited to running non-formal education programmes, and implementing small-scale innovative experiments in schooling. While continuing with existing NGO programmes, efforts should be made to identify technically competent NGOs, and enable them to assume a larger role by functioning alongside government agencies in a significant manner.

5.7. Bagaram shares …. "If there is a SURE"

Baga Ram, aged 47, belongs to Lukhon ka tala, Village- Sarali, Block Sindhri, Dist- Barmer. He had hardly completed primary level of schooling. Poverty led him to neighboring state Gujarat as migrant worker and he was engaged in a factory dealing with chemicals. As ill luck would have it, Bagaram lost his vision while working in the factory. Bagaram, disheartened, returned home. Without livelihood he was a liability in the family. But he was hopeful of reorganizing his livelihood. He was married but decided not to go for a child.

A local NGO named SURE linked Bagaram with a disability pension and helped Bagaram with rail & bus pass. The NGO assisted Bagaram to run a petty shop. Bagaram of his own initiative started a floor grinding mill. Subsequently, he prepared cement brick made of stone chips and other materials available locally. Bagaram, though blind, has employed 5 persons. 'Quality assurance is made by me', shared Bagaram. His unit delivers 300 bricks per day. The sale price of a brick is Rs 15 and input cost including labor charges is Rs 10/. In business, Bagram says, he leaves no stone unturned. He has linked his brick making unit with the building material needs of Indira Awas Yojana. Last year he had sold 7500 bricks. In the current year he was sure to sell more. From NREGA scheme he had received Rs 17, 000 for building a water harvesting-cum-storage structure and Rs 35000 for man-days. Materials worth Rs 23000/- were provided by the Panchayat. The total allotment was Rs. 75000/-. Bagaram is member of Samal Sangathan in which there are 15 other blind members. They meet on 15th of every month. Resource Centre, started in 2010 has arranged employment opportunity to all its members.

Bagaram also procures stationary items and sells to local customers. Those come to grind wheat also buy grocery items from the petty shop and procure stationery items. He processes about 90 kg floor per day and charges 1.50 per kg of floor. Bagram prepares basket using local materials to store grain and cereal. A basket sells Rs 100-500. Bagaram practices yoga being trained by the NGO. He also motivated the other members of Sambal Sangathan to prepare utility items like basket, charpai, and color rope (chindhi) charpai. One of the members of the sambal sangathan shared that all of them had NREGA job card, PDS Card. Some of them are engaged in NREGA Works like providing drinking water, helping in assembly work, fencing land etc. Bagaram feels that a PWD beneficiary can assist in assembly work, brick making, fencing, etc. Advocacy and lobby at Panchayat level will enable PWD households to get lot of benefits from NREGA especially those belonging to SC/ST communities. It can provide them permanent livelihood. SURE has also linked many PWD households to construct tank in support of private company CAIRN. Some of them have received Rs 12000/- as initial support. SURE in collaboration with CAIRN-has promoted goatry and Sheep rearing units among PWD households with a revolving animal approach. Bagaram shares that any PWD can be like him "if there is a SURE"

Observations:

The case of Baga Ram of Barmer is an eye opener for those working on livelihood support for blind people. A beneficiary of eye health can be included in a variety of income generation programmes and beneficial schemes like brick making and integrating that with the building material needs of Indira Awas Yojana, running petty shop and stationary unit floor unit, doing agriculture, basket making. SURE has also mobilized support from a private agency to construct tank. Bagaram has also availed benefit from NREGA, Indira Awas Yojana, Trained by SURE, Bagaram also practices Yoga. Baga Ram's leadership has helped other PWDs to avaial NREGA job card, PDS card, etc. SURE has infused leadership, life skills and integrated PWDS with available community development schemes to make a self sustained eye health and social inclusion initiative. The case of Baga Ram and the members of their Sambal Sangathan is a replicable model.

5.8. Vision Restored-Livelihood Restored

Blindness due to cataract presents an enormous problem in India not only in terms of human morbidity but also in terms of economic loss and social burden. Restoring someone's sight can enable that person to be economically productive and independent. It liberates carers to go back to work, or attend education. It

means social resources can be used to bring relief to other people in need. Research in Kenya, Bangladesh and Philippines has shown that following cataract surgery, household income can increase by as much as 33%. Research estimates the global savings from tackling avoidable blindness could be as much as US$223 billion over 20 years. Through '**seeing is believing**' we can empower communities to become more productive, more sustainable, and help break out of the cycle of blindness and poverty. Dingar Meher, aged 52 belongs to Taljhori village, Boisinga Block, Bolangir. Born blind Meher is running a grocery shop in his hamlet. Meher says that the average daily sale is about Rs 250/-. Meher's family consists of 4 members, wife and two children. SBI has extended a DR loan of Rs 25,000/- to Meher 3 years back. Biranchi Paramanik, aged 75, of west Bengal, remained visually impaired for 2 years. He came to know that his blindness was due to cataract. His cataract was operated in 2008. He was to look after an 11 member family. Being barber by profession and a marginal farmer, he was fully depending on his saloon for livelihood. His blindness deprived him from continuing his profession. He sold his saloon to some one. After his surgery his vision was restored. He was trained in vermi composting, growing organic vegetables, etc. Now Paramanik grows vegetables round the year in his12 decimal land. Besides family consumption, every alternate day he gets an income of INR 200 in his farm yard itself by selling vegetables to local vendors.

5.9. SEWA Rural: A Public Private Partnership Model

SEWA Rural (Society for Education, Welfare and Action–Rural) is involved in health and development activities in rural & tribal areas in the Jhagadia block in southern Gujarat since 1980. The organisation runs hospital, community based outreach health care, comprehensive eye care, health training centre, vocational training institute for rural youth and a women development center for promoting women empowerment.

The focus of all programmes has been vulnerable members of family i.e. the women, children & elderly especially belonging to the poor sections of society.

The organization gets cooperation and support from local community, individual well wishers and donors, voluntary organizations, State and Central Government, industries, charitable trusts, and academic institutions from India and abroad.

The organisation is managing a 100 bed general hospital at Jhagadia and extensive outreach eye care and community health programmes for the last three decades. It has experience of managing programmes related to Comprehensive Eye Care, Primary Health Care (PHC), Reproductive & Child Health (RCH) and Safe Motherhood and New Born Care at the grass roots level and secondary level care in OBGY, Pediatric, General Medicine and tertiary level Eye Care at base hospital in Jhagadia.

SEWA Rural is approved by government as a recognised center for its various schemes and programmes like Chiranjivi Yojna, Janani Suraksha Yojna, Rashtriya Swasthya Bima Yojna, Balsakha Yojna, National Blindness Control Programme through DBCS, Microscopy and DOTS center under Revised National TB Control Programme, Compulsory Rotating Internship and Rural Service bond for doctors, Family Planning Center, training center for IMNCI and DNB center in Ophthalmology. Recently under the RCH II and NRHM initiatives, SEWA Rural has been selected as best Practice NGO and Service NGO by the state government.

SEWA Rural has been selected as a member in the District health Society, Bharuch under the RCH II and NRHM initiative in promoting NGO - GO partnership. SEWA Rural is also an active partner with other like minded NGOs in promoting the activities of Dai Sangathan and Jana Swasthya Abhiyan at the state level.

Diagnostic eye camps are regularly organised in interior villages of Bharuch, Narmada, Surat & Vadodara districts. The local community does necessary publicity in surrounding area of the proposed camp site. As a result people get treatment & spectacles, if necessary, near their homes. And yes..... patients with cataract

are identified and brought to the hospital at Jhagadia on the same day. Similarly they return home the next day following the operations. Hundreds of old persons who used to live a dependent life are now living a new life following the restoration of their vision. SEWA Rural is a member if the Vision 2020 right to sight India Programme which is an advocacy group to provide impents to the goal of National Programme for control of blindness.

SEWA Rural since 2003 is managing a **"Family Centered Safe Motherhood and New Born Care Project"** in entire Jhagadia Block covering a population of about 175,000 and in partnership with district and block level govt. health dept. The main aim of the project is to develop an evidence based model to reduce maternal and neonatal mortality and morbidity in resource poor settings. Community level and family centered interventions are introduced for ensuring proper antenatal care (including aspects of birth preparedness and complication readiness) and intranatal and postpartum care. This has been made possible by building up the cadre of front line volunteers which include village level ASHA alike women volunteers (about 165 Aorgya Sakhis) and Trained Birth Attendants (TBAs - the dais, about 100 are now active at present, while rest are gradually wearing out). For referral of complicated cases from periphery to base hospital, communication and transportation network is established at large. In Addition the front line volunteers have assurance obsteric and newborn care (CEmONC) and also recognized as a First Referral Unit (FRU) by Government of Gujarat and UNICEF.

The micro level interventions have resulted into significant reduction in maternal and neonatal mortality over the pas few years. There has been about 66% reduction (from 19 to 4) among cases of maternal deaths and about 45% reduction (from 47 to 27) in Neonatal Mortality Rate as compared to baseline information. Over and above the increase in institutional delivery rate from 22% to 54%, there has been significant improvement and positive increase in coverage of various services and process indicators in aspects of prenatal care, internantal care, immediate new born care and postnatal follow up both for mothers & babies in the field level.

The organization's current work on maternal mortality focuses on the development and replication of a community-based approach. It provides health education and training to families, communities and front-line health workers—birth attendants, paramedics, doctors and students of medicine, social work, rural studies and health management—on maternal health issues. It works to ensure more institutional deliveries and professional involvement in home deliveries. It conducts research to provide more reliable estimates of maternal mortality and morbidity. And it advocates for maternal health programs with government ministries, policy makers and service providers.

The state government of Gujarat is enlisting SEWA Rural to support the national effort to train new community health workers who will provide preventive primary health care, counseling, and referrals in village communities. In response, SEWA Rural will establish a new training and resource center focused on maternal mortality reduction. The center will scale up the group's work in Gujarat, training more than 2,500 frontline health workers.

5.10. Insurance Program

Government policies play a key role in promoting health insurance programmes. The Government of Karnataka for example, is running a major heath insurance scheme for farmer's cooperatives named Yashaswani.

M. M. Joshi Eye Institute, Hubli, an ORBIS paediatric project partner, is the lead network hospital for eye care under this scheme in north Karnataka. Taking it further, the Karnataka Government has now decided to expand this scheme to include all school-going children of both government and private schools in its ambit. This has been the result of sustained advocacy.

A person's medical insurance covers a medical eye problem. Vision plans provide coverage for glasses and contact lenses or at least give a person some type of discount on the doctor's fees. A person's medical insurance pays for examinations if s/he has eye health problems.

Many people with medical insurance have a separate rider policy to cover routine eye exams. The plan coverage varies among insurance companies. Insurance companies usually separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. Typically, vision insurance policies usually cover both the eye exam and the refraction, while medical policies cover the exam only.

Partners need to promote both types of insurance -- medical insurance as well as a separate vision plan, such as Vision Service Plan (VSP), annual eye exam, additional tests and office visits related to the medical diagnosis of "glaucoma suspect."

5.11. ORRC-convergence, integration and advocacy

ORRC has made a conscious and systematic effort to integrate almost all available development schemes floated by the government, the non-government and the private corporate agencies in its communities. A staff of ORRC shared that by integration/convergence with government/private schemes their ongoing programs get the benefit of expert human resource support, material support, and often their target groups receive financial support, health care support, livelihood support etc directly from the schemes. The agencies integrated with ORRC community programs are the Department of Disable Welfare, the Education Department, the Department of Health and family Welfare, the Department of Social Justice, housing, Government Library, Rural Water supply, Insurance agencies, Banks, Bisakha Milk Society, HelpAge Programme, although many of them do not directly provide fund/project support to ORRC.

ORRC has trained the members of a BPO in different trades supported by NABARD which includes various farm and non-farm activities. It runs a factory for blind people where many of them are engaged in making of leaf plates, washing powder, phenyl, candle, perfumes. ORRC has also trained them in door to door marketing of the products as shared by Mr P Chelliah, the president of a BPO (250 members). Chelliah also said that ORRC has capacitated them in getting certificates, pensions and other entitlements, themselves.

Local office bearers of government and other agencies working in the community level in schemes like NREGA, NRHM, ICDS, SSA, etc are very much part of ORRC's community programs. ORRC has tapped all available resources for its beneficiaries including handicap pension, widow pension, old age pension, etc. In return, ORRC, whole heartedly shares the credit of development results with those agencies. Cause of Blind People and other DSWs are presented in a right based approach through "Satyagaraha". Using appropriate advocacy strategy, ORRC's network of CBOs can press people's representatives in the state assembly and trough the local MP to address poor people's problem in appropriate forum when normal methods fail or a local functionary delays or does not solve a problem.

Observations:

The effort of ORRC of Andhra Pradesh is successful case of integration of eye health and social inclusion interventions with almost all available community development schemes. It is an approach developed by ORRC over the period of time to tap opportunities for its eye health beneficiaries. This approach has enriched its interventions in terms of quality, spread and coverage, scaling up of capacity and effect and networking with a range of agencies to propagate the approach.

5.12. JKS Community Approach: Access to development schemes is everybody's right

It was a Village Panchayat in Parvayipuram of AP. The personnel serving at the community level including President of the Gram panchayat, the ANM, the ASHA, the Angawadi Teacher, the NREGA field assistant/ Gramya Rojagar Shayak (NREGS), the Milk Society Secretary, the PDS dealer, the Adult Education/Night School Teacher, the Village Resource Person of NREGA, the Ideal Farmer of Agriculture Department, the Multi-Purpose Health Worker, the Panchayat Executive Officer (PEO), the local bank manager, etc were assembled in a thatched house used as community hall, each one with a couple of flip charts in hand to share their role in the implementation of different community development schemes and their linkages with a local NGO, JKS.

Presentation began by the office bearers on different themes including mitigation of climate change impact, health, water and sanitation, NRHM schemes and particularly eye health programme, inclusion of disables in SSA, micro-credit, livelihood etc. The Panchayat President shared how her effort has addressed sanitation & drinking water issues, provision of Indira Awas, organization of regular medical camps for PWD, organizing VHND in every AWW village of the panchayat. The teacher of a local school informed about the number of blind and visually impaired students in their roll. The teacher described the vision and mission of SSA and the methods used in imparting lessons to blind and visually impaired children. The teacher informed about regular eye screening camps in the school to detect eye health problems of children and their involvement in organizing VHNDs in collaboration with ANM and ASHA in the community.

A Rural Medical Practitioner (RMP) shared about his involvement in motivating people for eye testing and cataract surgery. The Milk Society Secretary shared about the role of the local NGO (JKS) in organizing a milk collection society and its effort in providing milch cows (Rs 30,000 per cow) to 30 member families on 30% loan, 60 % subsidy and 10 % own contribution. Per day collection of milk was 150 litres, said the secretary. It was good to hear that a number of PWD families were also members of the village milk society.

One of them said that PWDs are beneficiaries in almost all community development schemes besides their special rights as much as the other community members, may it be in health, education, livelihood, water & sanitation or welfare schemes. Access to schemes is everybody's right.

Observations:

JKS Community Approach is a unique case of involving community level office bearers in its eye health and social inclusion programme. This approach has helped in integrating its eye health beneficiaries with a range of community development schemes and resources and building a successful model of community level convergence of schemes to address the social inclusion and eye health needs of its beneficiaries. JKS approach has built up a knowledge pool on development schemes and ensured greater transparency, cooperation and resource sharing in implementation of different schemes in the community.

6. Strategy and Action Plan (SAP)

Specific strategies and processes for linking the Sightsavers' Community Eye Health and Social Inclusion (specific strategy and process for each of these two components) interventions with community development programmes are suggested below. Programs on Community Eye Health and Social Inclusion in communities need to be designed by linking with relevant community development schemes. If the full impact of poverty on the lives of persons with disabilities, their families, and their environment is to be addressed, then a comprehensive community-based approach is necessary. The approach is to work proactively to mainstream development schemes of different themes for sustainable community eye health programme and break down barriers such as poverty, lack of education, gender, religion, age, social stigma and geographic isolation, etc which prevent people accessing services and achieve the goal of social inclusion in community development process.

Objectives of the SAP:

- **To propose action plans for Community Eye Health and Social Inclusion by linking with relevant community development programmes**
- **To activate the role of community level stake holders (human & institutional) by capacity development programmes in the process of linking Community Eye Health and Social Inclusion interventions with community development programmes**
- **To build socially inclusive community development programmes by mainstreaming disability, with a view to being on-target with the Millennium Development Goals**
- **To adopt a rights-based approach to disability, with community development organisations oriented to understand disability as a cross-cutting issue.**
- **To establish programmes with stronger community base and identify strategic community based institutions for linkage in different mandates of SSI;**
- **To inform and orient partner organisations to broaden their scope of work, especially from pure service delivery to comprehensive community approach,**

6.1.1. Action plan: Creation and updation of a database on rural development schemes relevant to SSI prgramme in India

Responsibility: SSI is to work in coordination with government line departments, PRIs, NGOs and academic/reseach institutions.

Methodology: Maintaining a data base by review of secondary data and collection of primary data from the field on community development schemes floated by the state and central governments and those implemented in collaboration with bilateral and multilateral agencies and private corporate sectors. It is also important to analyze the stakeholders and the potential of the schemes from the point of view of eye health and social inclusion interventions

Project: Information Bank on community development schemes with relevance for Sightsavers' Community Eye Health and Social Inclusion (specific strategy interventions

Activities:

- A workshop for programme mangers and partners on the need, scope and methodology of a database on community development schemes relevant to SSI prgramme in India
- IEC materials on community development schemes having potential to link with eye health and social inclusion interventions
- A Newsletter to cover various community development schemes from time to time having relevance for SSI.
- "Case Shop" for writing Case Studies on good practices and innovations in social inclusion and eye health interventions.

Expected Outputs/benefits:

- Ready to avail information on community development schemes with potential to link with eye health and social inclusion interventions
- Partners and programme managers are equipped with methodological tools to document practices and develop information bank/data base

6.1.2. Action plan: Partnership development with front line functionaries of different community development schemes (government, bilateral, multilateral and corporate) having potential relevance to eye health and social inclusion interventions

Responsibility: SSI and project partners

Relevant Schemes: NRHM, ICDS, SSA, MGNREGA, TSC, etc

Key Stake holders:

- Institutional: Sub-centre, PHC, PRI, Mainstream School System, etc
- Human: ANM, AWW, Sarpanch/Panchayat President etc

Methodology:

- A variety of approaches, including interface meetings, focus groups, themed discussions and one on one meetings, conferences and speaking engagements, regular written communication etc should be used to engage with the stakeholders.

Project: Collaboration with NRHM, ICDS, SSA, MGNREGA, TSC, etc

Objectives:

- Strategic collaboration of partners with the Government's flagship Sarva Siksha Abhiyan (SSA),
- Collaborate with the Integrated Child Development Scheme (ICDS) programme implemented by the Department of Women and Child Development. Partners may organize/facilitate the monthly meetings of the ICDS department, where all anganwadi workers (AWWs) responsible for running the nutritional and Pre School educational needs of all children (0-6) – and sector supervisors of a block.
- Strengthen human resource development for health in communities. Trained health personnel are needed to address the burden of eye disease and avoidable blindness.
- Mobilizing the existing health workforce: The existing health workforce has a key role to play in expanding the coverage of eye health services: primary health care workers.
- Strengthen the eye health component in the training of primary health care and community health workers like ASHAs and ANMs.
- Sensitize district administration particularly people responsible for education on inclusive education and the situation of education amongst disabled people.

Outputs/Benefits:

- The services of the office bearers enriched, scaled up and brought value addition to eye health and social inclusion programmes.
- The Vision Centre in a village set-up is enriched by collaborating with NRHM and local health facilities
- Schools played a very important role in the early initiation and formation of health seeking behaviour in children.
- The fixed cost for treatment and surgery is reimbursed from the SSA.
- The collaborations helped reaching out to the remotest of hamlets.
- PWDs found suitable employment opportunity through MGNREGA and that happened due to the pro-active role of PRI.

6. 1.3. Action plan: Possible linkages of Community Eye Health and Social Inclusion interventions with relevant community development programmes

Responsibility: SSI programme staff; project partners

Relevant Schemes: NRHM, ICDS, SSA, MGNREGA, TSC, etc

Key Stake holders:

- Institutional: Sub-centre, PHC, AWC, PRI, Mainstream School System, etc
- Human: ANM, AWW, Sarpanch/Panchayat President etc

Methodology:

- Exploration of possible linkages by collection of information/reference of relevant studies and documented practices
- Collaboration with office bearers and institutions involved in different community development schemes in the community having relevance with SSI programme
- Engaging the stake holders in the process

Project: Adoption of community for action research on linkage of Community Eye Health and Social Inclusion intervention with relevant community development programmes

Objective: To develop innovative, replicable and cost effective eye health and social inclusion practices by the beneficiaries in the communities

Activities:

- Orientation of stakeholders of different schemes on the linkage of their interventions with SSI's eye health and social intervention
- Programme planning workshop on convergence and linkage at the community level

Expected Outputs/benefits:

- Process document
- Lessons on success and failures
- Formulation of replication strategy/scaling up strategy

6. 1.4. Action plan: Promotion of PPP in health sector

Responsibility: SSI and project partners

Relevant Schemes: National Rural Health Mission (NRHM), Schemes for Voluntary Organizations/NGOs under NPCB, the Reproductive and Child Health Programme, Janani Surakhya Yojana

Key Stake holders:

- Institutional: Sub-centre, PHC, AWC, PRI, etc
- Human: ANM, AWW, ASHA, Sarpanch/Panchayat President etc

Methodology: Adoption of Sub-centres, PHCs, AWCs, by the project partners; opening vision centres in PHCs; Partners contacting the relevant functionaries of the Department of Health and Family Welfare; organizing interface discussions; presenting concept note and proposal to the department with social cost benefit analysis.

Project: Using and enriching existing government health infrastructure for eye health and social inclusion interventions.

Objectives:
Engaging Private health care providers to help run sub-centres and primary health centres (PHCs).

Activities:

Adoption of PHC/existing government infrastructure by MOU
Training programs for existing health practitioners,
Capacity building of Registered Medical Practitioners (RMPs) through training and workshops

Outputs/Benefits:

- Major challenges in eye health segment are identified and addressed by integrating with existing primary health-care services, strengthening local health care infrastructure,
- Optimum treatment coverage is maintained,
- Community self-monitoring is ensured,
- Increasing involvement of local nongovernmental groups,
- Financial sustainability ensured,
- Equitable cost recovery systems implemented,
- Effective advocacy ensured
- Partnerships between state and non-state actors readily raised the profile of eye health amongst other health priorities,
- Effective deployment of a well trained eye health workforce based on an investment in human resources for health development and scale-up plans.

6. 1.5. Action Plan: Comprehensive Community Eye Health Programme

Responsibility: SSI, project partners

Relevant Schemes: National Rural Health Mission (NRHM), Schemes for Voluntary Organizations/NGOs under NPCB, the Reproductive and Child Health Programme, Janani Surakhya Yojana

Key Stake holders:

- Institutional: Sub-centre, PHC, AWC, PRI, etc
- Human: ANM, AWW, ASHA, Sarpanch/Panchayat President etc

Methodology:

- Use of interactive health education techniques through Information, Education, Communication (IEC) and Behaviour Change Communication (BCC) strategies
- Integrating IEC/BCC strategies and their accompanying activities into existing healthcare settings and community health education programmes
- Leveraging the capacity of Non Governmental Organisations (NGOs) and Community Based Organisations (CBO) to use the existing health schemes and facilities (sub-centre, PHC, etc) as platform
- Linkage with relevant insurance products

Project: Advocacy on Community Eye Health:

Objectives:

- To inform, educate and communicate information to targeted audiences
- To educate the public in how to prevent/treat the major avoidable blinding diseases
- To bring about 'health seeking behaviour' and 'prevention oriented mindsets' of target people leading to a change in attitude
- To guide agencies engaged in implementing different community development schemes to include disability in their own policies.
- To ensure that major national development processes and frameworks include the rights of people with disabilities.

Activities:

- Approach government officials and talk to them about the area of concern, e.g. vitamin A supplementation and food fortification.
- Arrange workshops with individuals and organizations with an interest in the elimination of avoidable blindness; one example is the VISION 2020 workshops.
- Form alliances with other causes: with the wider disability movement, general development and anti-poverty initiatives, other health programmes, or appropriate organizations in civil society (such as non-governmental organizations).
- Creating awareness: Advocating that the fight against poverty has to include people with disabilities and creating understanding about the barriers faced by people with disabilities living in the poorest communities
- Sharing knowledge: Linkage with experienced specialists in community based rehabilitation (CBR), health care, and education.
- Making expertise on different thematic areas available to share knowledge with partners and other agencies through publications, workshops and training programmes particularly on most cost effective interventions to prevent, treat and support disability
- Networking: Working with like-minded organizations to put disability on the national agenda
- Lobbying: inclusion of the rights of people with disabilities in flag ship development schemes.

- Meeting directly with policy makers and disseminating policy papers to explain their viewpoint: Partners to stay informed on developmental policies and programs of national and state governments, and to take specific targeted actions to promote the inclusion of disability issues.
- Partnership: Encourage local community organizations, parents' associations, Disabled People's Organizations, for promoting the rights of people with disabilities in their areas.
- Training of personnel on methods of integration and convergence of eye health and social inclusion interventions with various types of community development schemes
- Promote concept of training partnerships – GO-NGO: As Ministry of Health and family Welfare, Government of India develops its scale up plans for human resources for health in its flagship program NRHM; there is significant advantage in extending stakeholder consultation to include non-state actors who invest significantly in human resource development, including that for eye health.

Outputs/Benefits:

- Working together creates opportunities for more effective advocacy
- Training of person can bring tremendous value addition to partner's activities in terms of mainstreaming development programs in communities,

6. 1.6. Action Plan: Nutritionally vulnerable households in rural and urban slum communities and specific eye health problems

Responsibility: SSI and Project partners

Relevant Schemes: Integrated Child Development Services (ICDS), National Prophylaxis Programme against Nutritional Blindness, National Rural Health Mission (NRHM), Schemes for Voluntary Organizations/NGOs under NPCB, the Reproductive and Child Health Programme, Janani Surakhya Yojana,

Key Stake holders:

- Institutional: Sub-centre, PHC, AWC, PRI, PDS, School system etc
- Human: ANM, AWW, ASHA, Sarpanch/Panchayat President, mid-day-meal cook in the schools, Public Distribution System dealer, ANM, ASHA, etc

Methodology:

- Collaboration with ICDS & NRHM
- Institutional collaboration with Anganwadi Centre, Schools, etc

Project: Addressing child malnutrition to prevent specific eye health problems

Objectives:

- To ensure nutritional supplementation for children 0-6 age groups
- To link all children 0-6 age group with AWCs and local health facility for nutrition and Vitamin A supplementation

Activities:

- Awareness generation among parents on child nutrition and eye health
- Linkage with health facilities for vitamin A
- Observation of Village Health and Nutrition day
- Monitoring PDS activities
- Promotion and demonstration of nutrition garden

Outputs/Benefits

- Improved eye health among children
- Reduction in incidence of child hood blindness

6. 1.7. Action Plan: Enriching Inclusive Education Programme for Children and youths with Disabilities

Responsibility: SSI and project partners

Relevant Schemes: Sarva Sikhya Aviyan (SSA), Integrated Child Development Scheme (ICDS), Inclusion in Education of Children and Youth with Disabilities (IECYD), Rajasthan Education Initiative (REI) etc

Key Stake holders:

- Institutional: Sub-centre, PHC, AWC, PRI, PDS, School system etc
- Human: School teachers, Angan Wadi staff, Adult Education/Night School Teacher, Early Childhood Intervention Teacher

Methodology:

- Collaboration with SSA, CAPART
- Inclusion in Education of Children and Youth with Disabilities

Project: Ensuring education for all Children and youths with Special Needs

Objective:

- Mobilizing families to report disability, particularly in view of the prevailing negative attitudes to disabled persons in most communities.
- Every child and youth with special needs, irrespective of the kind, category and degree of disability is enrolled in mainstream educational institutions in an appropriate environment
- Accessing relevant provisions for eye care in SSA, IECYD and other schemes to youths and children

Activities:

- Educating the data collectors, or even the informants themselves, to have the knowledge and experience required to recognize that a person is disabled.
- Identification of CWSN and youths with special needs
- Training of School teachers in Eye Screening
- Eye screening of School Children

- Creating barrier free environment
- Interface meeting with office bearers of the relevant schemes

Expected Outputs/benefits:

- Increased enrollment of children and youth with disabilities in education system
- Education in a barrier free environment
- Improved eye health of Children by treatment and surgical interventions
- Partnership with relevant institutions
- Improved public-private partnership in special education

6. 1.8. Action Plan: Linking eye health beneficiaries with livelihood activities

Responsibility: SSI and partners

Relevant Schemes: Tribal/Rural livelihood Project, MGNREGS, Swarna Jayanti Gramya Swarojgar Yojana, Rural Innovation Fund (NABARD), livelihood project floated by bi-lateral agencies (DFID Livelihood Project), Grain Bank, income generation schemes by non-government, private and banking and cooperative agencies

Key Stake holders:

- Institutional: Panchayati raj Institution, National Handicapped Finance and Development Corporation (NHFDC), commercial bank, NABARD, KVIC, Cooperative Bank, Milk Union, Insurance Company and government line departments including Rural Development, Panchayati Raj, Forest and environment, Agriculture, Animal Husbandry, Revenue, Civil supply

- Human: Village Agriculture worker/Lady Village Agriculture Worker, Livestock Inspector, Milk Union staff, Cooperative Bank Secretary, Commercial Bank Staff, Gramya Rojagar Shayak (MGNREGS), SGSY Resource Person

Methodology:

- Advocacy for inclusion of PWDs in flagship livelihood schemes for rural and urban areas
- Evidential policy research for advocacy
- Identification of suitable livelihood opportunities in farm and non-farm sectors
- Linkage with schemes and institutions by creating positive attitude of office bearers towards PWDs

Project: Advocacy for inclusion of PWDs in MGNREGA

Objectives: Greater and assured opportunities for PWDs in MGNREGA

Activities: Workshops, Lobby, satyagraha, interface meetings, memorandum to appropriate authorities, evidential policy research, IEC activities on the following issues:

- Appropriate amendments should be made to N.R.E.G.A. 2005 with explicit expression of disability to ensure complete and meaningful inclusion of Persons with Disabilities to effectively access this programme. A minimum of not less than 3% of the resources at all levels shall be allocated for works specifically benefiting Persons with Disabilities as required under Sec. 40 of Persons with Disabilities Act 1995.
- Appropriate and clear cut instructions and guidelines against all forms of discrimination, in relation to persons with disabilities should be issued by competent authority in Govt. so as to ensure that Persons with Disabilities are able to access, use and enjoy the benefits under the N.R.E.G. act on an equal basis with others. These safeguards, inter alia, should cover areas such as – Registration, Issue of Job Cards, Work Allotment, Equal Wages, Payments, etc.

- Communication Material should be made accessible to Persons with Disabilities in terms of Format and Mode. The information about this programme should reach persons with disabilities as well as the implementing machinery at grass root levels emphasizing inclusion of persons with disabilities.
- Preference should be given to Persons with disabilities in the recruitment of jobs at administration and supervisory roles at District, Block and Panchayat level in accordance with the provisions of Persons with disabilities Act 1995. E.g. Rozgar Sevak , Site Supervisors, Programme Officer etc. (the list is indicative only)
- To ensure inclusion of Persons With Disabilities, each adult with disability should be considered as a separate household regardless of whether s/he has a family or not. [As per the Administrative Reforms Commission-A.R.C. recommendations]
- Job Card should include information on disability status and category.
- Organisations of Persons with Disabilities as well as organisations working on the issue of Disability should be consulted for identification and recommendation of Work.
- Appropriate and adequate representation of Persons with Disabilities should be ensured in all planning, designing, implementing, monitoring and evaluation bodies at all levels, including National and State Employment Guarantee Councils (S.E.G.C.s).
- Considering the difficulties involved in developing a universally applicable SSR for all Persons with Disabilities, Time Based Wages – and not Task Based Wages – should be provided to all Persons with Disabilities as specified in I.L.O. convention.
- Disability segregated information, both on the records as well as virtual, should be mandatory in all monitoring reports of work generated under the N.R.E.G.A.
- Social Audit, Vigilance committee, Central and state data to include information about Persons with disabilities also.
- Preference should be given to Persons with Disabilities especially Women with Disabilities in allocation of jobs.
- Crèche supervisor post should preferably go to Women with Disabilities. E.g. Karnataka has made such provisions.
- Particular care should be taken to emphasise the need for universal and inclusive design of assets and infrastructure to be created under N.R.E.G. Programme.
- Appropriate Areas of Work and Tasks should be designed and assigned to the persons with disabilities, keeping in mind the abilities, qualification, degree / category / nature of disability.
- Appropriate projects should be designed in consultation with organisations for and of persons with disabilities.
- Work should be assigned to Persons with Disabilities as close to their residence as possible. In case of work provided beyond 5 kilometres, appropriate transport facilities should be provided to Persons with Disabilities.
- Ensure accessible toilet facilities for workers in general, and Women and Men with Disabilities in particular at the work place.

Outputs/Benefits:

- MGNREGA clearly defined the space for PWDs as per law of land
- Amendment of provisions of MGNREGA for clarity on the role of PWDs
- PWDs availed their right to livelihood through MGNREGA

Project: Capacity building of PWDs for accessing livelihood opportunities

Objectives:

- To create skills in PWDs by aptitude testing
- To link PWDS with vocational training centres
- To create/identify a pool of trainers to train PWDs on different trades based on their aptitude and interest
- To access the PWDs to micro finance and insurance products
- To impart marketing, negotiation and accounting skills

Activities:

- Vocational training
- Mentor training for relatives to partner with PWDs in business and enterprise development
- Training on marketing, accounting skills and orientation on micro-finance and insurance products

Benefits/Outputs:

- PWDs pursue livelihood activities based on their aptitude and interest
- Capacity of PWDs built to manage livelihood pursuits

6. 1.9. Action Plan: Relevance of Micro-Insurance products for the benefit of eye health beneficiaries

Responsibility: SSI and partners

Relevant Schemes: Rashtriya Swasthya Bima Yojna, Comprehensive Health Insurance Scheme (CHIS) and Vision Insurance, Aam Admi Bima Yojna (AABY), Janshree Bima Yojna, National Agricultural Insurance Scheme (NAIS), Micro Credit to Self Help Groups

Key Stake holders:

- Institutional: Birla Sun Life Insurance, SBI Life Insurance, Oriental Insurance, Royal Sundaram, Alliance Insurance, Reliance General Insurance, IFFCO Tokyo, General Insurance, Life Insurance Corporation, HDFC Chubb, Cholomandalam Ms General Insurance, Tata Aig

- Human: Insurance agents, Doctors, Facilitators,

Methodology:

- Discussion with eye health doctors, insurance marketing personnel/agents
- Workshop on various needs of PWDs to minimize risks due to theft, financial constraint to access to eye care etc (like security of assets and micro-income generating activities of PWDs, eye care treatment and other needs)

Project: Linking eye health beneficiaries with insurance products Objectives: To reduce perceived risks like financial constraint to access to eye care services and loss of livelihood, educational and other assets of eye health beneficiaries

Activities:

- Awareness creation about relevant insurance products

- Interface meetings of PWDs with Insurance Marketing Personnel

- Actual Linkage

Outputs/Benefits:

- Reimbursement of treatment and other costs by insurance company
- Recovery of cost of assets in case of theft, fire or other calamities

6. 1.10. Action Plan: Climate change impact on eye health

Responsibility: SSI and partners

Relevant Schemes: NRHM, ICDS, MGNREGA, Social Forestry/Plantation, Wetland Management/Water-shed Management, TSC, National Biogas & Manure Management Program (NBMMP), Integrated Afforestation & Eco Development Project (Ministry of Environment & Forest, Government of India), National Biogas & Manure Management Program (NBMMP) (Department of Renewable Energy, Government of India), Environmental Promotional Assistance Scheme (EPA of NABARD)

Key Stake holders:

- Institutional: the Village panchayat, PHC, CHC, Sub-centre, Agriculture Department, ITDA, Village School, and the State Renewable Energy Development Agency (SREDA).
- Human: Sarpanch, Health Officer, ANM, ASHA (Provide ORS), AWW (IEC), Forest Officer, Agriculture Extension Officer, Water Resource staff, NREGA Staff (NREGA and climate Change mitigation actions), NGO Staff

Methodology:

- Engaging community people with experts in the process research
- Integrating government line department functionaries from health, education, forest and environment, rural development, water, sanitation and hygiene in the process research

Project: Field research on impact of climate change on eye health

Objectives:

- To assess the impact of climate change on eye health
- To assess the impact of climate change on livelihood, nutrition, water and sanitation situation which also influences eye health in a community?

Activities:

- Collection of relevant base line data
- Collection of seasonal data by engaging community people, experts and local functionaries

Outputs/Benefits:

- Empirical data on climate change impact on eye health
- Data will be useful in formulating appropriate strategy and interventions in mitigating climate change impact on eye health

Project: Mitigation of climate change impact on eye health

Objectives: To take initiatives for mitigation of climate change impact on eye health

Activities:

- Promotion of smokeless cooking stoves/bio-gas
- Awareness programme to prevent heat strokes
- Advocacy for facilities in local health care facilities to address climate change impact on eye health

Outputs/Benefits:

- Greater awareness and alertness to mitigate climate change impact on eye health

- Improved community public health facilities

6.1.11. Action Plan: greater involvement/collaboration with PRI (Consequent to the 73rd Constitutional Amendment Act, the State Governments are now evolving modalities and institutional arrangements for facilitating the involvement of Panchayati Raj Institutions (PRIs) in implementation of various programmes under 29 subjects including 'Empowerment of Disabled'**).**

Responsibility: SSI; partner agencies

Methodology:

- Collaboration of partner NGO as a mentor with Gram Panchayat
- Encouraging PRI to establish a Community Forum as agent for Change: A local Eye Care Forum in Panchayat level with ANM, ASHA, Panchayat and local CSO involved in eye health program can make a valuable contribution in determining eye care needs.
- Village Health and Nutrition Days (VHND) can be used as appropriate platform. Partners need to take proactive role in fixing such events in collaboration with community health sector office bearers and Panchayat leaders.
- Encourage disabled people to participate in palli sabha and gram sabha meetings and raise their issues of concern.

Project: Mentoring with PRIs for 'Empowering People with Disabilities'

Objectives:

- To build the capacity and leadership profile of Village panchayat and its members to empowering people with disabilities
- Build the capacity of Village panchayat to conduct awareness programmes, facilitate convergence and integration, undertake educational and human resources development activities and undertake livelihood and employment generation activities

Activities:

1. Mentoring with PRIs to organize Awareness Building Programme:

- PRIs organize Awareness programmes for the prevention of disabilities mainly through camps, exhibitions by various health care professionals such as para-medical & medical doctors, anganwadi workers, community rehabilitation workers, social welfare workers, etc.
- PRIs organize various activities so as to encourage the disabled children participate in various educational and rehabilitation programmes.
- PRIs creating awareness among the children with disabilities and their parents on various benefits and their legal rights.
- Provision of information in the form of pamphlets and small booklets by the PRIs.

2. Mentoring with PRIs on Convergence and Integration of schemes under PRI domain with eye health and social inclusion interventions:

- Ensure convergence of the various programmes which are meant to benefit the disabled.

- Develop good linkages between various agencies/departments such as health department / hospitals / education department / DIETs / voluntary organizations working in the field of disability.
- Oversee the functioning of services, rehabilitation centres and vocational rehabilitation centres for the disabled and promote linkages with their outreach activities.
- Ensure that requisite percentages of funds are allocated to various key programmes such as those catering to the prevention of disabilities

3. Mentoring with PRIs to enrich inclusive education programmre:

- Ensure that all the children with disabilities are identified in a systematic manner, located in either the community, anganwadi centres, health centre or school; at least once in a year
- Ensure that all the children with disabilities are attending the anganwadi centres or pre-primary schools in their area.
- Ensure for provision of barrier free environment in schools.
- Children with disabilities are not discriminated against and are allowed admission in appropriate schools
- Ensure that the local schools or health centres treat children with disabilities with dignity and consideration
- Normal students of a school should not be allowed to ill-treat or hurt students with disabilities.
- Arrange aids and appliances under the available programmes and ensure that they are made available to the persons identified by them in a timely fashion.
- Village panchayats should be entrusted with monitoring of usage of (through **Gram Sabhas**) these appliances and whenever necessary, they should arrange for the trained personnel(s) to demonstrate correct application.
- With the help of block level panchayat/village panchayats should arrange/locate craftsmen who can be trained to repair such appliances, where required, for their fitment.

4. Mentoring with PRIs for Human Resources Development:

- Make arrangements for training of personnel who are involved in identification and early detection of disabilities.
- Ensure that teachers at the block and cluster levels are being trained to manage children with disabilities in schools.
- Arrange training of the public functionaries, NGOs and other social workers in handling of the problems concerning disabled persons in cooperation with various specialized centres.
- Ensure that the posts of various specialized personnel who are required for comprehensive care of the disabled are filled up immediately. These include specialists such as clinical psychologist, special educators and rehabilitation therapists.
- Ensure that a team of a doctor, a psychiatrist and a special educator or a special trained teacher is visiting each school regularly, at least once in a year.
- Ensure that all of the teachers in any school are getting trained for inclusive education.

5. Mentoring with PRIs on Livelihood and Employment:

- Organize small groups of disabled persons for viable income generating activities with the help of block level panchayats.
- Make arrangements for vocational training programmes of the children with disabilities at their right ages.

Benefits/outputs:

- Panchayt resources and schemes used for eye health and social inclusion interventions
- Eye health and social inclusion interventions become a regular activity of the Panchayats

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