Maharashtra State Rural Livelihoods Mission

State Perspective Implementation Plan (SPIP)

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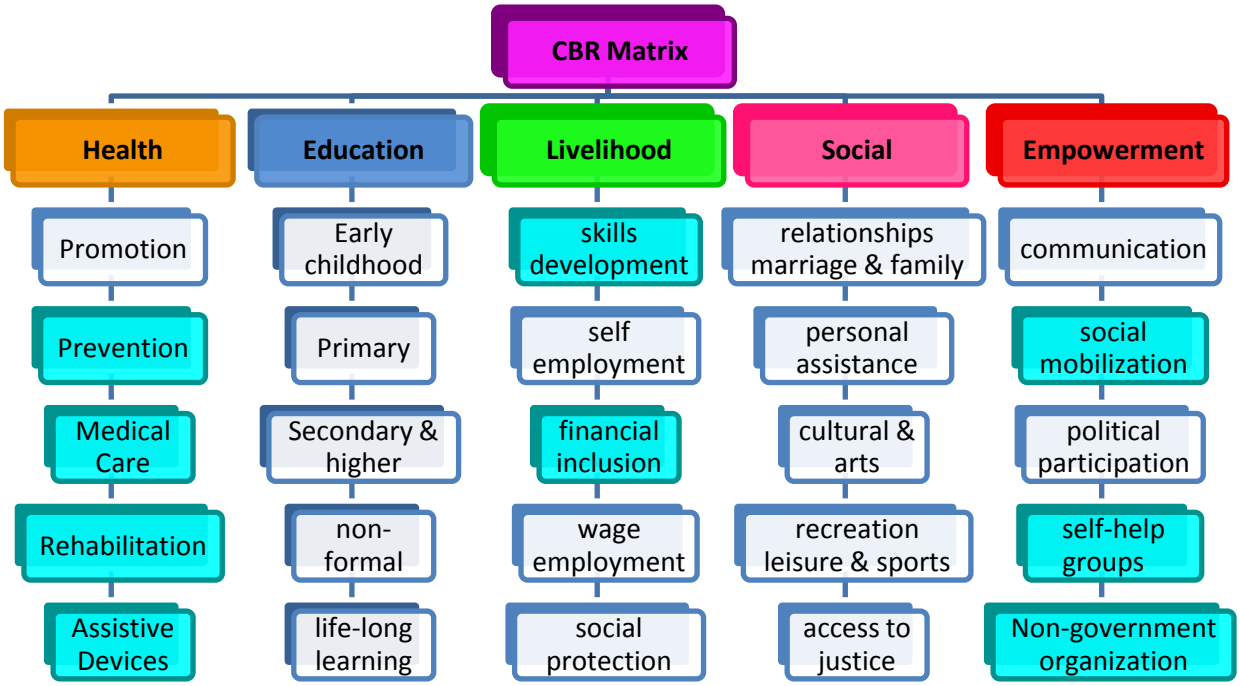
1. Introduction

Disability is a multidimensional phenomenon and its causes are attributed to several factors (Desai: 1995; Pandey and Advani: 1995; DFID: 2000). In many developing countries disability and poverty are closely linked which often results in a vicious circle. Improving the economic condition of the poor is not the only solution to deal with the issue of disability; there are socio cultural factors underlying discriminatory practices that also need to be addressed. Enfield (2001) classified discrimination faced by persons with disabilities into three types: Attitudinal, Environmental and Institutional. Attitudinal discrimination is perpetuated due to ignorance and lack of understanding of the capabilities of persons with disabilities, often leading to over-protection, which in turn leads to social isolation. Institutional discrimination is when the law discriminates against persons with disabilities. Environmental discrimination occurs where public services including building and transport are not barrier-free.

Quite simply, social inclusion means ensuring that everyone is included in society rather than excluded. Social inclusion for disabled people is based on the social model of disability and involves breaking down the barriers in society that prevent their full participation in society. This includes, for instance, promoting positive attitudes and perceptions (e.g. disabled people in politics), modifying the built environment (e.g. ramps in public buildings), providing information in accessible formats (e.g. our website in large print) and making sure that laws and policies support the exercise of full participation and non-discrimination (e.g. employment discrimination laws). Social inclusion focuses on rehabilitation and equal opportunities of all disabled people and centres on the key aspects of health, education, livelihood, social and empowerment. This is depicted in the widely used community-based rehabilitation (CBR) matrix, below. Following this model, we strive for a society which incorporates the needs of disabled people and other marginalized groups. As such, our approach to social inclusion for disabled people embraces the CBR Matrix which is a tool for inclusive community development and poverty reduction.



Social inclusion is often used interchangeably with the terms social cohesion, social integration, and social participation, positioning social exclusion as the opposite. The latter is a contested term that refers to a wide range of phenomena and processes related to poverty and deprivation, but it is also used in relation to marginalized people and places. The chapter highlights and responds to core questions related to social inclusion of persons with disabilities within the State of Maharashtra. It addresses the importance of developing interdisciplinary knowledge and collaboration among community and government functionaries in challenging social exclusion and promoting social inclusion for persons with disabilities. The chapter consists of 4 parts;

1. Disability Scenario
2. Social Inclusion of PwDs
3. Livelihoods of PwDs
4. Enhancement of livelihoods of PwDs

This chapter on Social Inclusion of PwDs is prepared for use by the MSRLM project more specifically for the project implementing agencies i.e. the SPMU functionaries, DPMU field staff, NGO Partners, block level functionaries, CRPs and the community. In addition to disability specific programmes, MSRLM would ensure inclusion of PwDs in all the programmes being implemented by other thematic areas.

2. Disability Scenario

2.1. Disability and Health

There is a huge gap in terms of health services available for disabled and non-disabled people in the country. Issues vary from inaccessible buildings and diagnostic equipments, negative/stereotypical attitude of health professionals or their ignorance, lack of training to communicate with persons with hearing/speech impairment or intellectual disability, inaccessible transport to reach the health centre, or sheer expense of treatment/rehabilitation. Health services need to cater to all, including persons with disabilities. Services are required for persons with various disabilities, including those with deteriorating conditions, leprosy, multiple disabilities, deaf-blindness, haemophilia, spinal injuries, intellectual disabilities, hydrocephalus, range of syndromes, and many more.

Poor nutrition, limited access to vaccination programmes and health & maternity care, poor hygiene, bad sanitation, inadequate information about the causes of impairment and natural disasters are some of the causes for disability in rural areas. Most are easily preventable with proper care. According to the World Health Organization (WHO), as many as 50% of disabilities are preventable and directly linked to poverty. It is estimated that only 2% of people with disabilities in developing countries including India, have access to rehabilitation and the basic services.

Ministry of Social Justice and Empowerment (MSJE), Government of India, is the nodal ministry with responsibility for disability, though there are several other ministries and government departments that are directly engaged with addressing the problem of disability in India, and many have earmarked funds to develop activities concerning disabled people. MSRLM would conduct meetings and consultations with various departments at district level on convergence regarding utilization of the funds and services available for the disabled and facilitate the process so that the benefits reaches the concerned.

A multi-sectoral approach including social integration interventions, health, education, and vocational programs are important issues related to rehabilitation services. Primary health care system must play a major role both as a provider and supporter, and should engage with initiatives such as early identification of impairments and providing basic interventions, referrals to specialized services such as physical, occupational, and speech therapies, prosthetics and orthotics, and corrective surgeries.

Major issues & challenges regarding the health of PwDs are listed below;

1. **Disability Certification** - From the findings of disability survey undertaken in Ratnagiri and Yavatmal, it is found that only 5% and 6.1% of the total identified PwDs had disability certificate. This concludes that above 90% of the PwDs are in queue for receiving the certification.

2. **Early Identification** - No provision and support for timely and appropriate early intervention due to which their difficulties become more severe often leading to lifetime consequences, increased poverty and profound exclusion.
3. **Awareness Raising** – Lack of knowledge in various areas such as types of disabilities, strengthens and abilities of PwDs, disability laws and legislations, government schemes etc
4. **Referral and support Services** - No adequate information regarding available referral support makes it extremely difficult for both family members of PwDs as well as the community workers for availing and advising on appropriate rehabilitation services.
5. **Corrective surgeries** – In absence of adequate information and knowledge the beneficiaries are unable to reach and avail of surgical intervention that could ease out the trauma of physical disability.
6. **Assistive Devices** – There is a serious lack of availability of assistive device. The types of assistive device are extremely meager and mostly related to medical rehabilitation. However, the device related to social functioning are negligible and almost nil.

2.2. Disability and Education

Children with disabilities are among the most disadvantaged in terms of access to schooling and completion of elementary education. More than one-third of all out-of-school children are disabled. Most of them are from the poorest strata of Indian society. Disability is frequently both a cause and consequence of poverty.[1]

Out of the disabled persons only 4% persons had attended any vocational course. About 25% of the disabled persons of age 5-18 years attended the preschool intervention programme. This proportion was about 23% in urban areas and about 26% in rural areas. The current enrollment ratio for disabled persons in the ordinary school was higher in the rural areas than in the urban areas with corresponding proportions 40.1 per cent and 38.0 per cent respectively. About 20 percent disables were enrolled in special schools in the urban areas as against three per cent in the rural areas[2]. In the year 2003 the government of Maharashtra extended the facility of provisions to college courses; and even seats were reserved for these adolescents in the physically handicapped category[3].

Major issues regarding the education of PwDs are listed below;

1. **Enrollment of CwSNs** – Out-of-school children composed mainly of migrant children, children with disabilities, and those with other disadvantages. Due to lack of knowledge about the

[1] *http://www.rtemaharashtra.org/index.php/children-with-disabilities, 15/11/2014*

[2] *NSSO Survey 58th round, 2002*

[3] *Directorate of Technical Education, Maharashtra State, Mumbai. Allocation and reservation of seats: reservation for physically handicapped candidates. Available at http://www.mkcl.biz/mbacet2008/frmSeatDistribution.aspx/; accessed 2008, April 4, 15/11/2014*

abilities of the CwSNs and over protection or fear of barriers present in the outside world the parents / care givers do not enroll their CwSNs. Misperception regarding child's educational development (IQ).

2. **Barrier Free Environment** - The schools infrastructure and facilities such as accessible toilets, ramps etc are not in place.
3. **Children with severe disability** – In most of the cases, children with multiple or severe disabilities are dumped in the house.
4. **Special Schools** – Unavailability of special schools and special teachers.

2.3. Disability and Livelihoods

Overall, employment of people with disabilities fell from 42.7% in 1991 to 37.6% in 2002 despite strong economic growth[4]. Since most organized sector jobs available to PwDs were earlier available in government and public sectors, globalization has constricted job opportunities due to disinvestments by the government in the public sector[5]. The PWD Act of 1995 provided for 3% reservation in all government and public sector employment. Although the Act provides incentives to private sector employers for promoting disabled persons' employment, the 3% reservation rule is not mandatory for private employers[6] . More than fifteen years after the reforms, disabled people have about 60% lower employment rates than the general population, a gap that has been increasing over the past fifteen years[7].

About 27% of disabled persons were found to be employed with the corresponding figures for rural and urban areas at about 29 and 24 percent respectively. Most of the employed disabled persons in the rural areas were engaged in primary sector whereas in urban areas the tertiary sector followed by secondary sector played the dominating role in employment opportunities so far as the disabled persons were concerned. About 74% disabled males and 79% disabled female workers in rural areas were engaged in the primary sector. About 32% of the disabled (age 5 years and above) were working before the onset of disability[8].

2.3.1. Livelihoods and social sector initiatives in the State

- ✓ A forum Maharashtra Rural Livelihoods Innovation Forum (MRLIF) critical for the MSRLM's mission as a whole to bring in its fold good practice and livelihoods innovations that are replicable as well as forge strategic partnerships with agencies and individuals in the State

[4] World Bank, 2007
[5] ILO, 2003
[6] Friedner, 2009; Mishra & Gupta, 2006
[7] World Bank, 2007
[8] NSSO Survey 58th round, 2002

within the larger objective of – Promotion and Support for Innovations and Partnership Development – which aims to create institutional mechanism to identify, nurture and support innovative ideas to address the livelihoods needs of the rural poor.

- ✓ The Software for Assessment of Disabilities, Maharashtra (SADM) provides doctors in 42 district hospitals, general hospitals and medical colleges with login details to access the system. The doctors, who are deemed eligible to issue the certification by the State, are required to enter details about the applicant based on which the percentage of disability for the patient is calculated by the system. The disability certificate will then be generated.[9] 10,737 people were issued disability certificates using SADM technology out of a total of 16,855 applications. Also, 1,715 rejections were meted out. So far, 74% of the assessments have been completed.

Major issues regarding the livelihoods of PwDs in rural areas are listed below;

1. **Government schemes** – Due to lack of awareness regarding the information about available government schemes, the schemes do not reach the disadvantaged group.
2. **Work under MGNREGA** – In the year 2013-14, 18670 PwDs (16.72% out of the total registered) worked in NREGA and the persons days generated were 474721 i.e. 25 days per person. These figures indicate low registration of PwDs in MGNREGA and also the person days generated per persons is too less.
3. **Allotment of houses to PwDs** - In the year 2013-14, only 0.35% (375 houses) houses were sanctioned to PwDs out of the total houses sanctioned (107779 houses). Non compliance of 3% reservation for PwDs under IAY.
4. **Skill Development** – Very few vocational training centre available within the region and in many cases VTCs specific for PwDs are located in other districts hence the skill development aspect of PwDs remains untouched.

[9] *Global Accessibility News, 27 May 2013*

3. Social Inclusion & Enhancement of livelihoods of PwDs

3.1. Social Mobilization & Institution Building

Social mobilization is the cornerstone of participatory approaches in rural development and poverty alleviation programmes. It is a powerful instrument in decentralization policies and programmes aimed at strengthening human and institutional resources development at local level. Social mobilization strengthens participation of rural poor in local decision-making, improves their access to social and production services and efficiency in the use of locally available financial resources, and enhances opportunities for asset-building by the poorest of the poor.

The Constitution's 73rd Amendment has made the village council, the Gram Sabha, into a very powerful tool of social mobilization. Many types of neighborhood groups, health and literacy programmes, SHGs and the mass media - newspapers, radio and TV - also play a vital role in social mobilization at the community level. Social mobilization of rural poor at community level will be successful if directly linked with issues affecting their livelihoods. For successful social mobilization of the rural poor, there is a need for improved access to public information on local development issues directly linked with their livelihood interests. An effective way of doing this is by facilitating free access to public information on local development programmes and activities, which has been a critical factor in the success of Panchayati Raj in the States of Kerala and Andhra Pradesh.

To enhance the participation of rural PwDs in the MSRLM other development activities, social mobilization would be done by the internal CRPs and RRs at the community level. Formation of PwD SHGs known as Disabled Persons Groups (DPGs) is one of the major outputs of social mobilization.

3.1.1. IEC material

Translation and publication of the booklet that explains the Convention in simple local language would be the effective material for social mobilization. Publication to be undertaken by the State KM team on information leaflets about the entitlements, various government Schemes and the law for the Recruitment of Persons with Disabilities in the wider Public Sector. Also production of subtitled film for the rights of persons with disabilities could be done by the State KM team. All the IEC material developed should be circulated to the districts.

3.1.2. Disability Orientation

Disability orientation to be organized and conducted for the government functionaries at the district and block level. Disability orientation and mobilization at the community level would be the responsibility of Cluster Coordinators, internal CRPs and RRPs.

3.1.3. Formation of DPGs

The SHGs promote the habit of thrift and encourage their Exclusive PwD SHGs known as Disabled Persons Groups (DPGs) to be formed and the existing SHGs should also be made inclusive of PwDs. Guidelines on formation of DPGs have been prepared and circulated to the district offices. Team needs to ensure that the benefits also reach the PwDs present in the non DPGs i.e. existing SHGs.

3.1.4. Disbursement of RF & CIF

Leadership training to DPG members (president and secretary of the DPG) is the prerequisite for availing the RF and preparation of Micro Investment Plan (MIP) by the DPGs prior to disbursement of CIF would be done.

3.1.5. Formation of Disabled Persons Organizations (DPOs)

A federation of DPGs known as DPO would be formed at block level. This would comprise exclusively of PwDs from DPGs. Special financial products would be made available to the PwDs at the DPO. Also DPO would be the major support to the DPGs to take ahead their issues. A series of capacity building programmes would be organized for DPOs which include financial inclusion, financial literacy, team management etc along with exposure visits.

3.2. Capacity Building

To develop long term sustainability of the programme and empowering the PwDs in real terms and making them self reliant, the project implements a strategy of building its team and community institutions an empowering them with skills and project management capabilities so that with the support of team and community the overall development of PwDs is possible.

3.2.1. Disability Orientation to the team

Disability orientation programme would be organized for the State, district, block and cluster teams. All the MSRLM officials have the basic orientation to disability. A core State level team will be constituted under MSRLM, which would be responsible for undertaking capacity building at the district level. This team would be adequately trained to equip them for conducting such trainings.

3.2.2. Capacity Building of DPGs

Once the DPG is formed, in addition to the regular SHG trainings, the leadership training is undertaken for the DPG members to inbuilt the leadership qualities in them. Also after this training the DPG is eligible for receiving RF. All members of DPGs would undergo the basic training of SHG module in addition to their specific leadership training. The DPG members would also receive training on preparation of micro investment plan so as to equip them with preparation and management of projects. Trainings as per the need assessment of DPGs would also be organized.

3.2.3. Capacity Building of DPOs

Series of trainings would be organized for DPOs in order to make them potential organization to cater the needs of PwDs and DPGs. The members of DPOs require special training to manage a federation. Members from DPGs who get elected as DPO members will receive training in stages that would include – communication, financial inclusion, federation management, public speaking, goal orientation etc.

3.2.4. Capacity Building of block and Cluster teams

Detailed work orientation to cluster teams would be organized. The block and cluster level functionaries under MSRLM would receive disability orientation on a specially designed module.

3.2.5. District Coordination Team

District Coordination team (DCT) would be formed comprising of relevant government and MSRLM district officials, PwDs and representatives from community. The focus of the DCT's work in the first year will be to provide recommended options regarding the design of the new livelihoods program and demonstrate by rolling out as pilot intervention. Role of DCT enclosed as Annexure I.

3.2.6. State Resource Team

State Resource Team (SRT) would be a pool of 15 master trainers selected from pilot districts. SRT is formed for scaling up the disability pilot in other districts. Capacity building of SRT would include an intensive 13 days training which would include an exposure visit to other State.

3.2.7. Capacity Building of CRPs

The Community Resource Persons (CRPs) are the people who would be helpful in bringing about changes in people around them. The CRPs are rooted in and accepted by the community; they are the chosen leaders and thus legitimate representatives of the communities. These people use local knowledge, skills and wisdom that are in accordance with local customs and beliefs, and therefore easily accepted by the community. Thus for them to work effectively they need to undergo training which should be uniform in all the districts.

CRP cadre includes active PwDs, community activists, book keepers and para-professionals. They will be supported by the MSRLM through investment in their knowledge and skills to enable them to provide services and be accountable to community level institutions. 2 days training programme on disability orientation would be organized for CRPs. This programme would include 1 day field visit. Role of CRPs enclosed as Annexure II.

3.2.8. Capacity Building of RRPs

The development of PwDs and their community will not take place until there are changes in attitudes of community towards PwDs and a will to change one self and change the situation. There is a need to introduce a new cadre of RRPs to understand the conditions or situations faced by PwDs due to various reasons & their exclusion from mainstream at grassroot level. For this they need necessary information & capacity building. RRPs would be chosen from the active CRPs maintaining an adequate balance of

PwDs and others. Each RRP would be handling 5 DPGs and providing services to all members. This would include therapies at doorstep, early intervention, liasioning for livelihood and education support. To start with, a batch of 30 RRPs, 15 each from the 2 pilot districts namely Ratnagiri and Yavatmal would undergo an intensive 8 weeks rehabilitation training programme at SANCHAR, Kolkata.

3.3. Social Inclusion in Health Sector

The health care system is usually responsible for providing medical care and rehabilitation services, including assistive devices. Most basic rehabilitation activities can be carried out in the disabled person's own community using local resources. PHC can play a major role in this context both as a provider and supporter. Many people with disabilities need to be referred to specialized rehabilitation services outside their own communities. PHC personnel can facilitate links between people with disabilities and specialized services, such as physical, occupational and speech therapies; prosthetics and orthotics; and corrective surgeries.

The team needs to make serious efforts to ensure that the CRPs/RRPs are well trained in the disability and rehabilitation area. The team can also strengthen specialized services so that they are a better support to the CRPs/RRPs. Convergence with the health department would not only expedite the certification process of the identified PwDs but also provide the support services in various areas like early identification, referral services etc.

Strategies

1. **Awareness Raising** - Use of local channels, newspapers and other IEC material to be used for generating awareness about disability within the community.
2. **Early identification** – To prevent the impairment CCs and CRPs to ensure that the medical checkups of CwSNs in the age group 0 t 5 yrs is completed. If any therapy is required, the CRPs should inform the CCs or the concern authorities and ensure that the CwSNs receives the treatment. Few other services and supports that needs to be ensured and enhanced are of these are provision of assistive devices; training and counseling of family; assistance and support to access mainstream services such as preschool and child-care (e.g. referral). Variety of settings for delivering services includes health-care clinics, hospitals, early intervention centres, rehabilitation centres, community centres, homes and schools.
3. **Mental Health** - The interventions that may be offered should be based on local need and availability. To provide support to a PwD with mental illness access to vocational and/or work-based support services. Dissemination of information on mental disorders that may fight against prejudices associated to these disorders, programmes promoting living in the community and employment, and measures to increase their participation in the community activities.

4. **PwDs with Severe Disability** – PwDs with severe disability are not able to perform work under the circumstances of the general labour market hence sheltered workshop could be one of the intervention for them. Entrepreneurship development is another area of intervention for the persons with severe disability.
5. **Disability Certification** - Awareness to be generated in the community so that they can take up the responsibility of certification of PwDs in their area. Team needs to facilitate the process of certification and if required make the necessary arrangements for travel of PwDs to the civil hospital.
6. **Assistive Device** – Team would facilitate the process of availing the personal assistive devices from the Ministry of Social Justice & Empowerment. For this convergence with the Health and Social Justice departments is must.
7. **Access to Health services** - Team shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. The CCs and CRPs should provide the necessary information to the PwDs in need of referral services.

3.4. Social Inclusion in Education Sector

Good co-operation between communities and the education sector is imperative if the goals of Education for All are to be met. With more than 90% of children with disabilities in developing countries not attending school, it is evident that steps must be taken to ensure access to education for all of these children. The community school plays a central role in this work.

Children with Disability are subjected to negligence, segregation, deprivation and discrimination because of physical and mental characteristics, and the wide-scale negative social attitude towards them. Given the variety of disabilities, the needs of children with disability are category specific and important to be kept in mind while planning and making provisions in education for them. Lack of reliable data regarding the actual numbers of Children with Disability greatly hampers planning and provisioning for them. Physical barriers and transport facilities are critical barriers to CWSN accessing schooling.

Strategies

1. **Enrollment of CwSNs** – Team should ensure that the identified CwSNs are all enrolled in the regular or special schools. Team need to address the issues related to CwSNs out of school through parents counseling, parents-teachers meeting etc.
2. **Education of CwSNs** - The educational sector should be more inclusive by adapting newer techniques with respect to content of the curriculum, methods of teaching and ensuring that classrooms, facilities, and educational materials more accessible.

3. **Barrier Free Environment** - Making all existing school accessible and ensure barrier free environment to the CwSNs. For example building ramps in convergence with the Public Works department.
4. **Children with severe disability** - Children with multiple or severe disabilities who might require extensive additional support, the teams should make available the use of innovative methods best suited to their context for example home visits by the teachers so that they can access education.
5. Orientation to all teachers to address the exclusion and discriminatory practices by children and teachers against the CWSN which greatly contributes to their inability to complete schooling.
6. Adequate Community Mobilization and awareness building
7. Assessment of PwDs in order to determine the vocational training that best suits the individual
8. Increase of vocational training programs for PwDs

3.5. Social inclusion in Livelihoods

Productive and decent work is essential for the social and economic integration of individual women and men with disabilities. A gainful livelihood provides an individual with income, self esteem and a sense of belonging and a chance to contribute to the larger community. The employment and labour sectors promote vocational training, employment and good working conditions. Ministries responsible for vocational training, employment, labour as well as social services can facilitate social and economic integration by providing vocational rehabilitation services, vocational guidance and skills training through both mainstream training institutions and through specialized training centres and programmes. The employment and labour sectors encourage equal employment opportunities through national policies and legislation. Collaboration with the employment and labor sectors is essential to ensure that both youth and adults with disabilities have access to training and work opportunities at community level. Productive and decent work in a conducive environment is essential for the social and economic integration of individual persons with disability (PWDs).

Strategies

1. **Skill Development** –Skill development training programmes to be organized for identified PwDs who are willing to undergo the training in order to enhance their skills. In blocks the DPO will interact with members of the VOs, DPGs and with other stakeholders and come up with an analytical overview of the existing and potential job options in the block. The mapping of the employment and skill scenario of various sectors will give clear leads as to what are the sectors where jobs will be generated in the coming years. The DPGs should mobilize the disabled youth bring them under DPG fold and do the necessary networking with the VTCs and other institutions for skill development. Once the DPG members undergo skill development training, the DPO have to look into their job placement through the institutes that conducted the training

or other institutes ready to take up the skilled PwDs as employees. On the other hand, some DPG members who are willing to start their own entrepreneurship, DPO should facilitate the loan process for these members through proper channeling agencies.

2. **Vocational Training Centres** – Strengthening of existing VTCs in the area of disability and livelihoods to be undertaken
3. **Job Placement** – Teams to facilitate the process of job placement for the PwDs who had completed the skill development training
4. **Entrepreneurship development** – Teams to facilitate the loan process from appropriate agencies for PwDs who are willing to start their own business and also arrange for their business specific training requirements.

3.6. Gender Exclusion

While all human rights and development norms and standards apply to women and girls with disabilities, they have not enjoyed the full rights on an equal basis with others. For far too long, women and girls with disabilities have been invisible, both to the advocates of women's rights and of disability rights, and this has increased their vulnerability. Women and girls with disabilities (W&GwD) are likely to experience the "double discrimination," which includes the gender based violence, abuse and marginalization. As a result, women with disabilities often must confront additional disadvantages even in comparison to men with disabilities and the women without disabilities[10].

Factors contributing to the existing gender gap in disability include;

- Invisibility of women and girls with disabilities in the work on women, disability rights and development
- Double discrimination faced by women and girls with disabilities often compounded by other factors such as being minorities, indigenous people, refugees, persons living with HIV and AIDS and older people.
- Lack of empowerment and capacity development of women and girls with disabilities, including in leadership and their participation in the decision making in political, economic and social spheres.

Strategies

To accelerate the progress on disability inclusive gender equity and women empowerment, the following points are essential:

1. Awareness raising campaigns

[10] *Background Paper for Informal Session on Women with Disabilities, Note by the Secretariat, Fifth Session of the Conference of States Parties to the Convention, on the Rights of Persons with Disabilities (New York, 12-14 September 2012)*

2. Gender and Disability inclusive strategies
3. DPGs to register and act on the complaints if any from the WwDs and if required approach the higher authorities for support
4. Reservation for WwDs and girls with disabilities in all the programmes implemented by the teams

3.7. Access to entitlements

MSRLM team with the support of DPGs, VOs, DPOs, local NGOs, community and government functionaries would ensure that all the entitlements as per the legislation are accessible to the persons of disabilities. There are total 28 entitlements for PwDs guaranteed by the Central and State government. However, the pre-requisite to the entitlements are as per the PwD Act, 1995 which specifies that PwDs having 40% and above disability would be entitled for government facilities. To that extent, certification is a must. To determine a course of action in order to streamline the processes set out by the system, guideline is being provided herewith for each of the 28 entitlements for PwD grouped under major sectors Education, Health, Livelihoods and Social Security. List of 28 entitlements enclosed as annexure III.

3.8. Livelihood Interventions

MSRLM objective for disability pilot is "To design and develop 'Strategy for Social Inclusion by mapping exclusion' in general and specifically roll-out 'Disability and Livelihood Interventions' in pilot districts with the support of MSRLM's state, district and block teams". Livelihood interventions planned and being initiated are as follows;

- Formation of DPGs initiated
- Formation of DPOs
- Formation and capacity building of SRT
- Formation and orientation to DCT
- Initiating farm and non-farm activities for the identified PwDs –
- Successful enterprises running in the block
- Financial institutions, micro finance institutions working in the block or in the District.
- Key livelihoods activities of the SHGs in the block/ lead sectors in the block.
- Infrastructure/ common facility created in the block for the promotion of livelihood activities of the SHGs.
- Existing arrangement for converging social services to the SHGs eg. Health, education, ICDS etc.

3.9. Convergence within and between the departments

Convergence at the grassroots implies integrated grassroots planning and implementation. Convergence planning can achieve multiple goals such as maximization of returns from the investment, promotion of public private-community partnerships, sustainable development, meeting the unmet needs of the community and emergence of good governance. The instruments include pooling of resources, both human and capital, transfer of productive and eco-friendly technologies and value addition through provision of backward and forward linkages. The achievement of objectives without compromising on essential conditionalities of the converging programmes will form the bottom line of partnership(s). The discussions would facilitate realization among the stakeholders that convergence approach would help everyone to realize the common goal of poverty reduction and creation of quality and durable assets for PwDs.

Strategies

To make the convergence more effective and trend setters, the following suggestions deserve attention of the MSRLM team, State Government Departments and other stakeholders;

1. **Identify the schemes of each department that involve PwDs as target group / beneficiary** – Team would identify all the central and state government schemes in which there is a provision of 3% fund reserved for PwDs and /or PwDs are involved as beneficiaries.
2. **Identifying potential areas/activities/schemes of each department for convergence** - The existing perspective/annual plans of various schemes in the selected area will be studied and discussed in the district/block level consultations of the district team with the concern district / block government department functionaries to address the identified needs.
3. **Social Mobilization/Sensitization -** Disability sensitization programme for the District and block officials of the concerned departments/organizations should be undertaken by the district MSRLM team. A special module/session on 'Attitudes and behavioural change' is necessary to sensitize the functionaries. To make convergence planning more people centric, the activities planned in convergence with the line departments/organizations should be discussed in the Gram Sabhas. This intervention may enable the community to suggest a set of related activities to be taken up in the Gram Sabha which will form the basis for designing of convergence projects with line departments/agencies.
4. **Fund Provision/Mobilization** – As per the plan, the funds required for activities that would be carried out in convergence with the government departments/institutions would be allocated by the concern department/institution. If any activity of the plan that needs to be carried out in convergence and fund provision is not available with the department/ institution, then MSRLM should extend funding for such activities.
5. **District Coordination Team (DCT) -** To make the process of planning, implementation and monitoring more effective, MSRLM has gone for formation of the District Coordination Team.

The DCT will develop initial recommended design options for a new disability livelihoods program to begin implementation in 2014-15. This would include options relating to the following:

1) Program design and access to entitlements;
2) Eligibility and assessment processes; and
3) Program communication/requirements (e.g. reporting, awareness generation).

The District Coordination team will assist in recommending a phased approach to implementation with a primary focus on 2014-15 deliverables, but also providing recommendations for 2015- 2018 work, keeping in view the multi-year approach. The District Coordination team will develop a discussion guide on the recommended options, which will be used to gather feedback from the disability community prior to making final recommendations to the State office by March 31, 2014. The issue of adequacy and benefit levels will be well within the scope of the work of the District Coordination team. The focus of the District Coordination team's work in the first year will be to provide recommended options regarding the design of the new livelihoods program and demonstrate by rolling out as pilot intervention.

Decisions taken by the DCT regarding its work will be based on the support of the majority of members. Minority opinions will be noted on request. DCT will functionally report to District Magistrate administratively and for programmatic report to the MSRLM State office. The activities to be performed by the District Coordination Team is enclosed as Annexure – I and the members constituting the DCT is enclosed as Annexure – II. Functions of DCT is enclosed as Annexure - III

6. **Utilization of Human Resources of other department/organization -** Support of human resource of the concern department would be sort for administrative and technical purpose. Other resources such as medical equipments, medicines, vehicles, available infrastructure etc would be utilized on need basis. MSRLM block and cluster teams would be coordinating with the concern department officials for the activities to be carried out in the field.

Such thematic convergence with the government departments and other government organizations envisaging a variety of tasks to be undertaken by the team in coordination with the departments and organizations is an illustration. This type of convergence interventions would benefit the PwDs for improving their livelihood support systems on a sustainable basis. Several innovative activities would be undertaken for livelihoods of severely disabled persons which would set an example for other districts to replicate.

4. Annexure

4.1. Annexure I: Role of District Coordination Team

1) Provide advice to design implementation program for Inclusion of Person with Disability (PwD) in MSRLM project and other government programs.
2) Provide guidance for social mobilization, sensitization and capacity building to the field functionaries and promote to form Self Help Groups of PwDs.
3) Arranging certification and assessment camp for personal assistive devices.
4) Ensuring entitlements/benefits to all eligible PwDs as per government norms.
5) Coordinate and assist disability functional assessment with help of MSRLM team and their partners.
6) Provide advice and input reading models of service delivery for the Livelihoods, skill development and other new program of PwDs.
7) Monitor the program activities undertaken for PwD in the block and provide guidance as required.
8) Liaison with various agencies for arranging for the assistive devices in consonance with the State Disability Team.
9) Make livelihood opportunity assessment in terms of available trades and market.
10) Define assessment and eligibility processes for determining who the work-limiting disability population is and design appropriate program with the help of expert wherever required.
11) Develop a discussion guide on the recommended options for the disability livelihoods program and plan and facilitate consultations/discussions with the disability community.

4.2. Annexure II: Role of CRPs/ CBR workers

- The CRP, social Mobilizers will interact with the local Panchayats, field level officials to start the social mobilization process.
- CRPs and social mobilizers will help to indicate the status of local resources and status of access of poor to assets / resources – natural, physical, human, financial, socio cultural etc
- Sensitizing the family members, especially about SHGs
- Sensitizing the key persons of the village about the SHGs
- Identifying active members of the villages and training them throughout their stay at village so that they continue the facilitation process after the CRPs i.e. developing a cadre of CRPs at the Villages
- Organize meeting of the SHGs and excluded poorest of the poor to have a study of the status of the SHGs and the poverty related issues in the villages.
- Prepare a status report to have a base line.

- Form groups with excluded poor and poorest of the poor women.
- Conduct group level training on management norms and financial management norms.
- Help SHG members to identify book keepers.
- Impart training to the book keepers.
- Organize handholding training on record keeping.
- Impart training on preparation of micro credit plan and facilitate preparation of the same.
- Impart training on formation of village organization and their management.
- Select active women and train them up as CRPs.

4.3. Annexure III: List of 28 entitlements for PwDs

1. Special Certificates to School and College Students
2. Government Scheme – SSA
3. Government Scheme – IEDC
4. Scholarship
5. Children's Educational Allowance
6. Government Scheme - Scheme of Integrated Education for the CWSN
7. Disability Certificate
8. Identity Card
9. Specialized Health Services
10. Corrective Surgery
11. MSHFDC
12. Skill / Vocation Training
13. Government / Public Sector Job
14. Government Scheme – MGNREGA
15. Government Scheme - Prime Minister's Employment Generation Programme (PMEGP)
16. Bus Pass Concession
17. Railway Concession
18. Concession for Air travel
19. Driving Certification
20. Personal Assistive Devices
21. Income Tax Concessions
22. Disability Pension
23. Government Scheme – Indira Gandhi National Disability Pension
24. Government Scheme – Indira Gandhi National Handicap Pension Scheme
25. Government Scheme – Sanjay Gandhi Niradhar Anudan Yojana
26. Government Scheme – Indira Awas Yojana (IAY)
27. Government Scheme – Nirmal Bharat Abhiyan
28. Scheme of Assistance to Disabled Persons for Purchase/ Fitting of Aids and Appliances (ADIP)