

MANUAL
COMMUNITY BASED REHABILITATION

Dr. Bhushan Punani
Nandini S. Rawal
Jasmine S. Sajit

Printing courtesy:
National Association for the Blind

NAB Symbol
RURAL ACTIVITIES COMMITTEE
NATIONAL ASSOCIATION FOR THE BLIND

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November, 2000

First Edition (1987): 3000
Second Edition (1996): 3000
Present Edition (2002): 5000

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This publication is made possible by a grant from
National Association for the Blind

Cover design: Sajit S.
Computer setting: Zakir Sipahi
Printing courtesy: Damji Tank, Naranbhai Patel and Prashant
Secretarial assistance: Leelamma Thomas and Lalitha Menon

Published by: Nandini S. Rawal, Secretary, NAB RAC on behalf of
the National Association for the Blind, 11, Khan Abdul Gaffar
Khan Road, Worli Seaface, Bombay 400 025 (India)

Printed at: Multicategory Workshop for the Handicapped, Blind
People's Association, Vastrapur, Ahmedabad 380 015

Type Setting: Cama Computer Training Centre for the Blind, Blind
People's Association, Vastrapur, Ahmedabad 380 015

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Dedicated to

Our Guiding Spirit for ever.....

(Photo of Jagdishbhai)

Jagdish K. Patel

Ever-lasting source of inspiration.....

Abbreviations

ADL	: Activities of Daily Living
BPA	: Blind People's Association, Ahmedabad
CBR	: Community Based Rehabilitation of the Visually Impaired
IE	: Integrated Education
MSJ&E	: Ministry of Social Justice & Empowerment
NAB	: National Association for the Blind (India)
NAB RAC	: NAB Rural Activities Committee
O&M	: Orientation & Mobility
Project	: CBR Project
PWD Act	: Persons with Disabilities Act, 1995
CAHD	: Community Approaches to Handicap in Development

Glossary

Prevalence Rate: It means the number of persons having disability per 1,00,000 population at point in time.

Incidence Rate: It means the number of persons who became disabled during 365 days preceding the date of survey per 1,00,000 population.

Blindness: It refers to a condition where a person suffers from any of the following conditions, namely-

- a. total absence of sight; or
- b. visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye with correcting lenses; or
- c. limitation of the field of vision subtending an angle of 20 degree or worse.

Mobility: It is defined as "movement" not just a particular technique or device; it is the aim of obtaining freedom of movement safety in travelling as well as minimizing the level of stress placed upon the visually handicapped person.

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

Activities of Daily Living: It comprises everything entailed in human life and relationships. These are the basic activities necessary during an ordinary day.

PREFACE

I am delighted that Bhushan Punani, Nandini Rawal and Jasmine Sajit have brought out much awaited and updated third edition of Manual. I have personally pursuing progress of the concept of CBR across the country and especially under the auspices of the National Association for the Blind as well as the Blind People's Association. I am delighted know that this concept is no more just a pilot project or a programme, it is emerging as a national movement. A lot of initiatives at the national and international level have been taken for promoting this concept in many developing countries.

The major national level initiatives include implementation of the National Programme for the Rehabilitation of the Persons with Disabilities as well as District Rehabilitation Programme under the auspices of the Ministry of Social Justice & Empowerment. I am proud to know that the Department of Social Justice & Empowerment has initiated and supported a state-wide programme, popularly known as Maharishi Ashthawakar Yojna. The target for this scheme is to cover each and every person with disability across the State of Gujarat. Similarly, expansion of the concept of integrated education under the auspices of the Gujarat Council for Educational Research and Training would enable thousands of children with disabilities to have access to neighbourhood schools. I am sure this Manual would be extremely useful to all the persons promoting and implementing all these very ambitious programmes.

As all these initiatives are likely involve a large number of functionaries across the country, I think the Authors now publish this Manual in Hindi, all regional languages. I am confident that leading Developmental Agencies, State Governments and proponents of the CBR would come forward to support publication of this Manual in different languages.

I am confident this concept of CBR will enable each and every person with disability in the country and also in other developing countries to access appropriate services on comprehensive rehabilitation and social integration. The National Association for the Blind as well as Blind People's Association would always to pleased to extend fullest cooperation to any organization or individual willing to promote the concept of CBR.

I am honoured to know that this Manual has been dedicated to Late Jagdish Patel, the greatest proponent of CBR and the person who inducted me into field of rehabilitation. Last but not the least, I congratulate Bhushan Punani, Nandini Rawal and Jsmine for untiring efforts of flame of CBR burning for ever, and ever stronger.

Arvind Narottam Lalbhai
President: Past: National Association for the Blind
: Blind People's Association

From NAB General Secretary's Desk:

(To be received in the first week of October)

Acknowledgments

We are pleased to present the third and much richer version of our earlier CBR Manual, popularly known as Green Book on CBR. The present Manual contains our updated philosophy and methodology of operation of our community based rehabilitation Projects for the rural visually impaired. Our first volume of Manual was published in 1987, followed by the second edition during 1996. The second edition of the Manual was distributed around the world, especially in the countries in Africa region. Considering ever increasing demand for the Manual, we have updated and improved the same. This Manual now presents a more comprehensive and practical approach for the promotion of comprehensive CBR programmes in the developing countries for the persons with all categories of disability.

To late Jagdish K. Patel, our guiding spirit, ever-lasting source of inspiration and our mentor, who encouraged and guided us to promote the concept of CBR, we very respectfully dedicate third Manual as a memorial. We present this Manual to Mrs. Bhadra Satia, life-time partner of Jagdish Patel and General Secretary of the Blind People's Association as our appreciation for her devotion to the cause. Similarly, credit for the publication of third edition of the Manual goes to Dr. Rajendra T. Vyas, General Secretary, National Association for the Blind for extending his fullest cooperation and for sanctioning the grant for meeting cost of printing. t

We thank Mr. Arvind Narottam Lalbhai, President; Mr. Jahangir Cama, Vice President; Mrs. Nandini Munshaw, Secretary; Mr. Nanalal Kanabar, Secretary; F. J. Porwal, Treasure; Harish Panchal, Director (Training) and Executive Committee Members of the Blind People's Association for their support and guidance from time to time.

Our Manual would have not been started had Mrs. Jasmine Sajit, Project Coordinator, Satellite Project for Children with Multiple-disabilities started the work with gusto. Mrs. Vimal Thawani, Vocational Counsellor and Mrs. Brahada Shankar, Coordinator, NAB, RAC contributed to the text of the Manual by giving their valuable suggestions.

We thank Mr. Zakir Sipahi for the pains he has taken in so beautiful setting the Manual. We are also grateful to Mr. Sajit S. for designing the cover page, Mr. Pankaj Shah, Mr. Damji Tank, Naranbhai Patel and Prashant for printing the Manual in a record time at most reasonable cost. We are grateful to Capt. HJM Desai, Vimal Thawani, Akhil Paul, Bhaskar Upadhaya, Late Madhukar Suryavanshi, Dr. B. K. Panchal, Jasmine Sajit, Kinnari Desai, Durgesh Nandini, Rambahi Jadav and Bharat, all of them true architects of the concept of CBR presented in the Manual.

Leelamma Thomas and Lalitha Nair deserves special thanks for their back breaking efforts in typing and retyping so patiently and tirelessly. Last but not the least, we thank the Members of the NAB RAC for their valued support and guidance.

- Authors

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Note: (Only for planning - not to be taken in the text)

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CONCEPT AND EXTENT OF DISABILITY IN INDIA

1. Definition: Disability

In India, the broad definitions of different categories of disabilities have been adopted in the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 as well as under the Rehabilitation Council of India Act, 1992.

1.1 "Person with Disability" means a person suffering from not less than forty percent of any disability certified by a medical authority.

1.2 Blindness refers to a condition where a person suffers from any of the following conditions, namely:

- Total absence of sight; or
- Visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye even with correction lenses; or
- Limitation of the field of vision subtending an angle of 20 degree or worse.

For deciding the blindness, the visual acuity as well as field of vision has been considered.

1.3 "Person with low vision" means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device.

This definition is incomplete as it inadvertently omits quantification of the acuity as well as the field of vision as is done in the case of the WHO definition. It is desirable to modify this definition and the following quantification should be added:

"Low vision are those who suffer visual acuity between 20/200 to 70/200 (Snellen) or 6/18 to 6/60 in the better eye after the best possible correction or a Field of Vision between 20 to 30 degree."

The WHO working definition of Low Vision (WHO, 1992) is as follows:

"A person with low vision is one who has impairment of visual functioning even after treatment, and/or standard refractive correction, and has a visual acuity of less than 6/18 to light perception or a visual field of less than 10 degrees from the point of fixation, but who uses, or is potentially able to use, vision for the planning and/or execution of a task".

The points emphasized are that there is significantly reduced

vision, visual performance is affected but that there still is vision that can be used. This last point is very important: if there is usable vision, training to use that vision might be possible. In addition this person is not labelled blind.

Table 1.1
Categories of visual impairment

Category	Corrected VA-better eye	WHO Definition Standard*	Working#	Indian Definition
0	6/6-6/18	Normal	Normal	Normal
1	<6/18-6/60	Visual Impairment	Low Vision	Low Vision
2	<6/60-3/60	Severe Visual Impairment	Low Vision	Blind
3	<3/60-1/60	Blind	Low Vision	Blind
4	<1/60-PL	Blind	Low Vision	Blind
5	NPL	Blind	Total Blindness	Total Blindness

* The standard WHO definition is solely based on visual acuity and does not take into account functional vision.

The working definition has been adopted since WHO Consultation in 1992. This working definition is solely used for reporting purposes and should not be used for eligibility of services. The standard definition is used in medical reports and publications and is solely based on visual acuity and does not take into account functional vision.

1.4 "Hearing Impairment" as defined in the Act means loss of sixty decibels or more in the better ear in the conventional range of frequencies. The classification of hearing impairment as adopted by the Ministry of Social Justice and Empowerment is as follows:

Table 1.2
Categorization of Hearing Impairment

Category	Type of Impairment	DB Level (in better ear)	Speech Discrimination (in better ear)	%age of Impairment
I	Mild	26-40 Db	80-100%	<40%
II	Moderate	41-55 Db	50-80%	40-50%
III	Severe	56-70 Db	40-50%	50-75%
IV a.	Total Deafness	No hearing	No discrimination	100%
b.	Near Total Deafness	91 Db & above	No discrimination	100%
c.	Profound	71-90 Db	<40%	75-100%

Source: Ministry of Social Justice & Empowerment

Thus persons with mild or moderate hearing loss have not been included in the category of persons with hearing impairment. Only persons with severe, profound and total hearing impairment have been included in this category.

1.5 "Locomotor Disability" as defined in the Act means disability of bones, joints or muscles leading to substantial restriction of movement or any form of cerebral palsy.

Detailed guidelines as adopted by the Ministry of Social Justice & Empowerment explains the extent of disability in percentage terms due to various conditions in different parts of the body. Depending upon the extent, the categorization would be as follows:

- | | |
|-------------------|---------------|
| a. Mild | less than 40% |
| b. Moderate | 40-74% |
| c. Severe | 75% and above |
| d. Profound/Total | 100% |

Only those having 40 percent or more disability have been considered as persons with locomotor disability.

1.6 "Mental Retardation" as defined in the Act, means a condition of arrested or complete development of mind of persons which is specially characterized by sub-normality of intelligence.

The categorization of mental retardation, on the basis of IQ levels has been done in the following manner:

- | | |
|-------------|-------------|
| a. Mild | IQ 50-70 |
| b. Moderate | IQ 35-49 |
| c. Severe | IQ 20-34 |
| d. Profound | IQ under 20 |

The definition of mental retardation on the basis of IQ is outmoded. It is not possible to decide retardation just on the basis of IQ. This definition excludes mental illness, epilepsy, learning disability etc. A number committees have already been constituted to give a fresh look at these definitions.

1.7 Person with Multiple Disabilities

The PWD Act (1995) defines "person with severe disability" means a person with eighty percent, or more of one or more disabilities. It, however, does not clearly define persons with multiple disabilities.

1.7.1 Definition by the National Trust: As per the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999, multiple disability means a combination of two or more disabilities as defined in clause (I) of Section (2) of the Persons with Disabilities Act, 1995. In addition to the above, multiple disabilities include individuals who are Deafblind, autistic, cerebral palsied, neurologically impaired. These disabilities may either be congenital or acquired.

1.7.2 Persons with Deafblindness: The condition of deafblindness is used to describe a heterogeneous group of children and adults who may suffer from varying degrees of visual and hearing impairment, perhaps combined with learning difficulties and physical disabilities, which can cause:

- severe communication
- developmental, and
- educational problems.

It includes children and adults who are:

- blind and profoundly deaf
- blind and severely or partially hearing
- partially sighted and profoundly deaf
- partially sighted and severely or partially hearing

A precise description is difficult because the degrees of other disabilities, are not uniform, and the educational needs of each child will have to be decided individually. The above mentioned statement should not be taken as a definition but a description of deafblindness.

(Source : Contact (1993) A Resource for Staff Working with Children who are Deaf and Blind, Edinburgh: Moray House)

1.7.3 Autism: The National Trust Act, 1999 defines autism as a condition of uneven skill development primarily affecting the communication and social abilities of a person, marked by repetitive and ritualistic behaviour.

1.7.4 Evaluation of Multiple Disability: In order to evaluate the multiple disability, the same guidelines shall be used as have been developed for evaluation of single categories of disabilities. In order to arrive at the total percentage of multiple disability, the combining formula $a + \frac{b(90-a)}{90}$ as given in the Manual for Doctors to Evaluate Permanent Physical Impairment, developed by Expert committee on Disability Evaluation shall be used, where 'a' will be higher score and 'b' will be the lower score. However, the maximum total percentage of multiple disability shall not exceed 100 percent.

For example, if in one person, percentage of hearing impairment is 30 percent and visual impairment is 20 percent, then applying this formula, the total percentage of multiple disability will be calculated as follows:

$$\frac{30 + 20(90-30)}{90} = 43 \%$$

The board for evaluation will have a specialist from the fields of the respective disabilities which constitute the multiple disability. To evaluate and certify autism, any one of the three experts may be included in the medical board, viz. Psychiatrist, or Paediatrician, or Clinical Psychologist.

2. WHO Disability Sequence

Generally various terms like impairment, disability and handicap are used interchangeably and at random. WHO has adopted a sequence underlying illness-related phenomenon as:

Disease ----> Impairment ----> Disability ----> Handicap

Table 1.3
Explanation of Various Terms as Adopted by WHO

Condition	Concerned with	Represents
Impairment	Abnormalities of body structure and appearances; organs or system functioning	Disturbances at organ level
Disabilities	Impairment in terms of functional performance and activities	Disturbances at personal level
Handicaps	Disadvantages resulted from impairment and disabilities	Interaction with and adaptation to individual's surroundings

Source: WHO Classification of Impairments, Disabilities & Handicaps

The International Classification of Impairments, Disabilities & Handicaps (ICIDH-2) likely to be officially adopted in 2001 proposes a common language of functioning and disability. The new terms proposed are "Activity Limitation" for "Disability"; and "Participation Restriction" for "Handicap". "Disability" will be used as an umbrella term covering all three terms: Impairment, Activity Limitation and Participative Restriction.

3. Survey of Persons with Disabilities

1861: First attempt by National Census Organization which collected data on disability along with decennial census.

1941: Disability census discontinued as it was felt that data was not reliable.

1974: WHO estimate: 10 percent population of the world was that of persons with disabilities.

1981: Disability census resumed for compilation of information on total disability and following figures were obtained:

Totally blind : 0.479 million
Totally dumb : 0.277 million
Totally crippled : 0.364 million

These figures were withdrawn subsequently as these seemed to be misleading. No information on disability was collected during 1991. The Govt. of India has assured that information on disability will be compiled during 2001 census.

1981: National Sample Survey Organization, Department of Statistics conducted a comprehensive survey on the magnitude of physical disability in its 36th Round Survey conducted during July-December, 1981. It published a detailed report as Survekshana, Vol. VII, No. 19.

1990: Dr Helander revised this estimate to 5.21 percent

In India, surveys of disability have been undertaken from time to time by various governmental and non-governmental organizations.

1991: The NSSO carried out a survey of disability in its 47th Round during July - December, 1991 with the basic framework including the concepts, definitions and operational procedure as followed in 36th Round. The NSSO brought out two reports - Report No. 393 on physical disability and Report No. 391 on delayed mental development among children and hearing disability among children in the age group 0-4.

1992: Plan of Action: The first attempt to really make some sort of estimation on projected population of children with disability was done while evolving National Policy on Education (1986) and the Plan of Action on (1192) implementation of this policy. It estimated 12.59 million children in the school going age with disabilities.

1999: The National Association for the Blind, Gujarat Branch Carried out a door-to-door survey without the support of the UNICEF in 31 talukas of Gujarat.

2000: The Gujarat Council for Educational Research & Training carried out another door-to-door survey without the support of the UNICEF in different 31 talukas of Gujarat.

2001: The Census of India 2001 included persons with disabilities in its census.

2002: The National Sample Survey Organization is likely to conduct a nation-wide survey of disability in India.

4. Estimated Number of Persons with Disabilities

Out of all the estimates, surveys and projections, the findings of the National Sample Survey seem to be the most appropriate, relevant and comprehensive. The statistical analysis of demographic pattern of persons with disabilities is based on "A Report on Disabled Persons" published by the National Sample Survey Organization.

Table 1.4

Estimated Number of Persons with Disabilities (Millions)
(Figures in brackets show percentages of total of that column)

Type of Disability	Rural			Urban			Total (3)+(6)
	Male (1)	Female (2)	Persons (3)	Male (4)	Female (5)	Persons (6)	
Visual	1.539 (46.15)	1.796 (53.85)	3.335 (83.27)	0.308 (45.97)	0.362 (54.03)	0.670 (16.73)	4.005
Hearing	1.409 (54.76)	1.164 (45.24)	2.573 (79.36)	0.339 (50.67)	0.330 (49.33)	0.669 (20.64)	3.242
Speech	0.942 (62.84)	0.557 (37.16)	1.499 (76.25)	0.296 (63.81)	0.169 (36.19)	0.467 (23.75)	1.966
Hearing & Speech	2.009 (57.42)	1.490 (42.58)	3.499 (78.07)	0.557 (56.66)	0.426 (43.34)	0.983 (21.93)	4.482
Locomotor	4.396 (64.58)	2.411 (35.42)	3.499 (76.15)	0.557 (64.26)	0.426 (35.74)	0.983 (23.85)	8.939
Physical (at least one of above)	7.442 (58.82)	5.210 (41.18)	12.652 (78.32)	2.078 (59.34)	1.424 (40.66)	3.502 (21.68)	16.154

4.1 Major Observations: The major observations from these figures are:

- Number of physically disabled persons in India was 16.15 million during 1991 and they formed about 1.9 percent of the total population.

- Out of all the physical disabilities, locomotor constitutes 55.33 percent, followed with speech & hearing which constitute 27.70 percent, and least visual impairment with 24.79 percent.

- 78.3 percent persons with disabilities live in rural areas. In case of visual impairment, 83.27 percent people live in the rural areas.

- Males in case of all physical disabilities constitute 59 percent of total population of persons with disabilities. However, in case of visual impairment, females constitute 54 percent of total number of visually impaired persons.

- About 12.4 percent of these persons suffered from more than one type of physical disabilities.

- About 9 and 7 percent households in rural and urban India respectively have at least one disabled person in the household.

- Among these households, about 92 percent had one disabled person, about 7 percent had 2 disabled persons and less than 1 percent reported 3 or more disabled persons, both in rural

and urban sectors.

5. Distribution of population of the visually impaired

Table 1.5

Distribution of population of the visually impaired ('000)

Gender	Rural (%)	Urban (%)	Total(%)
Men	1539 (38.42)	308 (7.69)	1847 (46.11)
Women	1796 (44.85)	362 (9.04)	2158 (53.89)
Total	3335 (83.27)	670 (16.73)	4005 (100)

The estimated population at 880 million population level is 40 lakhs (4 million). When extrapolated, the estimated population during 2002 at 1004 million population level would be 4.56 million.

5.1 Gender-wise Distribution of Visual Impairment

Table 1.6: Male - female population (1991)

	Male (%)	Female (%)
Visually impaired	46.11	53.89*
Total population	50.50	49.50#

Source: * Survey of Disabled Persons, NSS, 1991

General Population Survey, 1991

The gender distribution of population of visually impaired of 53.89 percent females as compared to that of 49.5 percent of total population establishes that incidence of visual impairment is relatively more among females. The figures in Table 1.7 also establish that incidence as well as prevalence of visual impairment is comparatively higher among females in both rural as well as urban areas.

Table 1.7: Gender distribution of visual impairment

Gender	Incidence		Prevalence	
	Rural	Urban	Rural	Urban
Males	22	15	471	263
Females	28	25	548	346

Source: Survey of Disabled Persons, NSS, 1991

5.1 Rural-Urban Distribution of Visual Impairment

Table 1.8: Rural-Urban Distribution 1991)

	Rural	Urban
Visually impaired	83.27	16.73
Total population	80.00	20.00

Source: * Survey of Disabled Persons, NSS, 1991
General Population Survey, 1991

More than 83 percent blind persons are in the rural areas as compared to 80 percent in case of overall population. It establishes that prevalence of visual impairment is comparatively more in the rural areas as compared to urban areas.

6. Extent of Mental Retardation

According to Pandey and Advani (1995), no systematic survey is known to have been conducted in the country in respect of the mental retardation. However, in certain areas, limited surveys have been conducted to ascertain the extent of mental retardation. In a study conducted at Nagpur (Verma, 19680, out of a total sample of 30,326 individuals, 1001 individuals with mental handicap were identified with overall prevalence rate of 30/1000. The prevalence was 42/1000 in the age-range of 8 to 15 years while it was 16/1000 in the age-range 16-22 years.

In another study of a sample of 8,583 individuals conducted at Lucknow (Gupta and Sethi, 1970) established prevalence rate of mental handicap as:

Overall:	2330
Rural :	2530
Urban :	1850

The prevalence was more among boys who outnumbered girls by 210. Seventy five per cent were below the age of 10 years while 4 per cent were over 20 years of age, 24.8 per cent had an IQ less than 50.

Narayanan (1981), on the basis of survey of three villages in Bangalore district in 1970, found the prevalence of 'severe' mental retardation to be 340. In two other villages of the same district, in 1979, the prevalence rate of severely mentally handicapped people was found to be 680.

In another study in two villages in Bangladesh district in 1983, Subramanya estimated a prevalence rate of 274, in a sample of 1,498 children of 3-14 age-group. The male-female ratio was 2:1 of the total individuals identified, 65.8 per cent were mildly mentally retarded.

it would be seen that although the samples used in these studies were small and very sophisticated tests for identification were not used, the trend is more or less the same as in most populations all over the world where approximately, 2 to 3 per cent of the population is expected to be mentally handicapped, mental handicap being defined as a condition characterized by significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period.

On this basis, the following estimates may be projected:

Individuals with mental handicap: 20 million
 Moderately, severely or profoundly handicapped: 6 million
 Adult over 20 years of age: 0.8 million
 Children below 10 years of age: 15 million
 Boys: 10 million
 Girls: 5 million

7. Projected Population of Children with Disabilities

According to Mukhopadhyay and Mani (2000), as in several countries, India is still in the process of refining the procedures by which children with special needs can be identified. The first attempt in this regard was made during the National Policy on Education of 1986 and Plan of Action 1992. It estimated number of special need children of school going age at 12.59 million including 3.6 million mentally retarded children and 3.19 million children with physical disabilities in the age group 5-14 years.

Table 1.9

Projected population of children with disabilities (in Million)

S.N.	Category of Disability	Age Group (Years)	No. in Million
1.	Children with Disability	5-14	3.19
	1.1 Locomotor Handicap		1.48
	1.2 Hearing Handicap		0.65
	1.3 Speech Handicap		0.19
	1.4 Visual Handicap		0.15
2.	Mentally Retarded	5-15	3.60
3.	Learning Disability	5-14	3.60
4.	Children with Disability	16-18	2.20
	TOTAL		12.59

Source: Plan of Action, 1992

Among school going age children with disabilities, the children with mental retardation and learning disabilities constitute almost 60 per cent of estimated number. Whereas children with visual impairment constitute only 1 per cent, children with speech impairment merely 1.5 percent and those with hearing impairment 5 percent of estimated number of children with disabilities. In other words, mental handicap and learning disabilities are most prominent among children, followed by locomotor handicap and least in case of visual impairment.

A comparison between incidence as well as prevalence of disabilities estimated in two National Sample Surveys conducted during 1981 and 1991 respectively, the estimate is showing a declining trend from 2 percent to 1.8 percent. This trend is showing further improvement in respect of declining number of children with disabilities due to improvement in nutrition

status, best access to health services, early identification, better pre-natal and post natal services, effective immunization in case of polio and vaccination etc.

8. Prevalence and Incidence of Disability

Prevalence means number of persons born with disability or became disabled per 1,00,000 population in the country till the date of survey. Whereas incidence means the number of persons born with disability or who became disabled per 1,00,000 population in the country within a specified period of 365 days preceding the survey.

Table 1.10
Comparative Prevalence and Incidence of Physical Disabilities

Sector	36th round (July -December, 1981)			47th round (July -December, 1991)		
	Male	Female	Persons	Male	Female	Persons
1	2	3	4	5	6	7
Prevalence Rate						
Rural	2045	1632	1844	2277	1694	1995
Urban	1532	1297	1420	1774	1361	1579
Incidence Rate						
Rural	-	-	-	99	81	90
Urban	-	-	-	90	75	83

Source: Survey of Disabled Persons, NSSO, 1981 & 1991

The following findings emerge from the analysis of data on prevalence and incidence of disabilities:

8.1 Prevalence

- The prevalence of physical disability during 1991 was 2 percent in the rural areas and 1.6 percent in the urban area.
- Between the two sexes, the prevalence of disability was marginally higher among males than among females.
- The inter-state variations in prevalence rate are significant in both the sectors. In the rural areas, it ranged from 1.2% in Assam to 2.9% in Punjab, while in the urban areas, it ranged from 1.1% in Rajasthan to 2.0% in Orissa. These rates among males are higher among males than among females in all the states.

8.2 Incidence

- The Incidence Rate was 90 in the rural areas and 83 in the urban areas.

- This rate is also observed to be higher among males than that among females.
- The state-wise differences are quite high, ranging from 30 to 171 in rural areas and from 46 to 144 in urban areas.

8.3 Comparison of Prevalence Rates

A comparison of Prevalence Rate of physical disability observed during 36th and 47th Rounds reveals that:

- In both rural and urban areas, the prevalence for males as well as females increased marginally over the period from 1981 to 1991. The prevalence increased in rural areas from 1.84% to 1.99% and in urban areas from 1.42% to 1.58% during this period.
- The rural-urban as well as male-female pattern in the prevalence rate is found to be similar in both the rounds.
- The disability-wise data shows that both prevalence and incidence of visual, speech and hearing impairments have shown marginal to substantial decline and prevalence of locomotor disability has shown substantial increase from .82% to 1.04% for the rural areas and from 6.79% to 9.62% for the urban areas during this period. Whereas there is no increase in the incidence of this disability during this period.

9. Rural - Urban Distribution of Disability

Table 1.11
Rural - urban population (1991)

Nature of Population	Rural (%)	Urban (%)
At Least one Physical Disability	78.32	21.68*
Visual Impairment	83.27	16.73*
Total Population	80.00	20.00#

Source: * Survey of Disabled Persons, NSS, 1991
General Population Survey, 1991

The population of persons with disabilities is 21.68 percent in the urban areas as compared to that of 20 percent for total population which establishes that chances of survival of a child with disability are comparatively higher in the urban areas as compared to rural areas. Lack of early intervention services, prevention of disability or the lack of awareness among the rural masses may be responsible for comparatively higher prevalence of disability in the urban areas.

Whereas the population of visually impaired of 83.27 percent in the rural areas as compared to that of 80 percent of total population establishes that the incidence of visual impairment is relatively more in the rural areas. It may be due lack of eye care services, delay in medical and surgical intervention, superstitions and lack of public awareness among the rural

population as regard eye care etc.

10. Age-wise Distribution

Table 1.12
Age-wise Distribution (per thousand)

Age Group	Visual		Hearing		Speech		Locomotor		Any Disability	
	Rur	Urb	Rur	Urb	Rur	Urb	Rur	Urb	Rur	Urb
0-4	4	5	NA	NA	47	47	27	30	-	-
5-14	24	21	85	80	262	261	224	223	150	165
15-59	255	304	387	377	539	513	487	503	425	458
60&Above	717	670	526	541	197	225	240	227	398	346

The following observations may be made from these figures:

- When all physical disabilities are considered together, 16 percent persons are in the school-age group, 44 percent in the working age group and 40 percent in the aged group.
- In case of visual impairment, distribution is highest at the level of 70 percent in the age group 60 years and above and the lowest in the age group less than 4 years. Only one-fifth of total number of such persons are in the school-age group.
- Locomotor and speech impairments are most prominent among the infants and the school-age children. The extent of these disabilities is least as compared to other disabilities in the age group 60 years and above.
- Hearing impairment is comparatively lower in the younger age group as compared to that in the higher group.
- Visual and hearing impairments are more prominent in the higher age-groups, whereas speech and locomotor impairments are the phenomena of the younger age groups.

11. On-set of Disability

In India, majority of physical disability is acquired; congenital impairment is almost negligible.

Table 1.13
Age at Onset of Disability in Rural Areas Age Group 60 years & Above (Distribution per 1,000)

Disability	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-44	45-59	60 & Above	
Visual		9	8	9	1	3	3	4	18	255	689
Hearing		9	6	12	9	11	10	12	41	280	609
Speech		42	23	24	-	10	-	12	25	262	594
Locomotor		29	19	17	17	10	8	22	59	278	511

The highest on-set of disability in case of all the disabilities takes place in the age-group 60 & above. It is comparatively higher in this age group in case visual impairment, followed by hearing impaired.

In case both, visual as well as hearing impairment, the on-set of impairment is least in the age-group below 35 years. There is sharp increase of almost 5 times in on-set till the age of 35 years as compared to that in the age-group 35-44 years in case of visual impairment. This increase is 2.5 times in the similar age-groups in case of hearing impairment. Thus most of visual impairment occurs after age of 45 years and hearing impairments occurs after the age of 35 years. The major causative factors both in case of visual as well as hearing impairments are senile in nature.

Almost 4 percent of speech impairment and 3 percent of locomotor disability occurs below 4 years of age. The onset of disabilities in these cases takes place in comparatively in higher proportions as compared to other physical disabilities in the school-age of 4-19 years. Thus these disabilities are comparatively more prominent among younger people.

12. Causes of Disability

The National Sample Survey also compiled information on probable causes of disability as known to the informant in respect of only those who acquired the disability in the course of life.

12.1 Causes of Visual Impairment

12.1.1 National Sample Survey

Table 1.14
Causes of Visual Impairment (Distribution per 1,000)

S. N.	Causes of visual impairment	Rural	Urban
1.	Old age	273	214
2.	Cataract	236	280
3.	Other eye diseases	130	107
4.	Glaucoma	34	42
5.	Smallpox	29	35
6.	Injury other than burns	32	35
7.	Corneal Opacity	13	16
8.	Severe diarrhoea in childhood	11	13
9.	Sore eyes after one month	6	8
10.	Sore eyes during first month	5	3
11.	Burns	2	5
12.	Other reasons	49	74
13.	Not Known	161	131

Source: Survey of Disabled Persons, NSS, 1991

About 27-21 per cent persons reported 'old age' as the cause of

visual disability. Cataract, the incidence of which is generally high in old age, was found to be the cause in about 24-28 per cent cases respectively in the rural and urban sectors. Thus in almost 50 per cent of cases, on-set of visual impairment is merely due to cataract or old age. Xerophthalmia and congenital visual impairment which are major causes of visual impairment among children and at birth respectively have not been reported as a separate category of causes of visual impairment. As reported earlier, on-set of visual impairment in 0-4 age group is merely 0.8 per cent only.

12.1.2 NPCB Survey: The findings of the National Programme on Control of Blindness, however, establish that cataract causes almost 81 per cent of visual impairment in the country. This study also attributes only 0.04 per cent visual impairment to malnutrition.

Table 1.15
Causes of visual impairment in India (Distribution per 1,000)

S. N.	Causes	%age
1.	Cataract	81.00
2.	Refractive errors	7.00
3.	Corneal opacity	3.00
4.	Glaucoma	2.00
5.	Trachoma	0.20
6.	Malnutrition	0.04
7.	Others	6.76

Source: WHO - NPCB Survey (1981-86)

Both the National Sample Survey as well as WHO-NPCB Survey establish that the distribution of disabled persons by age at the onset of visual disability and by probable cause of such disability suggest that the visual disability is essentially an old age problem.

12.1.3 Back-log of Eye Surgeries: The WHO - NPCB Survey 1981-86 establishes that the national load for various causes of blindness in the country at 800 million population level is 31.84 million including back-log of cataract surgeries of 25.76 millions. These surgeries are pending and hence are likely to result in the affected persons becoming visually impaired.

The current estimated rate of cataract surgeries per annum in the country is 2.5 millions. Whereas the annual incidence of cataract alone is 2.97 to 4.67 million. Thus the coverage of people every year for cataract surgeries is lower than the incidence resulting in a gradual increase in the back-log of cataract surgeries. As per the projections of the National Programme on Control of Blindness, the back-log of cataract operations is likely to accumulate to 42 million by the year 2000 A.D.

12.2 Causes of Hearing Impairment

Table 1.16

Causes of Hearing Impairment (Distribution per 1,000)

SN	Causes of Hearing impairment	Rural	Urban
1.	Rubella (German Measles)	9	14
2.	Noise induced hearing loss	17	18
3.	Ear Discharge	175	143
4.	Other illnesses	186	197
5.	Burns	2	2
6.	Injuries other than burns	35	52
7.	Medical/surgical Intervention	10	21
8.	Old age	310	316
9.	Other reasons	77	88
10	Not known	179	149

Source: Survey of Disabled Persons, NSS, 1991

In this case also, major cause of hearing impairment is old age which accounts for 31 percent of this disability. Other major causes include illnesses (19%), ear discharge (17%) and injuries (4%). All these causes (40%) can be prevented or cured by extending medical intervention and enhancing level of public awareness. Thus lot of hearing impairment is either preventable or curable. Unlike visual impairment, the cases requiring surgical intervention, however, are only 1 to 2 percent.

12.3 Causes of Speech Impairment

Table 1.17

Causes of Speech Impairment (Distribution per 1,000)

Causes	Rural	Urban
Hearing	36	32
Voice disorder	90	63
Cleft palate	26	14
Paralysis	191	240
Mental illness/ retardation	91	90
Other illness	221	207
Burns	4	6
Injury other than burns	32	47
Medical/surgical intervention	15	29
Old Age	25	27
Other reasons	72	81
Not known	197	164
Total	1000	1000

Source: Survey of Disabled Persons, NSS, 1991

It would be seen that unlike visual and hearing disabilities, old age is not a prominent cause of this disability. About 9 per cent acquired this disability due to mental illness/retardation. Paralysis and other illness were the cause in about 40 per cent of the cases.

12.4 Causes of Locomotor Disability

Table 1.18
Causes of Locomotor Disability (Distribution per 1,000)

Cause	rural	Urban
Cerebral Palsy	48	43
Polio	328	346
Leprosy	30	19
Stroke	29	41
Arthritis	20	19
Cardio-respiratory diseases	4	5
Other illness	112	115
Burns	22	15
Injury other than burns	211	225
Medical/surgical intervention	22	15
Old age	62	49
Not known	60	44
Total	1002	999

Source: Survey of Disabled Persons, NSS, 1991

It would be seen that polio is the cause of this disability in about one-third of cases. Burns and injuries are the cause in nearly one-fourth of the cases. In about 2-3 per cent cases, the cause is leprosy.

13. Degree of Disability

Among the physically disabled, about 25 per cent in rural India and 20 per cent in urban India are observed to be severely disabled as they could not function even with aid/appliances. The corresponding percentage for males in rural and urban India were 23 and respectively. For females, the percentage were even higher-28 and 23 in rural and urban India. The all India pattern by sex and sector is reflected in the states also. The percentage of disabled person who cannot function even with aid/appliances is seen to be highest in the rural areas of Uttar Pradesh (32), Madhya Pradesh (31), Rajasthan (30), etc. and in the urban areas of Himachal Pradesh (31) followed by Uttar Pradesh (29), Bihar 26, etc. Tamil Nadu has recorded the lowest percentage of severely disabled persons in both the sectors-16 and 12 in rural and urban sectors respectively.

Of those who were enrolled once in an ordinary school but were not currently enrolled, 43 per cent are found to have discontinued due to onset of disability in the rural sector. The said percentage was 39 in the urban sector.

14. Marital Status of Persons with Disabilities

It is seen that at the all India level, out of 1000 disabled residing in the rural areas - 383 are never married, 387 are currently married while in the urban areas, the corresponding numbers are 453 and 359. The male-female differences in these proportions are quite significant. The proportion of the never

married and also the currently married among disabled males is much higher than among females in both the sectors. Almost 40 per cent of disabled females in rural India and 36 per cent of disabled females in urban India are either widowed, divorced or separated as against 11 and 7 per cent of disabled males (widowed, divorced or separated) in rural and urban India respectively. At the state level, the differences in the said proportion over sex and sector is observed to be large.

15. Literacy among Persons with Disabilities

In rural India, about 70 per cent of the physically disabled persons are found illiterate as against 46 per cent in urban India. Only about 4 per cent of the disabled in rural India have reported educational level "secondary and above" as against about 12 per cent in urban India. The urban bias in literacy is well known. It is more pronounced in the case of disabled persons probably because of the availability of better educational facilities in general and existence of special schools for the disabled in the urban sector in particular. The pattern of literacy observed at the all India level is also seen in all the major states. Kerala, as usual, has marked the highest literacy level among the disabled also in both the sectors. The lowest literacy level is found in Orissa in the rural sector and in U.P. in the urban sector.

Out of 1000 persons with disabilities living in rural India, only 12 have completed any vocational course. In urban India, a comparatively higher number of physically disabled persons (31) have done so. Of them about 20 to 27 per cent have completed courses in engineering trade and 73 to 80 per cent in non-engineering trade. The state-wise estimates show some in rural sector of the major state) have completed any vocational course. In the urban sector, the highest proportion is reported by Maharashtra (58). On the other hand, the lowest proportion (6 per 1000) is observed in Orissa and Madhya Pradesh in the rural sector and in Haryana (11 per 1000) in the urban sector.

As usual, the current enrolment ratio per 1000 disabled children is found higher in urban than in rural areas - 552 and 458, respectively for the two sectors. The ratio is also higher among males than females in both the sectors.

16. Employment Status

The NSSO Survey established that only 29 percent and 25 percent persons with disability are employed in rural and urban India respectively. Out of these, 60 percent were self employed, 7 percent regular employees and remaining 33 percent as casual labourers in the rural areas. The corresponding percentages were 48, 30 and 22 for the urban areas. Thus the scope for self-employment is much higher in the rural areas, whereas regular employment seems to be comparatively more prominent in the urban areas. The survey also establishes that a little less than 1 percent of persons with disabilities have chosen to begging as their source of livelihood in both sectors.

17. Living Arrangement

The NSSO survey established that 90 percent disabled people lived with their spouse and/or other family members. Whereas only 4 and 6 percent of such persons lived alone in the rural and urban areas respectively. These people did not have any other member in the family to take care of them. Another 4 to 5 percent such people lived with their spouse only. Thus a large majority of persons with disabilities are living with their family members only.

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CONCEPT OF CBR

CBR as a concept needs to be understood in depth. We must be clear that CBR is a strategy and not a mystique, a coordinated approach not a magic, (Vanneste, 1998) not a substitute but complimentary to institutional approach, a way of thinking and not a dogma, a concept, an ideology and a decentralized approach to rehabilitation service delivery.

However, to understand CBR, it is necessary to define and explain three terms: "community", "based" and "rehabilitation". It is important to know the exact meaning and implication of each term and to use them with consistency.

1. Community

1.1 E. Helander's (1992) Definition

A community consists of people living together in some form of social organization and cohesion. Its members share in varying degrees political, economic, social and cultural characteristics, as well as interests and aspirations, including health. Communities vary widely in size and socio-economic profile, ranging from clusters of isolated Homesteads to more organized villages, towns and city districts.

1.2 CBR Working Group (1997) Definitions

In the CBR context, community means a group of people with common interests who interact with each other on a regular basis; and/or a geographical, social or Government administrative unit".

1.3 CAHD Definition (2001)

Douglas Krefting, author of Understanding Community Approaches to Handicap in Development (CAHD, considers community as: "People, their families and the organizations that influence their daily lives."

1.4 Explanation of the Term "Community"

Generally communities are not, in every case, homogeneous or static entities. A "traditional" rural community may not have all its members coming from the same ethnic group, speaking the same language or sharing the same culture and religion. Only some

of these conditions may be present in many rural or marginal urban settlements, and as a consequence a "community spirit" might not be so easy to identify. In such a scenario, it may take longer to get a community response to the call for an effort to show solidarity with persons with disabilities.

In general terms, a community is a sub-set of society but it is larger than a family. It constitutes a group of people, living together in social association, harmony and understanding. The existence, involvement, co-operation, interest and participation of the members of community influences survival, progress, development and welfare of the individuals, directly or indirectly. This group of individuals generally has a common goal, common causes and develops a sense a belonging. They share their views on their political, cultural, economical and social ideology with each other.

A community, usually comprises of: family members, neighbours, friends, co-workers, reference groups or opinion leaders, local administrative authorities, local transport authorities, postman, school teacher, village headman, local revenue officials, nearby shopkeeper, local development agencies, local welfare agencies, and other such people or officials.

1.5 Explanation of the Term "Within Community"

In the ILO-UNESCO-WHO approach to CBR, the phrase "within community development" is understood to be the following strategy recommended by United Nations (Working Group on CBR, 1997):

... the utilization, [in an integrated programme], of approaches and techniques which they rely on local communities as units of action and which attempt to combine outside assistance with organized local self determination and effort, and which correspondingly seek to stimulate local initiative as the primary instrument of change.

The concept "within community" refers to the stimulation of local initiative which may be supported with outside support, advice and specialized inputs for ensuring community empowerment. The approach ensures that what is done at the initiative of community in the name of CBR actually fits into the reality of community and is solely owned by community itself.

O'Toole (1991) goes a step further and advocates that community Involvement in rehabilitation, therefore, is a process which needs to be nurtured and facilitated. It is not simply rehabilitation done at the community level but rather rehabilitation as a part of the process of community development whereby the community seeks to improve itself and that is beginning of community-based rehabilitation in the true sense.

2. Explanation of the Term "Based"

The term "based" connotes that rehabilitation and integration of the disadvantaged individuals is the responsibility of the family and the community. It is necessary for the community to realize that all human beings are of equal worth and are entitled to equal rights, privileges and responsibilities. We need to stress that it is the responsibility of the community to create appropriate opportunities for the complete rehabilitation and acceptance of the disadvantaged into the mainstream of society. The responsibility of caring for disabled persons is ultimately that of his family and community. Whatever Services provided by a specialist or an external agency are by and large need-based interventions and cannot be expected to be permanent in nature.

Ensuring the active participation and support of the community in promotion of comprehensive rehabilitation of its members is imperative due to following factors:

2.1 Foundation of CBR

CBR is founded on the principles of equity, equality, equal rights and social justice. It implies that the disadvantaged groups in a community have the inherent right of availing services and opportunities at par with other individuals. For them, the community is like a backbone, a support system which ensures their wellbeing, survival, growth, progress and complete integration. Community is like the roots of a fruit tree which encourages their active and meaningful participation in all spheres of social life. It is a bridge which connects the disadvantaged individual to a productive social life. CBR implies that persons with disabilities are entitled to at least all such privileges which they would have been entitled to had they not been disabled.

2.2 Importance of Community

Most human impairments are caused primarily by environmental factors such as disease, lack of health care facilities, lack of public awareness, superstitions, wrong treatment, lack of early screening and health check-up services. Thus most of disabilities are acquired and are not necessarily due to the fault of the individual. The family is the right place and community is the perfect base for creating a rightful place for the disabled and enhancing their acceptance as equal individuals in society. The family is the first social unit a disabled individual encounters and it is necessary that this unit accepts him totally and plans for his holistic development.

2.3 Attitude of Community

The Community Based Rehabilitation Development and Training Centre (CBRDTC) in its approach, uses professionals, volunteers and existing institutions in the community to take up a community development programme to integrate people with disabilities into the mainstream. The CBRDTC's approach is based on the understanding that the problems faced by people with disabilities in their daily lives are the result of not only their individual impairment, but also of the attitude and beliefs of the community in which they live. The problems that result from negative attitudes such as lack of social acceptance, lack of opportunities for education and income generation have to be resolved if persons with disabilities are to have equal opportunities and achieve full participation in society. For these reasons, the Centre's programmes are directed towards the whole community as well as the individual members who are disabled (Tjandrakusuma, 1998).

The CBRDTC approach recognizes the importance of integration of Persons with disabilities into the community with the active Participation and involvement of all its members. It also aims to create awareness and change the attitude of the community towards the disabled.

2.4 Rehabilitation - A Continuous Process

A CBR programme initiates the process and provides individual need-based services with the active participation, involvement and understanding of the community. The prime responsibility of the CBR programme is to provide the technical expertise and training in the skills of rehabilitation to persons with disabilities, the family and the community at large. The ultimate objective is that the community is expected to continue providing further training; support services, tangible as well as intangible inputs, and above all, accept the individual in its fold. Rehabilitation is a continuous process and the community take the responsibility of providing services on an ongoing services.

2.5 Use of Community Resources

Looking at community as the foundation of a CBR programme would help to sensitize one to the existence and use of abundant community resources. This would help to utilize resources from within the community and render the programme cost effective, low cost and economical. The cost to a CBR programme would merely be provision of technical support, external expert services and manpower for the promotion of the concept. It is the community that would contribute towards all the tangible and inputs through intangible local resources already available within the community. Some examples are: place for imparting training, local trainers,

raw material for local crafts, shed for income generation activities, marketing facilities, etc.

The interesting aspect is that most community resources are easily available, accessible and affordable. The CBR programme only needs to encourage the community to use these resources for the integration and complete rehabilitation of its disabled members.

2.6 Outcome of CBR Programme

If the community participates in programme planning and its implementation, the CBR approach would be sustainable and would ensure delivery of services forever. It would also ensure involvement, understanding and participation of the community on a permanent basis. It would promote sense of belonging among the Individuals and reduce their dependence on outside inputs and services. It would bring about self-reliance and complete rehabilitation of the individual.

Community has plenty of resources, the desire to support and the Potential to promote appropriate rehabilitation. What it lacks is appropriate information, skills, technology and support system which have to be organized by the CBR programme as inputs and service delivery mechanisms.

3. Rehabilitation

The dictionary meaning of rehabilitation is to "return or restore to previous state or condition". In other words, rehabilitation means to restore an individual to a social, functional and economic status which he or she enjoyed before the onslaught of impairment. It refers to all the measures, which need to be taken to bring the individual to he or his functional capabilities which he possessed before his impairment.

The understanding of rehabilitation needs to be modified in case of congenital by impaired persons or those who were performing such activities which can not now be easily performed due to the nature of activities. In case of congenital impairment, the term rehabilitation signifies restoration of an individual to a functional status which he or she might have attained if he or she were sighted in the same environment or family conditions. In case of such persons who can not perform the activities which they were performing prior to impairment, the term rehabilitation would mean performance of possible activities, which are close to activities being performed earlier. Thus rehabilitation signifies restoration of any individual to previous, probable or possible activities which that person may perform despite disability after certain training, retraining and access to other requisite tangible or intangible inputs.

3.1 ILO's Definition (Recommendation No. 89)

Rehabilitation involves the combined and coordinated use of medical, social, educational and vocational measures for training or retraining the individual to the highest possible level of functional ability.

Rehabilitation in this wider sense involves a number of separate Disciplines and different services: medical, social, and educational.

3.2 Sight Savers' Definition

Rehabilitation is a need-based, goal oriented, time limited process of providing a person with disabilities with the knowledge and skills required, together with the requisite special equipment and training in the use of that equipment, within an individually appropriate time frame, thus empowering him to change his life and to participate actively in his family and community to the fullest extent possible.

3.3 E. Helander's Definition

Rehabilitation includes all measures aimed at reducing the impact of disability for an individual, enabling him or her to achieve independence, social integration, a better quality of life and self-actualization.

Rehabilitation thus includes not only the training of persons with disabilities but also intervention in the general systems of society, adaptations of the environment and protection of human rights. The disabled should have the same rights to a life of dignity as others, and there must be no lapses on this front. (?) . Special attention may be needed to ensure access to healthcare, social services, education as well as work opportunities, housing, transportation, information, culture, social life including sports and recreational facilities, and representation and full political involvement in all matters that concern them.

3.4 Explanation of the Term "Rehabilitation"

In the general sense, rehabilitation encompasses (Kumar, 1997):

- Early detection, diagnosis and intervention.
- Medical rehabilitation, i.e., cure of curable disability and lessening the disability to the extent possible.
- Social, psychological and other types of counselling and assistance.

- Training in self-care activities including mobility, communication and daily living skills with special

- provisions as needed, e.g. for the hearing impaired, visually impaired and the mentally handicapped.
- Provision of technical and mobility and other such devices.
 - Specialized education services.
 - Vocational rehabilitation services including vocational guidance, vocational training, open placement and self employment, etc.
 - Providing all the available concessions, benefits, guidance and counselling.
 - Follow up.

3.5 Outcome of Rehabilitation

All measures that aim at rehabilitation should ensure: skill enhancement, independence, self reliance, self confidence, complete integration and empowerment of the individual. It should result into enhanced quality of life, enhanced work efficiency, gainful occupation and economic independence of the individual. It should enable the individual to lead a normal, productive and contributory life of dignity, respect and social acceptance.

4. Definition of CBR

CBR is an extension of the term rehabilitation with a major difference in the mode of delivery of services and the venue for imparting training and other inputs leading to comprehensive rehabilitation. When the term CBR is expatiated, it means imparting training and providing services to the individual in community itself with the active participation of the family and the community leading to comprehensive rehabilitation.

4.1 WHO Definition of CBR

The World Health Organization (WHO) recognized the need for an innovative delivery system and recommended the provision of essential services and training for persons with disabilities through CBR as part of the "Health for All" campaign. It entails acceptance of two important principles, that:

- It is more important to bring about even small improvements among the entire population than to provide the highest standard of care for a privileged few;
- Non-professionals, with limited training, could provide crucial services.

It defined CBR as:

CBR involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled and the handicapped persons themselves, their families and their community as a whole.

The WHO model of CBR has had a "impairment" bias, focusing largely on the transference of basic rehabilitation technique to community level workers, disabled people and their families. Over time, the definition of CBR has shifted away from an impairment based focus and moved towards "community development." (Chalker & Wirz, 1999)

4.2 WHO, ILO and UNESCO Position Paper on CBR

In 1994 WHO, ILO and UNESCO issued their Joint Position Paper with the following definition of CBR:

CBR is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families and communities, and the appropriate health education, vocational and social services.

This approach to CBR is multi-sectoral and includes all governmental and non-governmental services that provide assistance to communities. Many of the services which can provide opportunities for and assistance to people with disabilities are not traditionally considered relevant to CBR programmes and people with disabilities. Examples include rural development organizations, integrated child development services, agriculture extension services etc. (RICAB, 1997)

This approach moves away from the idea that CBR is somehow a form of "community therapy." According to Chalker & Wirz (1999) is perfectly possible for the services to their geographical location "to the community" but retain identical practice to that which is used in the institutional settings? Apart from a community based therapy; real and actual the true CBR must aim at empowering community disability services. CBR should also include thinking about issues of lives of people with disabilities at all time. The ultimate objective should be to provide access to people with disabilities to all services which are available to other people in the community.

4.3 Modification of the Definition

O'Toole (1991) advocates that there is need to widen the perspective of CBR from being strictly seen as an umbrella of primary health services and move towards encompassing other sectors of community services.

In the context of developing countries, the definition of CBR needs to be modified. It should:

- be cost effective, low cost individual need-based and result-oriented
- result in the complete integration of the individual into

the community.

Once rehabilitated, a person should lead a more productive life, thus helping the community economically.

4.4 Helander's Description

CBR is a strategy for enhancing the quality of life of disabled people by improving service delivery, by providing more equitable opportunities and by promoting and protecting their human rights.

It calls for the full and coordinated involvement of all levels of society: community, intermediate and national. It seeks the integration and intervention of all relevant sectors- educational, health, legislative, social and vocational - and aims at the full representation and empowerment of persons with disabilities. CBR should be sustained in each country by using a level of resources that is realistic and maintainable.

Referral services are needed to cater to those persons with disabilities who need more specialized interventions than the community can provide. There are certain interventions which require medical specialists, para-medical professionals or the services of rehabilitation personnel. These services necessitate the involvement of professionals as all skills cannot be transferred to community volunteers or the family.

4.5 SPASTN Definition

The Southern Region Seminar on CBR convened by the Spastics Society of Tamil Nadu (SPASTN) evolved a definition on CBR:

CBR is a process to bring about a transformation in the community (change in attitude, knowledge and skills), to enable the community members to have a clear understanding of disability services (medical, preventive, psychological, economic, socio-cultural, educational etc.) and to improve the overall quality of life of persons with disabilities.

The focus of this definition is transformation in community and extending disability related services for promoting quality of life. It lays stress on preventive aspects as well as community involvement and participation in promotion of services.

4.6 CBRDTC Definition

The Community Based Rehabilitation Development and Training Centre (CBRDTC) describes CBR as:

A set of efforts to change community behaviours (attitudes, knowledge and skills) to enable community members to improve their understanding about disability issues (socio-economic,

socio-cultural, medical, psychological, etc.) to be involved in disability prevention activities and to provide a positive environment (physical, psychological, socio-cultural, economic, etc.) to improve the quality of life of persons with disabilities (Tjandrakusuma, 1998).

Thus the purpose of CBR programme is to solve problems related to disability, with the involvement, understanding and active participation of community. The CBRDTC understands CBR as a system consisting of several components which can be illustrated as a house with three pillars consisting of:

- First Pillar: Members of the local community with an understanding of disability issues with positive attitudes towards persons with disabilities;
- Second Pillar: Volunteers and others who have specific knowledge of skills in CBR and also have positive attitudes;
- Third Pillar: Individuals and organizations outside the local community who have knowledge and skills in CBR, resources for CBR, along with positive attitudes.

The base represents the community development philosophy which believes in capacity and capabilities of the community. The roof represents the achievements of CBR when the community takes the responsibility of implementation of its own programme. (Tjandrakusuma, 1998).

3.7 CBR Forum Explanation

Today the main goals of rehabilitation have become broader than earlier, and focus beyond the individual, to his community where he is being integrated. Thus the universal mission of CBR may be expressed as:

- To enhance the activities of daily life of the persons with disabilities
- To create awareness and to achieve barrier free environment around him and help him attain equal human rights, and
- To create a situation in which the community participates fully and assimilates the ownership of his integration as client-owner relationship.

4.8 Comprehensive Definition

CBR is a goal-oriented, individual need - based, cost effective and result-oriented strategy of providing time bound and appropriate services within the community, with its active participation, involvement and with fullest use of its

resources. CBR strategy aims at confidence building of the community, bringing out efficiency of individual and promoting active participation, involvement and integration of the individual in community life. It seeks community participation at the planning, execution, management and monitoring of CBR programme. It ensures community's support to protection of human rights, equal participation, social justice, equal participation and complete development of the individual".

5. Characteristics of CBR

Experience gained in various countries confirms the importance of integrating the CBR services into primary health care, education and other developmental services. The level of integration, however, is dependent upon availability of medical and non-medical personnel in the community. CBR is a creative application of primary health care approach, appropriate education and other developmental services in comprehensive rehabilitation programmes. It involves measures taken at community level to use and build on the resources of the community, including the persons with disabilities themselves, their families and their community as a whole. The following characteristics are common to CBR programmes (Wadhwa, 1998):

- To establish the local communities to create awareness about persons with disabilities, recognize their rights and accept at least part of responsibility for their rehabilitation.

- To motivate the local communities to mobilize their own resources - human, material and financial, including persons with disabilities themselves, their families and friends to take an active part in rehabilitation training.

- To organize training for personnel at different levels and to use appropriate training material.

- To deliver services built upon existing community, organizational infrastructure, especially primary health care services.

- To establish a referral network to meet needs which cannot be met locally and work in conjunction with other sectors viz; education, vocational, employment, etc.

- To ensure strong political commitment for the promotion of CBR.

As such, CBR is an integrated rehabilitation programme based on trained community action with appropriate referral support at all levels of national health infrastructure. Similarly, transfer of

skills and technology is the most important step for CBR to succeed.

6. Understanding CBR

The basic concept inherent in the multi-sectoral approach to CBR is the decentralization of responsibility and resources, both human and financial, to community level organizations. In CBR approach, governmental and non-governmental institutional and outreach rehabilitation services must support community initiatives and organizations.

6.1 Multi-sectoral Approach

The Working Group on CBR (1997) considers that the starting point for understanding CBR is the following approach agreed to in 1994 by ILO, UNESCO and WHO:

CBR is a strategy within community development for rehabilitation, equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of persons with disabilities themselves, their families and communities, and the appropriate health, education, vocational and social services.

This approach to CBR is multi-sectoral and includes all governmental and non-Governmental services that provide assistance to persons with disabilities is not traditionally considered relevant to CBR programmes and persons with disabilities. Examples include community developmental organizations, agricultural extension services and water and sanitation programmes.

6.2 CBR Programme Criteria

The CBR Working Group (1997) has proposed the following seven criteria for the development and implementation of CBR programmes:

a. People with disabilities should be included in CBR programmes at all stages and levels, including initial programme design and implementation.

b. The primary objective of CBR programme activities should be the improvement of the quality of life of people with disabilities.

c. One focus of CBR programme activities is to working with the community to create positive attitudes towards people with

disabilities and to motivate community members to support and participate in CBR activities.

d. The other focus of CBR programmes is to provide assistance to people with all kind of disabilities; and for people of all ages, including older people.

e. All activities in CBR programmes should be sensitive to the situation of girls and women.

f. CBR programmes must be flexible so that they can operate at the local level and within the context of local conditions.

g. CBR programmes must coordinate service delivery at the local level. As far as possible, services should be available at the local level in a comprehensive manner. These services may include medical intervention, education & training, provision for income generation, care facilities and prevention of causes of disabilities.

The CBR Working Group (1997) advocates provision of specialized outside services, a comprehensive package of services and its delivery at the local level with the active involvement and participation of community at all level of planning, implementation, management, monitoring and evaluation.

6.3 Outcome of CBR

The goal of CBR is to demystify the rehabilitation process and give responsibility back to the individual, family and community. It should involve the community in the planning, implementation and evaluation of the programme. It is an attempt to generate and enhance in appropriate skills, distribute them where the needs are, by utilizing hitherto unexploited resources in the community (O'Toole, 1991).

CBR programme should restore the functioning and participation of the disabled individual to the normal level. It should grant equitable opportunities of social integration, participation and progress in the normal stream of social life.

The CBR should enable the individual:

- to stay within the fold of the family and contribute towards the family income.
- to function and perform as he used to function and perform prior to disability, that is restoring the fullest use of the senses to compensate for the loss of vision.

In other words, CBR programme is goal-oriented, need-based, and time bound activity which envisages community participation, ensures use of community resources and brings out fullest efficiency of the individual in a cost effective and environment friendly manner, that too within the community.

7. Extent of Coverage

From the experience of implementing CBR programmes for persons with all categories of disabilities at many locations in India, it has been established that a group of eight Field Workers, eight Itinerant Teachers and one Supervisor can easily cover 2000 persons with disabilities in one block or population of 2,00,000 within a period of five years.

It has also been established that the per capita cost of such services is less than Rs.1500 which is one-tenth of the cost compared to institutional programmes. The cost will further decline if the project covers persons with all categories of disabilities.

Thus CBR is the only alternative available at present for the comprehensive rehabilitation of persons with disabilities, particularly in developing countries. The components, technical transfer of skills, training of functionaries, appropriate strategy and coverage of CBR are still a matter of debate. Every CBR agency has a tailor made approach which is designed to meet the needs of that particular region.

8. Components of CBR

Due to cost constraint, commonalty of services, scattered target group and State policy, it is essential that the CBR should:

- a. cover persons of all age groups
- b. be cost effective and result oriented
- c. be realistic and need-based
- d. be in consonance with the State policy
- e. include all aspects of:

- Prevention and cure of curable disability
- certification of incurable disability
- social integration
- integrated education
- economic rehabilitation
- support services and concessions
- advocacy for the rights of persons with disabilities
- acting as a pressure group for influencing State policies
- community empowerment and participation
- use of community resources

9. CBR Service Spectrum

CBR programme for persons with disabilities should encompass all aspects of prevention, cure, rehabilitation, child preparatory services, integrated education, and support services. The nature of services, however, would vary with the type of target group as listed below:

9.1 For the General Population

- a. Health check-up
- b. Child screening
- c. Refraction, audiometry, ENT check-up, psychological assessment
- d. Public awareness
- e. General health care

9.2 For Curable Disabilities

- a. Diagnosis
- b. Physiotherapeutic intervention
- c. Medical treatment
- d. Surgical intervention
- e. Provision of assistive devices
- f. Follow-up

9.3 For Incurable Persons with Disabilities

- a. Identification
- b. Health check-up
- c. Certification of disabilities
- d. Individual assessment
- e. Individual counselling and family counselling
- f. Individual need-based training
- g. Social integration
- h. Integrated education
- i. Economic rehabilitation
- j. Support services and concessions
- k. Community awareness and involvement
- m. Advocacy, counselling and empowerment

In the case of medical rehabilitation, the CBR programme should confine its role to referral to the respective specialist agencies. The integrated education is handled by Itinerant Teachers by admitting children to accredited educational institutes in the same village preferably. Similarly, prevention and cure activities are exclusively handled by the medical professionals.

10. Range of Services under CBR

CBR programme should aim at providing individual need - based services to the general public, persons suffering from disabling conditions and persons with incurable disabilities. The project

will extend to all services which will result in public awareness, prevention and cure of disability and complete rehabilitation of persons with disabilities. The range of services under CBR is:

- a. Identification of persons with disabilities and their needs.
- b. Providing individual need based training.
- c. Encouraging health care agencies to provide health care services.
- d. Promoting integrated education for children with disabilities.
- e. Counselling the parents and creating public awareness.
- f. Involving other developmental agencies in service delivery.
- g. Ensuring economic rehabilitation.
- h. Providing work counselling to facilitate their self-employment.
- i. Enabling them to avail various concessions and benefits.
- l. Creating awareness about the rights of the disabled.
- k. Providing legal advice and creation of self-help groups.

11. Concept of Community Approaches to Handicap in Development (CAHD)

According to Krefting (2001), Dr. Handojo Tjandrakusuma, Executive Director of the CBR Development and Training Centre in Solo, Indonesia started the process of CAHD. The Centre for Disability Development (CDD) developed the concept further with the support of Handicap International and Christoffel Blindenmission. The Community Approaches to Handicap in Development (CAHD) is defined as:

- Community: People their families and the organizations that influence their daily lives.
- Approaches: The two-way relationship within communities that creates knowledge that will change attitudes so that community practices will include disabled persons and provide them with services and assistance.
- Handicap: Not recognizing the existence of disabled persons and people with impairments, their exclusion from society, and no provision of services to meet their needs.
- Development: Including disabled persons in the ongoing process of increasing personal freedom and sharing in a more equitable distribution of the world's resources.

CAHD is an interactive process that enables communities to make the transition from point a to point b. Point a and b are:

- a. The presence of handicap: Not recognizing the existence of disabled persons and people with impairments, their exclusion from society, and no provision of services to meet their needs.
- b. To the absence of handicap: Recognition of the existence of disabled persons and people with impairments, the inclusion of

these people in society, and the subsequent provision of services to meet their needs.

In this approach, people with disabilities are central to the effective development of CAHD. Changing attitudes to eliminate handicap requires an active interchange between disabled and non-disabled persons. This interchange is an interactive process that will enable both parties to change so that handicap can be eliminated. It is this process of enabling, both disabled and non-disabled persons, that will ensure that services and assistance will get provided and the inclusion of the disabled will happen.

12. Need for CBR

12.1 The Existing Scenario

On analysis of the existing scenario of demographic pattern of visual impairment in the country, the following observations can be made:

- In majority of cases, visual impairment is adventitious and its on-set takes place predominantly after the age of 45 years.
- Prevalence rate is the highest in the age group 60 & above and the lowest in the age group 0-4 years. It rises steadily with the increase in age both in the rural as well as urban areas. It is higher in the rural as compared to urban areas for all the age groups.
- Incidence rate is the highest in the age group of 60 & above and the lowest in the age group of 5 to 39, it is higher in rural areas (25) as compared to urban areas (20).
- As females constitute 53.89 percent of the population of the visually impaired, incidence of visual impairment among females is comparatively higher.
- As distribution of visual impairment is relatively more in the rural areas (83.69%), their population is predominantly rural.
- Rehabilitation centres are few, confined to urban areas and cover a few hundred people in the working age group 16-35 years.

12.2 Limited Coverage of the Existing Programmes

At present the existing special schools in India, cover only 25,000 and integrated education programmes cover 12,000 visually impaired children. Even if special education is extended to all visually impaired children of the school going age (which is

never going to be possible), the coverage would be only 6 percent of the total population of the visually impaired.

The existing vocational as well as on-the-job training centres at present cover a mere 8,000 visually impaired persons. The existing trades are urban-oriented and do not necessarily lead to employment.

12.3 Least Preference to the Visually Impaired

Most of the rehabilitation programmes aimed at the comprehensive rehabilitation of all categories of persons with disabilities are largely for the locomotor handicapped only. The coverage of the visually impaired in the following programmes has been almost negligible:

- Vocational Rehabilitation Centres and Special Employment Exchanges under the Ministry of Labour;
- District Rehabilitation Centres Scheme, Scheme of Community Based Rehabilitation, Scheme of Aids and Appliances for the Persons with Disabilities under the Ministry of Social Justice & Empowerment;
- Scheme of Integrated Education of the Disabled Children under the Ministry of Human Resources Development; and
- Disability Strategy under Council for Advancement of People's Action and Rural Technology.

12.4 Lack of Social Security Measures

Most developing countries have not yet introduced social security measures for assuring a minimum standard of living for persons with disabilities. Some State Governments have introduced disability as well as old age pension schemes. Due to limited budget allocation, cumbersome procedures, lack of public awareness, and lack of an effective delivery system, the coverage has been limited. The PWD Act, 1995 has also made no reference to social security measures for such persons. A visually impaired person is normally therefore cared for by his family members and the community.

Thus the majority of persons with disabilities have no access to rehabilitative, curative or support services under the existing pattern and nature of services. It is desirable to explore alternative avenues of reaching millions of such unreached persons. Considering these observations, the most realistic and practical solution to the problem of rehabilitation is introducing individual need-based, cost effective and rural based rehabilitation programmes.

12.5 CBR: Only Viable Alternative

Keeping in mind the concentration of persons with visual impairment in the rural areas, the late on-set of visual impairment, the exorbitant costs of setting up and maintaining an institution, and the inherent limitations of an urban based institution, the only viable alternative is a programme which can reach out and provide need based services to such persons of all age groups and yet be cost effective.

12.7 CBR - A Movement

All the initiatives and programmes discussed in this chapter clearly establish that CBR is no more a pilot project or a programme to reach the unreached. It is now, slowly but steadily, emerging as a movement for promoting comprehensive eye care and rehabilitation of persons with eye problems or visual impairment. The achievements and efficacy of existing CBR strategies establishes that the only way of reaching out to the unreached persons in rural areas is to initiate and implement CBR for persons with disabilities. For the developing countries, comprehensive CBR is not a matter of choice but a compulsion. While components, implementation plan, monitoring procedures and level of community involvement in the CBR approach may be graded options - the CBR approach per se is the only alternative available at present to reach the unreached millions of persons with disabilities in these countries.

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CBR: A HISTORICAL PERSPECTIVE

1. Historical Background

At the time of inception, rehabilitation services primarily focused on the urban persons with disabilities as their main beneficiaries. Welfare programmes began in the cities and gathered both strength and momentum in the urban context. With the passage of time, experts all over the world realized that concentrating on services mainly in the cities resulted in lop-sided development - the result being that the rural disabled population did not benefit from the fruits of rehabilitation efforts. Over time and with the advancement of services, secondary data started becoming available. The findings of this data were alarming - nearly 84 percent of persons with disabilities in developing countries lived in rural areas. Factual data shows that the majority of such persons were aged and thus not physically equipped to avail of training in urban training institutions.

During early 1980's Experts started to think critically. They concluded that the policy to attract rural persons with disabilities to the cities was incorrect as the cost of living there was high and cheap accommodation was impossible to get. More so, an urban-based training would be of little use to rural persons after they return back to their villages.

It was also increasingly felt that westernized urban industrial Training was not suitable for the rural disabled. Millions of such persons all over the world cannot be rehabilitated effectively by a few hundred urban institutions. Thus began a shift in approach - a few rural programmes were started by St. Dunstons, the Vocational Rehabilitation Office in the U.S.A. and the Sight Savers International in Africa but the turning point came when the Uganda Foundation for the Blind started a rural centre in 1954.

2. Action by International Agencies

This section charters the process of constructive steps taken by international agencies towards CBR.

2.1 World Council for the Welfare of the Blind

In 1954 at the first General Assembly of the World Council for the Welfare of the Blind, a resolution for the training and readjustment of rural visually impaired was advocated by Sir Clutha Mackenzie and backed by Sir John Wilson of the Sight Savers International and Capt. H. J. M. Desai, former Secretary

General of the NAB. Thereupon, the Assembly unanimously adopted the following resolution:

The World Council for the Welfare of the Blind believes that the fundamental training and re-adjustment of indigenous rural population should be primarily effected with due regard to their vocational and community background and in the case of newly visually impaired atleast to their past employment(usually as small holders and village craftsmen and in the case women as domestic rural workers) by providing training centres for these specific purposes, instead of concentrating them in cities and towns to be employed in sheltered workshops.

2.2 Asian Conference: Work for the Blind

The first Asian Conference on Work for the Blind was held in Tokyo, in 1955. It endorsed the World Council approach and passed the following resolution:

The conference, recognizing that the majority of the visually impaired in this region come from agricultural Communities, recommends that increased attention be paid by Governmental and other agencies to the location of suitable avenues of employment of the visually impaired who reside in rural areas and introduction of educational and Vocational and training services geared towards the Resettlement of the visually impaired in such areas. Special attention is drawn to the pilot scheme now being conducted in Uganda.

These resolutions were instrumental in setting up several rural training centres for the visually impaired. However, due to economic constraints, it was not possible to set up the requisite number of rural centres for the visually impaired. So the solution was to train and rehabilitate the visually impaired in their own homes through a community based system of delivery of services.

2.3 World Health Organization

The idea of CBR was mooted by the World Health Organization (WHO) when the technical report of WHO of and 1969 suggested that Rehabilitation services must be considered as a important and essential part of health care services. They also suggested that developing countries should have a cost-efficient substitute to institutional care.

CBR as a fundamental concept within International Health was established by WHO in 1978 in response to the recognition of the fact that financial and professional services were inadequate to address the overwhelming disability needs in developing countries. CBR was intended to reach the maximum of people possible in the most cost-effective and culturally appropriate way. CBR based projects were intended to build partnerships between rehabilitation personnel, communities, families, and most importantly, with the persons with disability. The idea was that such partnerships would form a conduit for the transfer of skills and knowledge at the grass-root level of communities.

The World Health Organization (WHO) published a manual entitled "Training in the Community for People with Disabilities." Its subsequent versions were revised and published during 1980, 1983 and 1989. This Manual has been used in about 60 countries and has been translated partly or entirely into about 30 languages. The Manual advocates that rehabilitation provided in institutions generally does not involve the communities in which the people with disabilities live. For rehabilitation to be holistic and successful, communities must recognize and accept that people with disabilities have the same rights as other human beings. This usually will require a significant change in attitude among all members of the community. And the most effective way of bringing about such a change in attitude is for members of the community to take on the task of rehabilitation. Empathy is one of the key drivers for attitudinal change.

The 1989 edition of the Manual contains 34 modules and 30 training packages for all categories of disabilities and for all level of functionaries. It also includes guides for local supervisors, community rehabilitation committee, people with disabilities and schoolteachers. It has training packages for seven types of disabling conditions: persons with difficulty in seeing, difficulty in hearing and speaking, difficulty in moving, difficulty in feeling, strange behaviour, fits and learning difficulty.

This Manual has been very extensively used all over the world. It has played a very significant role in the promotion of CBR as a concept and its application.

2.4 International Year for the Disabled Persons

Policy milestones in rehabilitation were directed towards being rural-centric, poor-centric, vocation centric and most importantly the disabled should not be isolated but integrated into society like any other abled person.

The United Nations General Assembly declared 1981 as the International Year of Disabled Persons (IYDP). Its plan of action

also concentrated on rural resettlement and the following guidelines were issued in Section 12(m):

To review the services and benefits to ensure that these assist and encourage disabled people to remain and/or become a integral part of the society wherein they live, rather than bring about segregation and isolation.

2.5 ICEVI Conference

The Third Asian Conference of the International Council for Education of the People with Visually Impairment held at Jakarta, Indonesia, in November 1981, in its Resolution No. 6 states:

That more community based training programmes for visually handicapped persons be developed in view of the fact that the vast majority of them live in rural areas, this should be based on survey of wage earning activities and task analysis in order to assimilate them into the rural Economy within their own environment.

2.6 United Nations' Concern for Persons with Disabilities

The World Programme of Action Concerning Disabled Persons adopted by the UN General Assembly by resolution 37/52 on 3 December 1982 encourages Member States, within the context of available resources, to initiate whatever special measures that may be necessary to ensure the provision and full use of services needed by disabled persons living in rural areas, urban slums, and shanty towns. Regarding employment, it emphasizes:

Member States should adopt a policy and supporting structure of services to ensure that disabled persons in both urban and rural areas have equal opportunities of productive and gainful employment in the open labour market. Rural employment and the development of appropriate tools and equipment should be given particular attention.

2.7 ILO's Historic Convention

Articles 8 and 9 of the ILO Convention (No. 159) and Recommendation (No. 168) concerning Vocational Rehabilitation and Employment (Disabled Persons), 1983, emphasize vocational rehabilitation of the rural disabled:

Measures shall be taken to promote the establishment and development of vocational rehabilitation and employment services for disabled persons in rural areas and remote communities. Each Member shall aim at ensuring the training and availability of rehabilitation counselors and other suitably qualified staff responsible for the vocational

guidance, vocational training, placement and employment of disabled persons.

Article 20 and 21 of the ILO recommendation concerning Vocational Rehabilitation and Employment (Disabled Persons), 1983, outline the following appropriate measures to be taken in this regard:

Particular efforts should be made to ensure that vocational rehabilitation services are provided for disabled persons in rural areas and in remote communities at the same level and on the same terms as those provided for urban areas. The development of such services should be an integral part of general rural development policies.

To facilitate this end, result, measures should be taken appropriate to:

- a. Designate existing rural vocational rehabilitation services or, if these do not exist, vocational rehabilitation services in urban areas as focal points to train rehabilitation staff for rural areas;
- b. Establish mobile vocational rehabilitation units to serve disabled persons in rural areas and to act as centres for the dissemination of information on rural training and employment opportunities for disabled persons;
- c. Train rural development and community development workers in vocational rehabilitation techniques;
- d. Provide loans, grants or tools and materials to help disabled persons in rural communities to establish and manage cooperatives or to work on their own account in cottage industries or in agricultural, crafts or other activities;
- e. Incorporate assistance to disabled persons into existing or planned general rural development activities;
- f. Facilitate disabled person's access to housing within reasonable reach of the work place.

These valuable guidelines of the UN and the ILO exhibit vision, concern and a very deep involvement at the highest International policy level in vocational rehabilitation, training, employment, resettlement, and integration of the rural disabled, including the rural visually impaired. These instruments convey momentous decisions of a historical nature. Their effective implementation would become milestones in the total rehabilitation and integration of the disabled.

2.8 Position Paper on CBR

WHO, joined by its sister organizations, the ILO and UNESCO, have pioneered CBR as the most viable strategy to meet the global challenge of disability. This partnership has now been formalized in a joint position paper on CBR (ILO/UNESCO/WHO, 1994). The concept of CBR enlarges the concept of rehabilitation to include all of the services that assist people with disabilities to develop their abilities.

2.9 ESCAP Declaration

The Social Development Strategy for the ESCAP Region Towards the Year 2000 and Beyond was adopted by the Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development, held at Manila in October, 1991. The Strategy has the ultimate aim of improving the quality of life of all the people of the ESCAP region. With that aim in mind, the basic objectives of the Strategy is the eradication of absolute poverty, the realization of distributive justice and the enhancement of popular participation. Within the framework of these aims and Objectives, the Strategy assigns priority to the region's disadvantaged and vulnerable social groups, including persons with disabilities.

To further to the concerns of persons with disabilities in the regional Social Development Strategy, thirty-three countries attending the forty-eighth ESCAP session in April 1992 joined in sponsorship of resolution 48/3 on an Asian and Pacific Decade of Disabled Persons, 1993-2002. In adopting the resolution, the Governments of the region expressed their collective commitment to the full participation and equality of people with disabilities.

The proposed agenda for action also envisaged development of community-based approaches as a means of improving access to Rehabilitation services, through:

- a. Provision of policy, institutional and financial support.
- b. Adaptation of existing manuals to meet the needs of communities in diverse cultural, linguistic, and economic contexts.
- c. Increase of training of field workers for work in slums and rural areas.
- d. Strengthening of the referral system, focusing on the first referral level.

e. Support for people with disabilities and their advocates to initiate and develop community-based rehabilitation (CBR) activities.

f. Training of advocates and household members in basic Rehabilitation techniques.

g. Use of experience gained from the self-help movement of people with disabilities to extend CBR services to persons with mental disabilities.

h. Conduct of research, evaluation and information exchange.

2.10 ICEVI - Asia Region Conference

The International Council for Education of People with Visual Impairment (ICEVI) convened the Asia Region Conference with the theme "Reaching the Unreached" at Ahmedabad during 9-11 January, 1995. The Conference adopted a Plan of Action which emphasized promotion of community based rehabilitation in the Asian Region. The Plan of Action included:

It is felt that the goal of achieving community based rehabilitation for all persons with visual impairment by the year 2000 A.D. is no longer feasible. ICEVI, therefore projects a target to multiply the present coverage by atleast four times in Asia Region. Since the CBR programmes facilitate the services relating to identification, referral and early intervention for children with visual impairment, it is essential that there is effective interaction between CBR and education programmes.

Like in education, a uniform service delivery model cannot be adopted to provide CBR services. ICEVI strongly emphasized that minimum standards are assured in the services provided to the clientele as well as the training to field workers.

3. Indian Initiative

A large number of leading NGOs realized, during the early 1980s, that non-institutional rural projects for persons with disabilities were indispensable. A large number of NGOs developed, presented, implemented and perfected nation-wide programme on promotion of CBR. The major Indian initiatives include:

3.1 PL-480 Project

A Rural Rehabilitation Centre for the Blind was started during 1973 at Madurai with the financial support from PL-480 grant of the U.S.A. The Centre was established under the guidance of renowned experts Major Bridges and Mr. Robert C. Jaekle from the

American Foundation for the Blind, U.S.A. (now known as Helen Keller International).

3.2 Christoffel Blindenmission (CBM's) Initiative:

Mr. Robert C. Jaekle, truly the Father of CBR, joined the Christoffel Blindenmission and initiated a rehabilitation programme for the rural visually impaired in Tiruchirapalli District of Tamil Nadu. He also established a training centre at Musiri for the training of CBR field functionaries.

3.3 NAB RAC Project

During 1981, Capt. H. J. M. Desai, Chairman, Rehabilitation, Training and Employment Committee of the World Council for the Welfare of the Blind, in his book Planning Employment Services for the Blind in the Developing Countries, strongly recommended an organizational set-up, to be formed, which could effectively spread the concept of training, rehabilitation, and resettlement of the visually impaired in their rural surroundings. He also strongly advocated the formation of a Rural Activities Committee in every developing country under aegis of the national level voluntary agency for the blind, which could perform the task of initiating and coordinating such programmes.

A nation-wide project called "Social and Economic Rehabilitation of the Rural Blind" was promoted by the Rural Activities Committee (RAC) of the National Association for the Blind (NAB) during 1983 with the support of the then Royal Commonwealth Society for the Blind (now renamed Sight Savers International). The programme was subsequently modified and promoted as Comprehensive CBR Project for the Visually Impaired. This project was implemented by various agencies all over India and received support from a large number of funding and developmental agencies like:

- Sight Savers International
- DANIDA
- NORAD
- OXFAM
- Helpage International
- South Asia Partnership
- World Blind Union
- Ministry of Social Justice & Empowerment
- L.D. Jhaveri Foundation
- Shri Manav Kalyan Trust
- National Institute for the Visually Handicapped
- State Bank of India
- Department of Social Justice & Empowerment
- Raj Shobhag Ashram

The NAB RAC followed a following process for evolving the concept of CBR and developing it as a national movement, this process was:

3.3.1 Review of Existing Projects

The NAB RAC first decided to review the several existing programmes to design a project most suited for the rural visually impaired. Team members of the NAB RAC visited several rural projects including the "Rehabilitation for the Rural Blind - Musiri Extension Project" implemented by the South Asia Regional Office of the Christoffel Blindenmission in Tamil Nadu. The project aimed at prevention and cure of visual impairment and imparting training in orientation & mobility, daily living skills, home economics and vocational training to the incurably visually impaired. To achieve these objectives, a team of local Field Workers were imparted training in these skills at Musiri.

The NAB RAC officials also visited the Tata Agriculture Training Centre at Phansa in Gujarat and the Rural Mobility Training Centre at Bandung in Indonesia. They compiled literature on rehabilitation of the rural visually impaired, discussed various issues with Capt. H. J. M. Desai, Chairman of the NAB RAC, with Mr. Robert C. Jaekle, a renowned Mobility Instructor and Initiator of projects on rehabilitation of the rural visually impaired and other specialists in the field. The Musiri approach to rehabilitation at the doorsteps of the rural visually impaired was found to be the most appropriate and effective.

3.3.2 Modification of the Approach

The Musiri Rural Rehabilitation Project considered imparting of vocational training as the ultimate objective, with the family to provide further inputs for achieving economic rehabilitation. The NAB RAC, however, emphasized the need for promoting economic rehabilitation of the visually impaired as the ultimate objective. It also stressed on keeping the project cost low and thus decided not to make investment in infrastructure and capital intensive items. Thereafter, a nation-wide project called "Social and Economic Rehabilitation of the Rural Blind" was developed and presented to the then Director of the Sight Savers International, Sir John Wilson, and the Overseas Director, (late) Mr. Alan Johns. Both showed keen interest in the project, and two projects were financed on a pilot basis.

The first pilot project was initiated in 1983 at Dholka, a backward block of District Ahmedabad in Gujarat. The project was started under the auspices of the Indian Red Cross Society with Mr. Gautam Majumdar, known for his successful mission on eye donation, as Joint Project Director. The project has now become famous as a model of rural rehabilitation and is widely known as the Dholka Project. The second pilot project was initiated at Chikballapur in Karnataka with NAB Karnataka Branch as the Project Implementing Agency and Mrs. Ratna Atmaram Rao as the Joint Project Director.

3.3.3 Expansion of Scope

In the years 1983 to 1986, rural rehabilitation projects had four main aspects. They were:

- a. Prevention and cure of blindness
- b. Social rehabilitation
- c. Economic rehabilitation
- d. Support services

During 1987, it was realized that integrated education is a major Issue and that it must be included as a component of the project. The NAB RAC involved the NAB Department of Education to initiate and monitor this component. Integrated education thus emerged as the fifth component of the project.

- e. Eye screening and eye check-up

Subsequently, it was observed that it was essential to carry out eye screening of school children and the population as a whole to establish the backlog of eye treatment and eye surgeries. As prevention and cure of blindness were already components of the project, eye check-up and eye screening were also included as components to enhance the services in this respect.

- e. Integrated education

Thus approach to the the CBR project is comprehensive and it encompasses all components of eye screening, eye check-up, integrated education, social rehabilitation, support services and economic rehabilitation. The concept evolved and was developed by the NAB RAC. It covers all aspects of prevention & cure, appropriate education, social integration, gainful occupation, income generation and support services.

3.4 District Rehabilitation Centres Scheme

In January 1985, the Government of India launched District Rehabilitation Centre (DRC) Scheme on a pilot basis. The pilot project, started in collaboration with the National Institute of Disability and Rehabilitation Research (NIDRR), US Department of Education and UNICEF, aimed at providing a package of model comprehensive rehabilitation services to the rural visually impaired. The objectives of the Scheme were to:

- a. Create awareness that the disabled could be productive if given opportunities and support.

b. Help the disabled persons cope with concerns of day-to-day living and relieve family members of the burden of constantly taking care of them;

c. Establish a comprehensive model of rehabilitation services including

- Medical intervention,
- Education,
- Vocational training
- Employment

d. Promotion of voluntary efforts in the area of rehabilitation, and,

e. Creation of a cadre of multi-disciplinary professionals.

This scheme was launched in eleven different districts in India.

The Indian Institute of Health Management, Maharashtra evaluated the programme during 1989. The evaluation team was headed by Dr. Nirmala Murthy of the Indian Institute of Management (IIM), Ahmedabad.

The DRC Scheme did have considerable impact, according to the evaluation report, although there are many areas of deficiency which could be improved upon. Although the programme had been 'community located', it had not been 'community based'.

3.5 District Blindness Control Societies

India has had a National Programme on Control of Blindness since 1963. To begin with, the major focus of this programme was prevention and cure of trachoma and provision of vitamin A for prevention of Xerophthalmia. After the national survey of 1971-74 established that cataract caused almost 55 percent of blindness, cataract became the major focus of this programme. The major emphasis of the programme was on expansion of infrastructure and training of human in eye care with the objective of capacity building for cataract surgery. The programme was started with the objective to reduce the prevalence of blindness from 14 per 1000 in 1975 to 3 per 1000 by the year 2000.

The District Blindness Control Societies have been established since 1993 to promote eye care at the grassroots level. These societies seek better participation of local administration, Government departments, viz. social welfare, education and information. The main objective behind this initiative is to bring eye-care in the mainstream of society and bring about inter-sectoral cooperation. There is a scope for active

participation of NGOs devoted to eye care, CBR and rural development.

The rehabilitation of the incurably visually impaired people will include:

- Mobility training of the visually impaired
- Economic rehabilitation of the young visually impaired people
- Education of the visually impaired children in regular schools
- Community education about the specific needs of the visually impaired persons

The District Programme Manager (DPM), a key functionary in the DBCs set up is expected to perform the following functions in respect of promotion of community based rehabilitation in the area of coverage:

a. Identify a suitable project implementing agency as per the details given above.

b. This agency should be assisted to avail financial assistance for the implementation of CBR project in the area. At present such assistance is available. The District Collector would be over all in charge of this scheme.

There is tremendous increase in allocation of financial resources by the Government for promoting eye care services. International support for this purpose has also increased manifold, initially from DANIDA and WHO, and recently a large loan from the World Bank. These national efforts are being augmented by multi-million assistance from the World Bank in seven states of the country over a period of 1994 to 2001. As a result of these efforts and resource allocation, the total number of cataract operations increased from 1.2 million during 1989 to 2.7 million during April 1996 to March 1997 (Limburg, 1999), but this is still inadequate to clear the backlog.

A rapid assessment of cataract blindness and surgical coverage in the seven World Bank assisted States conducted during 1998 established that in most States, the prevalence of blindness had decreased as compared to situation during 1996. The prevalence, however, continues to be higher in females as compared to males, though figures show that the utilization of cataract surgical services has increased among women.

The District Blindness Control Society (DBCS) is the first systematic attempt on promoting comprehensive eye care which encompasses CBR along with eye screening, eye treatment, eye surgeries and prevention of visual impairment. Now, health oriented programmes have also now started recognizing the need for promoting CBR as a part of comprehensive health care approach.

3.6 CBR Network

Estimates show that there are over 800 organizations promoting CBR for persons with disabilities in India. The CBR Network, a Platform set up as a result of a workshop on CBR sponsored by NORAD in September 1992 got later converted into a legal entity in 1997. The objectives of the National CBR Network are:

- to document, in India, CBR approaches, methodologies, and Public policy in favour of CBR,
- to publish a CBR Frontline Digest for workers at the grassroots level,
- To share and disseminate information regarding CBR in a Partnership market,
- To influence public policy in favour of CBR, and
- To establish a database on CBR.

The CBR Network has divided India into four zones - North, South, East and West and leading disability development organizations have been entrusted the responsibility of promoting networking and disseminating information. For further details, see;

Website: <http://www.cbrnet.com>

E-mail: cbrnetwork@vsnl.com

3.7 Rehabilitation Council of India

Training is integral to rehabilitation processes. In the last two decades, several courses for training of physiotherapists, occupational therapists, prosthetic and orthotics engineers, CBR workers, special educators and other personnel have come into being. But it has been noticed that there is complete lack of uniformity in the syllabi offered by various institutions and organizations. The National Advisory Council for Welfare of the Handicapped felt that uniformity in syllabi is important and should be achieved. In pursuance of one of the recommendations of the National Council, the Government of India initially set up the Rehabilitation Council of India by a Government resolution. Subsequently an Act of Parliament was passed setting up the Rehabilitation Council of India in 1992. The Act came into force from July 1993.

The main purpose of the Council is to standardize the syllabi for training of various types of professionals needed in the field of rehabilitation. It also would register those who work in the Field of rehabilitation with a view to ensure that only qualified people render the services to people with disabilities.

Apart from these functions, the Council has also been trying to undertake programmes of continuing Rehabilitation Education so

that the country has a reservoir of trained people who could impart the best possible training to children and adults with disabilities. The object of the programme is to ensure that the knowledge of rehabilitation professionals is updated from time to time so as to provide the best possible service to people with disabilities.

Till date, a huge knowledge base has been developed in CBR which has yet not been fully disseminated to rehabilitation professionals. The Rehabilitation Council of India feels that it is utmost necessary that the knowledge and skills of professionals must be reinforced and updated with modern concept of CBR and its practice. It is therefore, proposed that the First Continuing Education Programme under the banner of the Rehabilitation Council of India should be on updated CBR - its concepts, technology and application.

Methodology : The Continuing Rehabilitation Education Programme on community based rehabilitation has to be developed in two modules:

Module I: Development of resource persons to form regional CBR faculty . The national resource persons would be identified from across the country with at least five persons from each region.

Module II: Development of resource persons to form regional CBR faculty of resource persons for different regions viz. East, West, South, North and central regions. The regional resource persons would be identified from the respective regions with at least 5 persons from each State or Union Territory included in the region. There should be proportionate distribution among different categories of disability.

As a part of the Continuing Education Programme, the Rehabilitation Council of India organized the first expert group meeting on "Updated CBR - its Concepts, Technology and Application" on 29-30 March 1995 at Amar Jyoti Charitable Trust, Kakardooma, Vikas Marg, Delhi. The objective of this meeting was to form the national CBR faculty of resource persons. On successful completion of expert group meeting (Module), the Rehabilitation Council of India decided to organize regional training workshops in different regions. The first regional training workshop was organized at Ahmedabad during 28-29 April 1995. This would be followed by similar workshops in three other regions.

As part of its Scheme of Bridge Courses, it has covered CBR professionals for completing bridge courses and seeking its registration.

Website: <http://www.rehabindia.com>

E-mail: rehabstd@nde.vsnl.net.in

3.8 National Policy for the Disabled

The Ministry of Social Justice & Empowerment convened a National Conference on Welfare of the Disabled during 20-22 September 1993 to discuss various aspects of disabled welfare. The last session of the workshop was devoted to finalizing a National Policy Document for the disabled where it was unanimously resolved that a separate scheme of CBR for the disabled persons in the rural and backward areas already evolved by the Ministry of Welfare should be adopted and implemented. Till this scheme is formally adopted, CBR projects would be funded by the Ministry under the existing scheme of "Assistance to Voluntary Organizations for the People with Disabilities".

3.9 Pilot Project on Medical Rehabilitation

The Ministry of Health, Government of India launched a Pilot Project on Medical Rehabilitation on 22nd November 1995 with the all India Institute of Physical Medicine & Rehabilitation as the Nodal Implementing Agency with emphasis on provision of rehabilitation services through primary health care.

The main objective for inclusion of CBR in the Health Care Delivery Services are:

- Prevention of disability causing disorders
- Early detection of disability causing disorders
- Early medical intervention
- Early rehabilitation intervention
- Capacity building of different centres from peripheral to specialized centres
- Training of human required for service delivery, teaching and research activities at different levels
- Equipping/strengthening Primary Health Centres (Wadhwa, 1998)

The rationale for incorporating CBR into health care system is that instead of creating another large vertically structured CBR Programme, it appears logical to train the existing health care Personnel in different aspects of CBR by equipping them with the knowledge and skills and better equipping all components of Health Care Delivery System in a phased manner, spread over a decade or more, throughout the country.

3.10 Persons with Disabilities Act, 1995

On 22 December 1995, the last day of the Winter Session of the Parliament, all the political parties for the first time during this session unanimously consented to consider non-official business and the result was the unanimous passing of "Persons with Disabilities (Equal Opportunities, Protection of Rights & Full Participation) Act, 1995. The President of India gave his assent to the Act on 1 January 1996 and it came into force with effect from 7 February 1996.

The main objectives of the Act are to spell out the responsibilities of the State towards the prevention and early detection of disabilities and recognition of the rights of persons with disabilities to enjoy equality of opportunity and full participation in national life.

Apart from the objectives of preventing the occurrence of disabilities, access to free education, reservation in vacancies, provision of aids and appliances, allotment of concessional land and non-discrimination in transport on road and built environment, the Act also envisages promotion and sponsor of research and manpower development programmes on various aspects including CBR.

The Act thus recognizes and endorses the need for promoting research as well as development of human resources in the areas of rehabilitation, including CBR. The section on education desires the appropriate governments to promote integration of students with disabilities into in the regular schools.

3.11 CAPART Initiative on Disability Strategies

The Council for Advancement of Peoples' Action and Rural Technology (CAPART) convened a national consideration at New Delhi in February 1995 as part of implementation of the Proclamation and Agenda for Action for Asia and Pacific Decade of Disabled Persons. This initiative sought to address a serious concern regarding the poor coverage of rural people with disabilities by the existing services, and the need for special efforts to be made to enable them to participate in rural development programmes.

Based on this consideration, CAPART has developed a strategy to promote the participation of people with disabilities in programmes for rural development. As part of this "Disability Strategy", CAPART will extend support to non-Governmental organizations whose project proposals are in consonance with the overall thrust and guiding principles of this Strategy, and which

will further its implementation. The focus area of the Strategy include:

a. Social mobilization

- Organization building
- Development of training and information materials
- Programme support

b. Capacity building

- Training of development workers
- Development of training packages and information materials
- Development of community based support services

c. Rural infrastructure development

- Innovations in eliminating physical barriers in the rural built environment
- Removing barriers in the work place
- Dissemination of barrier free designs

d. Indigenous technologies

- Identification and dissemination of low-cost indigenous technologies
- Development of information materials on assistive devices
- Promotion of measures for accident-prevention and safety
- Training workshops and exchange visits
- Evaluation and adaptation of existing technologies

e. Networking

- Initiating and supporting rural community networks

3.12 CBR Forum

The CBR Forum for Persons with Disabilities was constituted by Miseoreor, a German funding agency during 1996. It is a Programme Unit of Caritas India, its legal holder. Its mission is to play a proactive and promotional role in CBR of persons with disabilities in India, ensuring wide coverage with focus on the disadvantaged groups such as the poor, women and people living in rural areas and urban slums.

The CBR Forum encourages and supports appropriate organizations, programmes and projects for CBR but it does not implement the activity itself. It also supports measures on prevention of disabilities, appropriate training, creation of public awareness, networking, advocacy, innovations and research in issues pertaining to CBR.

The vision of the CBR Forum is that people with disabilities have equal opportunities leading to improved quality of life and fully participate in a society that respects their rights and dignity.

The CBR Forum is emerging as a leading source of funding for various CBR projects.

3.13 CBR Scheme of the Ministry

The Scheme to Promote Voluntary Action for Persons with Disabilities evolved during 1998 by the Ministry of Social Justice & Empowerment, Government of India, provides grant-in-aid to voluntary organizations for the promotion of CBR. The Ministry extends financial support for the following manpower (Ref. No. 21(25)/98-DD-II):

- Rural Rehabilitation Volunteers
- CBR Personnel or Multi-rehabilitation Workers
- Social Workers
- Specialists - Therapists and Educators
- Voluntary Workers
- Project Coordinators/Directors

This is first time that the Ministry of Social Justice & empowerment has given due recognition to the concept of CBR in its major grant-in-aid scheme.

3.14 Bridge Course for CPR Workers

According to the Rehabilitation Council of India, the use of expression CBR is improper due to following reasons:

- Communities are very poor
- People cannot take financial responsibility for the programmes
- Difficult for the community to take initiative in a developmental programme.
- During the day, most people in the village are away in the field, hence their involvement is not possible.

As the participation of community in the rehabilitation programme is crucial, the RCI has renamed the programme as "Community Participatory Rehabilitation" and has launched the Bridge Course for CPR Workers.

Objectives of the Bridge Course are:

- To involve the community in all activities of rehabilitation.
- To mainstream people with disabilities in village community.
- To enhance self esteem and guidance of people with disabilities with the involvement of community.

- To engage experts to visit rural areas to offer appropriate assistance and guidance.

Duration: One-month (6 days a week, 24 days) i.e., 145 hours.

Eligibility: Any person who has completed minimum 8th standard and has worked in rural areas for a minimum period of three years.

The Rehabilitation Council of India will provide Registration Certificate to all those people who complete this course as Rehabilitation Personnel. This is a bold step in the right direction as it will provide credibility to the field workers and the concept of CPR.

3.15 CBR Training Modules

To standardize training of CBR volunteers, workers and coordinators, the Rehabilitation Council of India has evolved and adopted 3 training courses:

- a. Training for CBR Volunteers - one month duration
- b. Certificate Course for Multi-purpose Rehabilitation Workers - three months duration
- c. Diploma in Community Based Rehabilitation for Disabled - One year duration.

These courses aim at developing a cadre of trained CBR workers at different levels. The course content for these courses is given in the Appendix.

3.16 Continuing Rehabilitation Education

The Rehabilitation Council of India has introduced the concept of Continuing Rehabilitation Education (CRE) for upgrading knowledge and skills of professionals/personnel working in disability sector. It has evolved these courses for all categories of disability. For the promotion of community based rehabilitation, the following courses have been evolved:

- Rehabilitation of persons with mental illness in community
- Community based rehabilitation for the locomotor handicapped
- Strengthening community based rehabilitation for the hearing impaired

The Rehabilitation Council of India provides financial support for the following heads of expenditure:

- a. Honorarium for Programme Coordinator
- b. Honorarium for resource persons
- c. Stationery and support material
- d. Boarding & lodging
- e. Contingency

The scheme encourages use of local resources and availing of services of local faculty. Similarly, the scheme desires that the local and regional participants should be encouraged to participate in the programme.

For more details, contact Member Secretary, Rehabilitation Council of India, 23- Rehabilitation Council of India, B-22, Qutab Institutional Area, New Delhi-110 016 Website: E-mail: rehabstd@nde.vsnl.net.in www.rehabcouncil.nic.in Tel. (Office) 011-2653 2408/2653 2384/ 2653 4287 Extn. (48) Fax 011-2653 4291

3.17 National Programme for Rehabilitation of Persons with Disabilities (NPRPD)

The Ministry of Social Justice & Empowerment has introduced the National Programme for the Rehabilitation of Persons with Disabilities (NPRPD) as a model for State Governments to provide rehabilitation services to the disabled. To begin with, this Programme will be launched in 100 districts all over the country.

The objective of this programme is to promote comprehensive rehabilitation for all persons with disabilities at their doorstep. For this purpose, the programme will have a delivery system right from the State level to the Gram Panchayat level. The envisaged infrastructure has the following salient features:

- a. To develop and maintain minimum level of services at each level of service delivery, from State to village level.
- b. To provide guidelines to States for assisting them to initiate and strengthen services.
- c. To provide appropriate information about the most cost effective, efficient and economical models in the field of rehabilitation.
- d. The service delivery system should have at least, at each level infrastructure for service delivery, provision of assistive devices and availability of trained manpower.
- e. As far as possible, services should be provided at the doorstep of the individuals.
- f. As community based services are cost effective, efforts should be made to provide services using community and family resources.
- g. The State should make efforts to use existing institutions, both in Government as well as Non-government sectors and the local authorities for delivery of rehabilitation services.

Hierarchical Pyramid of Provision of Services:

1. Provision of Basic Rehabilitation Services & First level of intervention, community based approach.
2. Middle Level-Provision of Both Institutional & Community Based Services
3. District Referral Centre Essentially Institutional intervention, referral and higher level services-Higher Education, Medical Services, Training Institutes.
4. State Apex Institutes- basically a referral centre & the highest level institute in the state for provision of selected rehabilitation services & information on other services.
5. National Level Policy Formulation, Monitoring & Evaluation & Actual Intervention in a few complicated cases.

(A picture of Pyramid to be drawn)

Policy Formulation

State Apex Institutes

District Referral Centre

Block Level Services

(Institutional & Community)

Community Based Rehabilitation

Families

Individuals

Service Delivery: The programme envisages providing the following

4 major services:

- a. Integration in the family and community
- b. Appropriate environment
- c. Medical intervention including medical rehabilitation
- d. Vocational training and appropriate employment

According to the programme, integration with the family is a minimum common denominator for all persons with disabilities. The next step however is their integration in the community. Such integration may be achieved through suitable training modules, identification of trainers for rehabilitation workers, designing and implementation of training modules. The NPRPD aims at providing comprehensive services to persons with all categories of disabilities.

For more details, contact: The Director, District Rehabilitation Centres Scheme, Ministry of Social Justice & Empowerment, 4 Vishnu Digamber Marg, New Delhi 110 025.

3.18 District Centres for Rehabilitation

The Ministry of Social Justice & Empowerment has introduced the District Rehabilitation Centres Scheme to enhance outreach of the services and cover larger areas through network of rehabilitation services in 100 districts. The Scheme aims at utilizing the existing infrastructure of the State Medical Colleges, Rehabilitation Centres, Red Cross Societies, local doctors and experts for the purpose of extending services to persons with disabilities. To begin with, 100 districts spread over all India have been identified for this purpose.

The services to be provided on an on-going basis include:

- a. Assessment of existing infrastructure and resources in the district and assessing their potential.
- b. Identification of persons with disabilities.
- c. Issuing of disability certificates.
- d. Promotion of prevention of disability through involvement of village level workers, creation of social communication and such other appropriate means.
- e. Setting up of composite fitment centres to provide assessment, actual fitment, and provision and follow up and repair of assistive devices.
- f. Promotion of barrier free environment.
- g. Promotion of appropriate educational services and vocational training.
- h. Assistance in employment and placement, etc.
- i. Providing referral services for higher level education, training and vocations.

For achieving these objectives, each fitment centre is allocated a budget of 1.3 million rupees. The salient feature of this scheme is that the fitment centre would undertake only those activities, which the government lays down in its policies and provides the funds for its implementation. Another important aspect of the scheme is that the National Institutes, Artificial Limbs Manufacturing Corporation of India and the District Rehabilitation Centres would implement it. In other words, various institutes and agencies of the Ministry of Social Justice & Empowerment would manage all the fitment centres.

The whole programme has been divided into two phases, with the first phase focussing on providing rehabilitation in the identified districts and the second to spread out the services to other contiguous districts. The monitoring and evaluation of these programmes may be undertaken by the National Programme on Rehabilitation of Persons with Disabilities (NPRPD). It is proposed to set up the National Monitoring, Evaluation, Policy Formulation and Training Unit through restructuring of the existing District Rehabilitation Centres.

For more details, contact Director, District Rehabilitation Centres at the address given earlier.

3.20 Community Approaches to Handicap in Development (CAHD).

Most of the work in the field of impairment, disability and handicap has focussed on persons with disabilities and their problems. In case of CAHD, as explained earlier, the focus has shifted to the causes of their problems. This shift has resulted in increased awareness of the "hidden dimensions" of impairment, handicap and disability. The objective of this approach is to include them in development; to increase resources to assist them, to create social changes that will ensure inclusion of the disabled as full citizens with equal opportunities and full access to participation.

The objective of a CAHD programme is to eliminate handicap, to change the negative cycle of impairment and disability to positive through planned and organized interventions that will:

- a. Change the attitude of people and their organizations so that there is equitable sharing of resources locally, regionally, nationally and internationally.
- b. Change the attitude of people and their organizations to eliminate the barriers that result in little or no assistance to disabled persons.
- c. Reduce the impact of impairment and disability on individuals and families through provision of assistive devices.

This project has already been initiated jointly by the Handicap International and the Christoffel Blindenmission on a pilot basis

in four countries including Tripura in India, two projects in Philippines, Dhaka in Bangladesh and Phokhra in Nepal. The training for CAHD is coordinated by the Centre for Disability Development (CDD), Dhaka, Bangladesh.

For more details, contact country offices of Handicap International or Christoffel Blindenmission.

3.21 Ashthawakra CBR Scheme

The Department of Social Justice & Empowerment, Government of Gujarat has introduced the Maharishi Ashthawakra Yojana for the promotion of CBR for the State of Gujarat. The Department has sanctioned a grant of Rs. 720 million for covering all 25 Districts of Gujarat over a period of 5 years. For the first year 2000-2001, the Department has sanctioned a grant of Rs. 53.7 million for this purpose.

This Scheme envisages covering persons with all categories of disability at their doorstep. As the scheme has been developed and is being coordinated by the Authors of this Manual, the scheme follows the implementation plan as outlined in this Manual. This is probably the largest CBR Programme being supported by any State Government in India. The target of this scheme is to cover 6,00,000 persons with disabilities in the State of Gujarat over the next 5 years.

These entire developments world over and in India establish that the concept CBR is no more a project, programme or a strategy. It is taking the form of a movement. The United Nations, while evolving a Convention on the Rights of Persons with Disabilities, recognized CBR as an option for the promotion of effective and appropriate services for the persons with disabilities.

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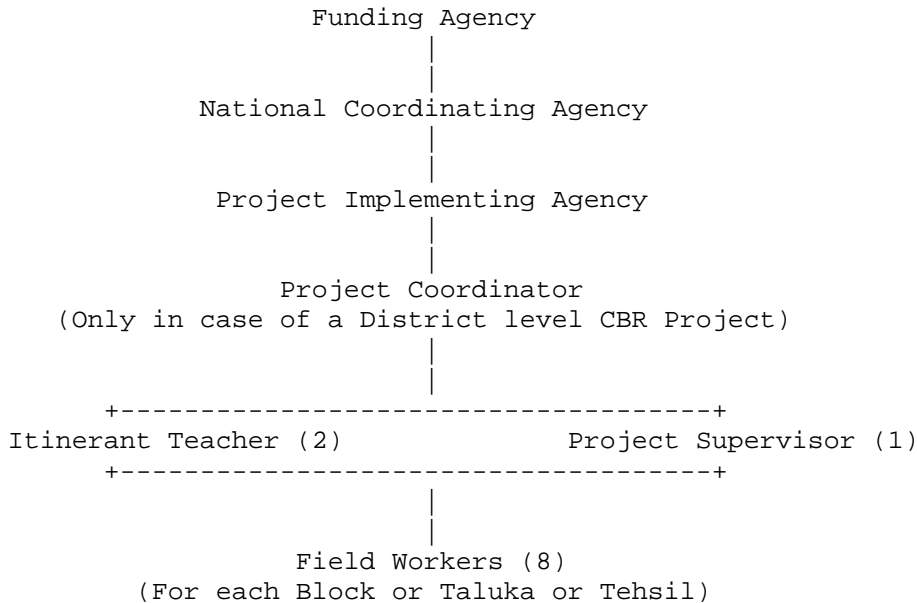
COMMUNITY BASED REHABILITATION
IMPLEMENTATION PLAN

1. Organizational Structure

The organizational structure of the CBR programme should be a simple linear one without overlapping of responsibilities. It has been divided into three tiers because of the following advantages:

- a. Developing a national network of services for the target group.
- b. Enabling extensive coverage of the target group.
- c. Providing essential local contacts and effective supervision.
- d. Ensuring involvement of other developmental agencies.
- e. Offering decentralized supervision
- f. Organizing centralized monitoring, coordination and evaluation
- g. Understanding of local environment, language and traditions.
- h. Promoting comprehensive services in remote areas.

The envisaged organizational structure is depicted below:



1.1 Tier I: Funding Agency

The Funding Agency will provide assistance to the National Coordinating Agency who will in turn remit or reimburse the same to the Project Implementing Agency. (The agencies may solicit funds directly and implement projects on their own also).

A Funding Agency may be any:

- International Non-governmental Organization (INGO)
- Non-governmental Organization (NGO)

- Any Ministry or Department of any National or Provincial Government
- Any corporate body
- Any developmental agency
- Any disability development or advocacy group
- A group of individuals

1.1.1 The existing funding agencies for CBR projects in India are:

- . Actionaid
- . Canadian International Development Agency (CIDA)
- . CBR Forum
- . CBR Network
- . Danish Programme on Control of Blindness
- . Department for International Development (DFID)
- . Hilton Perkins International
- . Indo German Social Service Society
- . Ministry of Social Justice & Empowerment, Govt. of India
- . Misseror, Germany
- . National Association for the Blind
- . Norwegian Agency for Development (NORAD)
- . OXFAM
- . Sense International
- . Sight Savers International (Royal Commonwealth Society for the Blind)
- . South Asia Partnership
- . State Bank of India
- . Swedish International Development Agency (SIDA)
- . World Blind Union

1.1.2 Roles of Funding Agencies

- a. Providing financial assistance for the initial approved non-recurring as well as admissible recurring expenditure to the National Coordinating Agency which in turn releases the same to the Implementing Agency in four installments on the recommendation of the National Coordinating Agency RAC.
- b. Providing technical inputs where necessary for the effective implementation of the project.
- c. Providing consultative inputs, such as services of experts where necessary.
- d. Obtaining, analyzing, and providing feed-back on the progress reports received from the National Coordinating Agency.
- e. Exploring new avenues for raising funds for the expansion of the projects.
- f. Convincing other bilateral and international Funding Agencies to adopt such projects.
- g. Creating public and institutional awareness and convincing Governmental agencies and Non Governmental Organizations to encourage, initiate, implement, support, sponsor, and finance such projects.

h. Periodic evaluation of the projects through regular reports, visits to the site, and other suitable means.

Thus the Funding Agencies will not only provide financial assistance but shall monitor and evaluate progress of the projects.

1.2 Tier II: National Coordinating Agency (CCO)

It should perform the staff functions of monitoring the project and playing an advisory role. It also identifies and initiates several projects all over the country.

1.2.1 Overall responsibilities: The National Coordinating Agency is expected to perform the following roles:

a. Sending project proposals, submitting budget and securing funds from the Funding Agencies.

b. Identification of project locations and the Project Implementing Agencies.

c. Helping in selection and training of field staff for the projects.

d. Liaison between the Funding Agencies and the Project Implementing Agencies.

e. Formulating policy guidelines for ensuring:

- proper implementation;
- monitoring and evaluation of the projects;
- securing regular reports from implementing agencies; and
- submit reports to the funding agencies.

f. Organizing meetings of the National Coordinating Agency, maintaining minutes and circulating notes on the proceedings of the meetings to the National Coordinating Agency Members at regular intervals.

g. Implementing and ensuring follow-up of the recommendations of the NAB and the Funding Agencies.

h. Organizing initial training and refresher training courses for the Project Supervisors and officials of the Project Implementing Agencies.

i. Creating public awareness of potentials and needs of the rural visually impaired by publishing and circulating materials and through the use of various media.

j. Motivating other social welfare and visually impaired welfare organizations to implement such projects and providing them with the necessary technical expertise in this regard.

k. Exploring various avenues of obtaining funds for the projects.

l. Representing views on committees and seminars, developing an information bank, influencing governmental policies and arranging coordination among various funding agencies regarding to rehabilitation of the rural visually impaired.

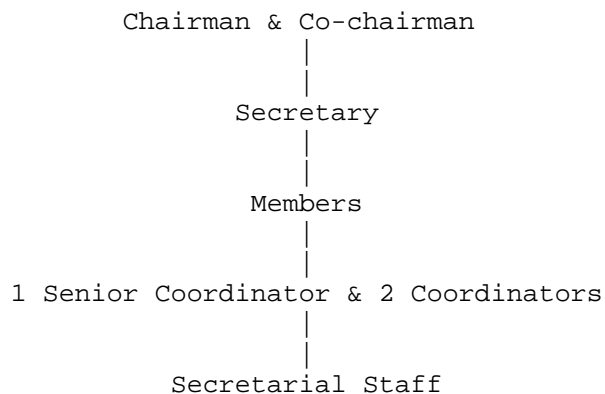
m. Promoting networking among the disabled welfare, rural development, health care and such other organizations willing to promote CBR projects in their areas of coverage. Disseminating information, documenting policy and creating a database.

n. Organizing regional and national level seminars and symposiums for promoting various aspects of community based rehabilitation, community initiatives, Government participation and innovative intervention strategies.

o. Promoting human resources through short term courses, encouraging standardization of course curricula, development of training material, publication of handbooks manual and such other measures.

p. Encouraging standardization of course curricula, development of training material and publication of material.

1.2.2 Structure of the National Coordinating Agency: It should be a duly constituted committee of persons interested in the promotion of CBR, CBR specialists, representatives of the Project Implementing Agencies. It should be constituted under the auspices of any leading disability development organization or it should be established as an independent NGO. It may have the following organizational structure:



The Chairman, Co-chairman, Secretary and all the Members are the honorary workers. They should be entrusted the responsibility of promoting services for the rural visually impaired on behalf of the NAB.

1.2.2.1 Chairman & Co-chairman: These should have the following responsibilities:

a. Convening, chairing and conducting regular meetings of the agency.

b. Maintaining links, coordinating and doing correspondence with the its headquarters and its other committee and activities.

c. Handling correspondence with the funding agencies and other concerned organizations.

d. Overall responsibility for smooth functioning of the National Coordinating Agency, proper utilization of the funds and effective implementation of the projects.

1.2.2.2 The Secretary should perform the following duties:

a. Handling overall correspondence pertaining to funds, projects, staff matters, funding agencies, regular reports, visits and visitors, regular meetings of the committee.

b. Monitoring day to day functioning of the staff members of the Committee, planning their tour programmes, evaluating their progress and reimbursing their expenses etc.

c. Handling day to day administration of the activities, flow of funds, compilation and dissemination of information, appraisal of staff performance, convening of meetings, maintaining and distribution of minutes and coordination with other members of the Committee and the Project Implementing Agencies.

d. Organizing training programmes for the field staff, arranging the visiting faculty, providing training material and conducting part of the training.

e. Organizing seminars, refresher courses, orientation programmes and group meetings for promoting the concept of CBR and developing the human resources.

f. Paying visits to the field for evaluating performance of the projects, conducting training, liaison with concerned agencies and individuals for promoting the concept.

g. Mobilizing resources from the governmental and non-governmental agencies both Indian and foreign by submitting the project proposals, organizing the visits and motivating their participation.

h. Submitting the monthly or quarterly reports of physical as well as financial progress of each project to the respective funding agencies and other concerned agencies.

i. Submitting monthly statements of expenditure to the headquarter in respect of field expenditure and other establishment and administrative expenses. Also submitting regular reports of performance for the purpose of publication etc.

j. Promoting net-working among development organizations in respect of promotion of CBR. Influencing policies of the State in this respect.

k. Implementing all the decisions of the Central Coordinating Agency and reporting back the progress. Maintaining minutes of all the meetings, circulating agenda, minutes and other such materials among members.

l. Encouraging publication of articles, new reports, success stories and such other material in the newspapers, journals and periodicals for creating public awareness. Developing and distributing audio-visual material and print material on the concept and projects etc.

m. Taking all other measures for fulfilling objectives of the Central Coordinating Agency, promotion of the concept of CBR, efficient functioning of the projects and extending services to the persons with disabilities.

1.2.2.3 Roles of the Senior Project Coordinator

a. Helping the Project Implementing Agencies in selection of the project area, formation of clusters, and selection of field staff.

b. Arranging the six-week training for the Field Workers and refresher courses for the Project Directors, Project Coordinators and Supervisors of various projects.

c. Modifying and adapting the training curricula and rehabilitation methods in accordance with regional needs.

d. Paying regular visits to the project to observe progress, guide the field staff and decide the future course of action.

e. Evolving adapting region specific techniques of screening, identification, assessment, evaluation, provision of need-based services to the individuals.

f. Any other duties entrusted by the Central Coordinating Agency.

1.2.2.4 Role of the Coordinators

a. Conducting training of the field staff and refresher and orientation courses for the Project Director and Supervisors.

b. Visiting and observing the working of various projects and reporting to the Central Coordinating Agency.

c. Coordinating various projects implemented by the Project Implementing Agencies.

d. Obtaining, analyzing regular physical and financial reports from the various projects and providing feed-back to the agencies.

e. Corresponding with other disability development and rural development agencies for evolving rehabilitation programmes.

f. Corresponding with State Departments of Disability Development

for encouraging them to implement such projects in their region.

g. Preparing publication materials for creating public awareness of the project.

h. Compiling and publishing various success stories of the successful cases of complete rehabilitation.

i. Maintaining appropriate computer software, data base and records of performance of various projects.

j. Representing the Central Coordinating Agency on various seminars, conferences, workshops and meetings pertaining to the concept of CBR.

k. Any other duties entrusted by the Secretary or other officials.

1.3 Tier III: Project Implementing Agency

As per the project ideology, the CBR project is implemented by a local visually impaired welfare, rural development, social development organization, service club, or a group of motivated individuals.

1.3.1 Legal Status: It should be a registered under:

- Public Trust Act, 1956
- Indian Society Registration Act, 1860, or
- Section 25 of the Indian Company's Act.
- Foreign Contributions Regulation Act, 1983
- Section 51 of the Persons with Disabilities Act, 1995
- Section 12 of the Income Tax Act, 1961

c. It should have a duly constituted, functional and democratic Managing Committee or the Governing Board as per constitution of such organization.

d. It should be willing to promote services for the rural visually impaired and avail adequate local support for eye care etc.

e. It must have its Head Office or branch office in the project area and must have involvement of local people in its management.

f. It should be maintaining its regular accounts, getting the same audited and fulfilling other statutory requirement in this respect.

g. It should be a trustworthy agency with transparency in accounts and operations.

1.3.2 Nature of Implementing Agencies: Select any of the following agencies as the Project Implementing Agency:

- State Branche of any national level disability development organizations.

- Disabled development agency
- Health care agency or any local hospital
- Rural development agency
- Social development organization
- Service clubs
- Educational institutions
- Local administration
- Prominent social worker

1.3.3 Required Characteristics: The Project Implementing Agency should have the following characteristics:

- a. Sound track record of rehabilitation or development work.
- b. Willing to promote CBR and avail local support for medical intervention.
- c. Adequate infrastructural facilities such as office, telephone, and vehicles.
- d. Experience of working in rural areas, on developmental issues or for persons with disabilities.
- e. Dynamic management, willing to experiment with new ideas and implement new projects.
- f. Good contacts with an eye hospital or health care agencies.
- g. Good contacts with rural agencies, local administration and community leaders.
- h. Sound financial position to ensure expansion of the project to other areas out of its own or raised funds, or continue the project after the end of the funding.
- i. Registered as society, trust, or both.
- j. Registered under Foreign Contribution Regulation Act.
- k. Willingness of assigning personnel to handle the day-to-day working of the project.

1.3.1 Roles of Project Implementing Agency: This Agency will actually implement the project and bear the following responsibilities:

1.3.4.1 As An Administrator

- a. Providing services of Honorary Project Director and other honorary advisory staff and entrusting responsibility for implementing the project.
- b. Providing office space, establishment, conveyance, and office infrastructure, such as furniture and typewriter and space for holding the weekly review meetings and for storing of project documents.
- c. Implementing the project according to guidelines set by the National Coordinating Agency and maintaining strict adherence to budgeted heads.
- d. Selecting project area, forming clusters, selecting the field staff, organizing training, assigning work to the field team and checking the same during weekly review meetings.
- e. Arranging for the routine supervision of the working of the field staff and arranging regular visits to the stake-holders of

the project.

f. Ensuring proper utilization of the project vehicles and maintaining the log book in the prescribed format.

g. Sending regular physical and financial reports in prescribed forms to the National Coordinating Agency.

h. Involving agencies like Panchayat, district administration, and developmental agencies and tapping local media for public awareness.

i. Encouraging other visually impaired welfare agencies in the area to take up similar projects.

1.3.4.2 As a Change Agent

a. Approaching the local health authorities for providing health facilities to the persons with disabilities under the project.

b. Arranging for the health checkup of all the persons covered under the project and taking the help of agencies organizing health care camps.

c. Approaching the District Education Officers for convincing them to admit children with disabilities to the regular schools.

d. Arranging services of Resource/Itinerant Teachers for the children studying in the integrated schools and providing them educational material.

e. Using personal contacts and charisma to acquaint the public with disability development and achievements of the respective project.

f. Building up a base to ensure continuity of the project even after withdrawal of funds from the Funding Agency.

g. Creating public awareness about achievements of the project.

h. Identifying and developing local leaders for the cause and adapting philosophy to suit the local conditions.

i. Networking with other agencies and being involved in mutual sharing of expertise and experience.

1.3.4.3 As a Resource Mobilizer

a. Mobilizing community resources needed for economic resettlement.

b. Contacting the District Administration, State and Central Government and donors to give funds for the Project e.g. for blankets, white canes, braille aids, assistance for economic rehabilitation.

c. Generating funds by appealing to the public by proving the potentials of the visually impaired.

d. Raising funds for putting in a minimum of 10% of the project budget.

1.3.4.4 As a Human Being

a. Being a friend and confidante of the field staff and getting work done in this manner.

b. Having a genuine concern for the visually impaired and being interested in seeing that they get their due share in life.

c. Solving the problems of the field staff, rapport building and taking timely action.

d. Being patient with field staff and the visually impaired alike.

e. Motivating field functionaries in the faces of conflicting situations and hurdles.

f. Remaining clear of casteism, regional conflicts and controversies.

1.4 Tier IV: Field Staff

1.4.1 Field Workers: A key element in providing appropriate rehabilitation services would be to ensure that the service extended is appropriate to the individual felt needs of a visually impaired person and are provided at the door step of the beneficiaries. For providing these services in a block, a team of eight Field Workers is required.

1.4.2 Itinerant Teacher: As integrated education requires specialist inputs, education of the visually impaired children should be handled by qualified Itinerant Teachers. As one such teacher is required for 8 children, the number of teachers would depend upon the number of school-age children identified and enrolled in the regular schools in the project area.

1.4.3 Field team: The field team for each block would thus consist of:

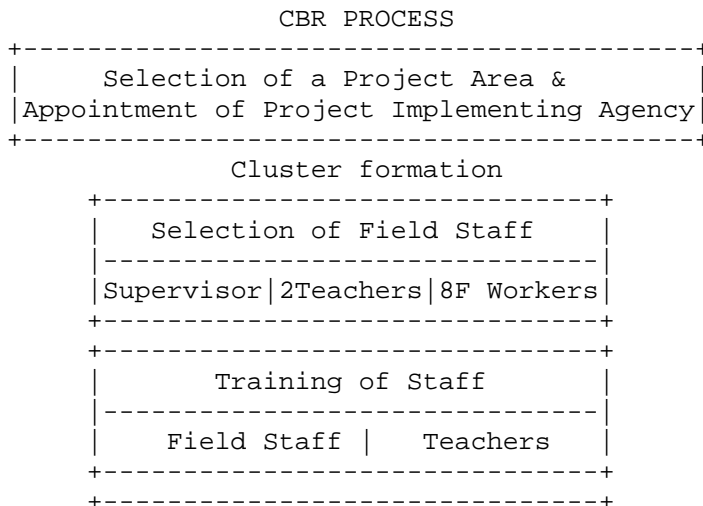
- a. One Project Supervisor
- b. Two Itinerant Teachers
- c. Eight Field Workers.

1.4.4 Project Coordinator: Wherever the Project Implementing Agency takes up a district level CBR programme and plan to cover all the blocks in a district in a phased manner with four block at any point of time, appointment of a Project Coordinator is essential. Such a Coordinator would coordinate functioning of all the field teams, organize training, monitor progress and evaluate performance.

2. CBR Implementation Process

The CBR Process Chart reflect the envisaged sequence of activities, responsibility areas and various aspects of rehabilitation. To maintain uniformity in the approach, a standard CBR Process Chart has been evolved. This may, however, be modified depending upon the geographical terrain, socio-economic conditions of the project area, nature of the Project Implementing Agency, extent of availability of different services and such other factors.

The CBR Process Chart is presented in a sequential form indicating the steps to be followed. The most important stages include appointment of a agency, selection and training of field staff, survey of the curable and incurable visually impaired persons, referral of curable persons to eye care agencies, extension of services of social integration and dividing the all the incurable persons into three groups viz. the children for integrated education, the adults for economic rehabilitation and the aged for social integration.



Door to Door Survey		
Visually Impaired	Persons with Eye Problems	
Eye Screening by Ophthalmic Surgeon		
Incurable Visually Impaired	Blindness Certificate	Curable Person
Initial Assessment in a Prescribed Format		Eye Treatment & Cure
Social Integration		
O & M	ADL	Counselling
General Concessions		
Travel	Monetary Assistance	Any Other
Educable Children Below 8 Yrs. of Age	Economic Rehabilitation Group	Social Rehabilitation Group
School Admission	Family Counselling	Identification of Trade
Pre-Braille Activities	Training, Support Services	Family Health Care
Counselling (Itinerant Teachers)	Launching Grant/ Subsidy (Field Workers)	Health Care (Field Workers)

Project Supervisor

2.1 Need for Implementing Agency

The implementation of the project would require coordination at the block level in remote areas. It is not possible for any national or regional level urban based organization to implement such a project effectively without the involvement of local organizations. The local agency is known and accepted in the area and is familiar with local customs, traditions and habits. Moreover, after the project funding is complete, this agency looks after the propagation of the project and fulfills the principles of sustainability and permanency.

The experience of implementing CBR projects at 134 locations in

India reveals that it is not necessary to depend only upon the development organizations for the visually impaired for the implementation of such projects. Local level rural development organizations, local eye hospitals, health care agencies and educational institutes have also proved very effective in this respect, as these organizations have effectively networked rehabilitation work with their existing services.

2.2 Selection Process

The following procedure should be followed for selecting the project implementing agencies:

- a. Select a tentative location for project implementation.
- b. Identify a suitable agency after compiling information.
- c. Explain project ideology and role performance to the agency.
- d. Invite a project proposal based on the project guidelines.
- e. Depute the Project Coordinators to verify the details.
- f. Forward the project proposal to the Funding Agency.
- g. Send all relevant materials to the selected agency.
- h. Depute appropriate staff for initiating the project.

2.3 Selection of Project Area

The first duty of the Project Implementing Agency is to select a rural area for implementing the project. The parameters for selecting the area are enumerated below:

2.3.1 Predominantly rural area: The area should be predominantly rural, i.e. 85 per cent or more of the total area being rural. For this purpose, the latest census reports may be referred to.

2.3.2 Remoteness of the area: The rural area should be at a distance of 20 km or more from a city or town, and villages in the area should have a population of less than 10,000 persons.

2.3.3 Backwardness of the area: Preferably choose a backward rural area for implementing the project. The government has declared many areas as backward. The parameters for classifying an area as backward are:

- a. Low per capita income (below national average)
- b. Low literacy rate (below 40 per cent)
- c. Drought proneness of area
- d. Low irrigation facilities
- e. Large percentage of dry land
- f. Paucity of medical facilities

Absence of medical facilities directly reflects that the general health of the rural areas is poor.

2.3.4 Existence of a rural-based hospital or a rural development agency: If the area has such a facility, this infrastructure can be used for providing medical services or for advancing rehabilitation services. This hospital would prove invaluable in the work related to the prevention of blindness.

2.3.5 Higher incidence of visual impairment: Select an area where studies or secondary data prove that there is a high incidence and prevalence of visual impairment. An initial survey of people with eye problems would establish the same. The prevalence and incidence rate of more than 525 and 25 respectively in the area would establish the higher rates.

2.3.6 Availability of transport facilities: The rural area should be easily accessible, otherwise the project monitoring would be difficult and expensive. Transport facilities to and from the area should be adequate.

2.3.7 High density of population: The density factor would result in a comparatively lower cost of reaching the rural visually impaired. The density of persons per square kilo-meter should ideally be 300.

2.4 Formation of Clusters

Once the project area has been selected, the entire area should be divided into groups of villages.

2.4.1 Geographical layout: Obtain a road map and a list of villages of the rural area from any of the following sources:

- a. Public Works Department
- b. Taluka Development Office
- c. District Collector's Office
- d. District Panchayat Office
- e. District Education Office
- e. A local publisher of area maps

Use the location code of the villages, which indicates proximity between the villages, as a guideline for the formation of the clusters.

2.4.2 Formation of clusters: Club the nearby villages or the Panchayats for the formation of the clusters. The villages covered in a Panchayat should be covered in the same cluster. Form a cluster of 10-12 villages based on proximity of villages and geographical locations. Thus the entire taluka/tehsil should preferably be divided into eight clusters.

2.4.3 Central village: In each cluster, locate one main central village which preferably should have:

- a. A post office
- b. Bus facility
- c. Population of 8,000-10,000 persons
- d. A high school
- e. Rural health centre
- g. Rural, land development or a cooperative bank
- h. Producer cooperative society etc.

Name the cluster after that main village. Eight clusters can be taken up at a point of time as the project provides for eight

Field Workers.

3. Selection of Field Staff

After selection of the project area, formation of clusters, the most important ingredient for the success of the project is the recruitment of proper field staff. The first two will be persons from the Implementing Agency who will give their honorary services for the project. The last three will be paid workers who will work exclusively for the project.

Table: Project staff

S. N.	Designation	No.	Qualification
1.	Project Director	1	Honorary Worker of Implementing Agency
2.	Joint Director	1	-do-
3.	Supervisor	1	Graduate with relevant experience
4.	Field Worker	8	Secondary pass, needy, enthusiastic and dynamic persons from the project area
5.	Itinerant Teacher	2	Graduate with teacher training course

The services of the Project Director and Joint Director will be provided by the Project Implementing Agency on an honorary basis. The last three categories of personnel will be paid workers who will work exclusively for the project.

The surest way to ensure success of the project is to take Field Workers from the target area itself. No publicity or advertising is generally required for this post. The Field Workers should be sons of the soil, with high school education, young, socially conscious men and women, who have returned to their villages to work. Select two Field Workers from each cluster. The Field Supervisor may be selected from any village of the project area.

The Teachers should be graduates who have completed a recognized teacher training course in -teaching the visually impaired. They may be recruited from the project area itself through advertisement in the local papers, or through word of mouth, or personal contacts.

3.1 Inviting applications

To select the Field Workers from the project area itself, create awareness in the area by:

- a. Approaching the Sarpanch and the school headmaster/teachers of the villages.
- b. Contacting opinion leaders of the villages.
- c. Contacting secondary schools in the area for collecting addresses of the students who have completed their school education within the past two years.
- d. Meeting the rural youth in the area.
- e. Involving volunteers of the rural development agencies.
- f. Putting a notice on the village notice board, school notice board, or at the entrance to the village temple.

The Project Implementing Agency should screen and invite suitable candidates for interview at the head-quarters of the Project Implementing Agency. Representatives of the National Coordinating Agency may also be present at the interview.

3.2 Criteria for Selection

Since the target is to select 16 Field Workers and one Supervisor, a minimum of 80-90 applications are needed to arrive at the best in the lot. The suitable candidates may be selected based on the following criteria:

a. Age: As the project involves a lot of travelling, prefer applicants below 30 years of age who can ride a bicycle.

b. Education: As the Field Workers are expected to prepare progress reports, maintain accounts, and train the rural visually impaired, consider only those applicants who have successfully cleared the secondary school examination.

c. Residence: Consider only those applicants who come from the project area, preferably from the central village of the respective cluster.

d. Training: Prefer those who have undertaken some training in rural crafts and agriculture or have work experience in such crafts. Similarly prefer applicants who have the experience of working with the visually impaired.

e. Aptitude: Consider only those applicants who are willing to join the job out of interest and are interested in the field work. For this purpose, test social consciousness and awareness by several aptitude, interest, and personality development tests.

f. Caste consideration: Consider only those applicants who do not believe in the caste system and are willing to work for the visually impaired persons from all casts, creeds, and religions.

g. Gender: Select female workers also as they would be useful for extending services to the female beneficiaries coming from conservative families where access to a male Field Worker may not be permissible.

h. Oratory: As the Field Workers are required to provide lot of information to the community and do lot of talking, the persons who are good orators and are good talkers should be preferred.

3.3 Rationale for Selecting two Candidates

Select two persons from each cluster for the purpose of training. One of them is dropped on completion of training and the second one is retained as the Field Worker. Thus 16 persons would be enrolled for training with the clear understanding of retaining only 8 Field Workers on completion of training. The rationale for selecting two candidates is given below:

a. Stand by: As the training is very intensive, should the selected candidate leave halfway, the second one can be absorbed in his or her place without affecting the project.

b. Cost: As organizing training is very expensive, it cannot be organized again and again. If one candidate leaves halfway organizing training for the replacement may not be feasible due to cost constraints.

c. Economical: As training costs viz. remuneration to experts and cost of literature would have to be borne irrespective of the number of persons to be trained, It is thus more beneficial to train larger number of persons.

d. Sense of competition: Due to sense of competition, each worker would be motivated to put his best efforts, remain alert and assimilate as much information as possible.

e. Wider choice: A choice is available and open to the agency to chose one worker. Otherwise, it would have to continue with the selected one even if found unfit for the work during training.

f. Inventory for expansion: For expansion of the project for other categories of disabilities, the stand by candidates would be easily available.

3.4 Importance Selection and Training

The field staff should be judiciously selected and properly trained. In a field project, one has to completely rely and depend upon the Field Workers to work and deliver services according to prescribed guidelines. As the Project Directors or Project Supervisor can not physically check the daily working of each Field Worker, much has to be understood from the Field Worker's reports. It is these Field Workers who can thus make or break a project. Every Project Implementing Agency must ensure that the field staff remains motivated and interested in the work.

3.5 Role of Implementing Agency

The Project Implementing Agency is solely responsible for the effective implementation of the project, monitoring the progress and handling account of the project. It is also responsible for seeking participation of local administration, community and other concerned officials in the project. As the organizational structure of the project envisages decentralized system of functioning at the local level, the Agency is completely independent to incorporate regional modifications and to administer the project. It has, however, adhere to project ideology, implementation plan, allocated budget and staff structure. It is expected to perform the following roles:

- a. Select the appropriate location.
- b. Provide class-room and other facilities for theory classes.
- c. Identify rural area for field training.

- d. Provide background material, stationery and other such items.
- e. Arrange lectures and the local faculty.
- f. Provide equipment for the audio-video presentation.
- g. Arrange boarding and lodging for trainees and the faculty.
- h. Arrange visits to visually impaired welfare organizations.
- i. Arrange visits to eye hospitals for ophthalmic orientation.
- j. Organize the training material.
- k. Monitor progress of training.
- l. Undertake periodical evaluation and examination.
- m. Keep appropriate records of performance of trainees.
- n. Select the field workers on completion of training.

3.6 Role of National Coordinating Agency

The National Coordinating Agency is expected to perform the following roles in respect of organizing training of the field staff:

- a. Evolve and finalize training philosophy and approach.
- b. Prepare the training schedule.
- c. Decide the place and timing of the training.
- d. Decide the training curricula and training method.
- e. Decide the extent of application of training devices.
- f. Assist in selecting the local faculty.
- g. Orient the local faculty.
- h. Arrange for the visiting faculty.
- i. Organize training material, reference material etc.
- j. Assist in organizing field visits to successful projects.
- k. Provide services of a Project Coordinator during training.
- l. Devise methods for evaluating the trainees.
- m. Evaluate performance of the trainees.
- n. Evaluate the effectiveness of the programme.
- o. Assist in the final selection of the Field Workers.
- p. Ensure cost effectiveness of the programme.
- q. Determine the extent and duration of the refresher courses.

3.7 Course Curriculum

The six-week training consists of class-room instructions and theoretical training for three hours every day followed by three hours of practical training under blindfold. The content of the training programme is given below:

- Historical background of services for the visually impaired
- Need for implementation and promotion of CBR
- Demographic details of the visually impaired
- Definition and type of visual impairment
- Physiology and anatomy of eye
- Causes and symptoms of visual impairment
- Introduction to eye care
- Introduction low vision and low vision aids
- Psychological implications of visual impairment
- Importance and consequences of rehabilitation
- Models of rehabilitation, their merits and demerits
- Survey methods
- Definition and philosophy of CBR
- Aims and objectives of CBR

- Components of CBR
- Methodology of CBR
- Organizational structure of the project
- Roles of Funding Agency, Project Implementing Agency
- Need for involvement of local agencies
- Role and responsibilities of the Field Workers
- Concept and components of social rehabilitation
- Importance of orientation and mobility
- Techniques, methods, process of O&M and mobility aids
- Importance and techniques of daily living skills
- Need and importance of parent counselling
- Need for community involvement in rehabilitation process
- Models of education of the visually impaired
- Introduction to integrated education
- Introduction to braille
- Components of integrated education
- Concessions available to the visually impaired
- Process of economic rehabilitation and its importance
- Introduction to various inputs of economic rehabilitation
- General introduction to agriculture, crafts, and trades
- General introduction to loan and subsidy schemes
- Need and importance of reporting, formats of reporting
- Monitoring and evaluation of the project
- Case closure and concept of complete rehabilitation
- Presentation of case studies and case closure

The training should include theoretical topics reinforced by practicals demonstrations and field visits etc.

3.8 Nature of Faculty

For conducting the training, the following faculty is required:

3.8.1 Local faculty: For all the topics which are of generic nature and which aim at imparting area specific training, involve the following local faculty:

- a. Psychologist
- b. Qualified Social Worker
- c. Braille Instructor
- d. Craft Instructor
- e. Ophthalmologist
- f. Resource persons from leading voluntary agencies
- g. Representative of Department of Social Welfare
- h. Representative of Financial Institutes
- i. Representative of Rural Development Agencies
- j. Representative of local administration
- k. Specialist in agriculture, dairying or other local agro-based activities

3.8.2 Visiting faculty: Invite the visiting faculty only for the specialized topics for which the faculty may not be available locally. The National Coordinating Agency generally arranges the following visiting faculty:

- a. Orientation & Mobility Instructor
- b. Instructor in Activities of Daily Living

- c. CBR Professional
- d. Qualified Social Worker for survey methods
- e. Special Teacher of the Visually Handicapped
- f. Instructor on record maintenance & reporting formats
- g. Resource persons from national institutes/organizations

3.9 Training Methodology

- a. Emphasis on case studies: Use the case method for both illustrating the principles of rehabilitation and encouraging the trainees to come forward with solutions to problem situations.
- b. Distribute material: Ask the lecturers to prepare a note on their subject. Cyclostyle and circulate the same among the trainees in advance.
- c. Revision sessions: Every night, an officer of the Project Implementing Agency and the Chief Officer (Rural Rehabilitation) should, together with the trainees revise the topics taught during the day and to help the trainees to improve their grasp of the subject.
- d. Emphasis on class participation: Encourage the trainees to participate actively during the lectures and to ask questions regarding their difficulties. Their participation will help to reflect the abilities of each person.
- e. Home assignments: Give the Field Workers simple home assignments to develop their skills of written analysis and communication. Give an assignment like "My experience on wearing a blindfold". A group of two trainees should be entrusted the responsibility of preparing the summary of day's lecture and the same should be presented the next day. Every day a new group should be assigned this responsibility.
- f. Periodic evaluation: Evaluate the trainees every week to gauge their progress. Periodically hold small tests in theory and practicals. Maintain the record of their attendance to establish their regularity.
- g. Variety in teaching methods: Incorporate variety in teaching methods to hold the interest of the trainees. The suggested methods are group discussion, case studies, presentation, role play etc.
- h. Field practicals: In the course of training, the trainees should be taken to a nearby village to conduct practicals on survey methods, approaching the families and filling up the initial survey forms.
- i. Simulation Methods: Use simulation methods, that is experience of various disabilities, role playing to understand disability, enacting different situations, blind fold experiences etc.

4. Identification of Target Group

4.1 Sources

The following sources may be exploited for identification of the visually impaired in the rural areas:

- a. Village school: Approach school authorities for getting an idea of the number of persons with eye problems or visual impairment.
- b. Village Panchayat: This office has documents related to the village statistics and information regarding socio-economic conditions of all the persons including the visually impaired.
- c. Opinion leaders: As they influence affairs pertaining to village life, seek their help in getting information regarding the target group.
- d. Display at religious places: As such places have a great hold on the lives of the rural populace, display notices at such places to elicit information regarding the target group.
- e. Door-to-door survey: As door-to-door survey is the most fool-proof method of identifying the target group, visit every house for this purpose.
- f. Beneficiaries themselves: Once a visually impaired person has been identified, he/she would be able to give details of other such persons in the village.
- g. Other development agencies such as youth clubs, women groups, cooperative societies, Khadi units, village school, hospital or dispensary and rural development agencies should be approached for eliciting information regarding the target group.

4.2 Door-to-Door Survey

After completion of six weeks training, the Field Workers should be assigned their respective clusters for work. They should survey each household in the respective cluster and complete the prescribed proforma with the following details:

- a. Name of village
- b. Name and address of the head of the family
- c. Name, sex and age of the persons with eye problems.

4.3 Eye Screening

It is essential that every person with an eye problem or who complains of loss of vision of any degree be examined by a qualified Ophthalmologist (not by the Field Worker) or an Ophthalmic Assistant. Such ophthalmic personnel would record the information in the prescribed vision screening proforma dividing all the persons identified during the door-to-door survey into curable and incurable categories.

The curable visually impaired persons should be taken up for further treatment, whereas the incurably visually impaired person should be certified thus.

4.4 Baseline Data

Based on the door-to-door survey and eye screening by the ophthalmic personnel, prepare baseline data sheets for the curable as well as incurable visually impaired persons.

a. Curable cases: The baseline data for curable cases would enlist information as regard name, address, sex and age of individual, date of screening, recommendation of ophthalmologist and the action taken for eye treatment, refraction or surgery, follow up etc.

b. Incurable cases: Apart from personal details, the baseline data in this category would enlist information on age of on-set and cause of blindness and the treatment availed etc.

c. Summary Baseline Data: Based on statistical information enlisted in proforma IV on Baseline Data- Curable cases and proforma V on Baseline Data -Incurable cases, prepare a summary of baseline data enlisting male and female curable as well as incurable persons identified in each age group ranging from 0-4 to 65 & above. This proforma will enable the project implementing agency to plan delivery of services for the respective age groups.

4.5 Eye Care

The project should organize referral services for general population in respect of eye check-up, child screening, refraction, public awareness and general health care. Similarly, it is required to promote referral services for curable visually impaired in respect of diagnosis, eye treatment, eye surgeries, and provision of glasses, low vision aids, etc. After preparing baseline data on curable blindness, the project should extend the following services:

4.5.1 Organizing Eye Camps: Collaborate with an eye hospital for holding eye camps to ensure that every person having eye trouble in the project area is checked up. This check-up and further surgical intervention or other treatment can be effectively done through an eye camp. Since the project has a field staff throughout the area, there will be synergy in operations. The funds for eye camps can be raised from service clubs, government health departments, or from funding agencies.

The National Programme for the Control of Blindness (NPCB), Director General of Health Services, Ministry of Health has initiated District Blindness Control Society (DBCS) in almost all districts in most States in the country. As the major objective of these societies is prevention and cure of blindness, this infrastructure may be tapped for organizing eye screening and eye surgeries. Generally District Collector of a respective district who is the Chairman of the DBCS should be approached for this purpose.

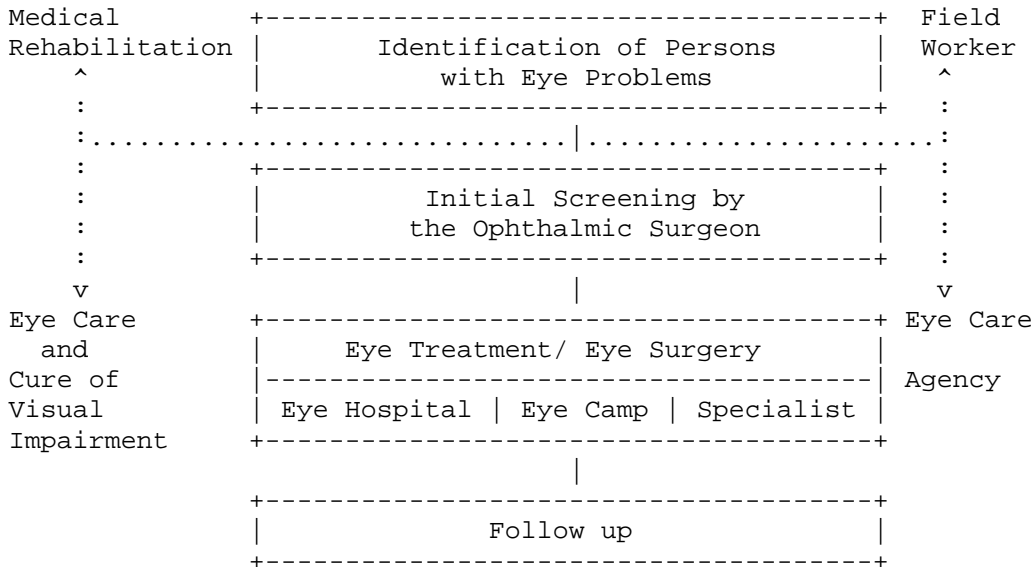
4.5.2 Importance of Involving Eye Hospitals: The NAB RAC's

experience of implementing CBR at 134 locations in India reveals that involvement of eye hospitals or eye specialists is essential for effective project implementation. In fact, wherever the Project Implementing Agency is a rural eye hospital, the results have been very encouraging. As eye hospitals enjoy better social acceptance than a rehabilitation organization, the whole concept is easily accepted by the beneficiaries.

4.5.3 Role of Field Staff: For the purpose of prevention and cure of visual impairment, the role of field staff should be limited to:

- a. Identification persons with eye-ailments or vision defects.
- b. Referral of such cases to a qualified ophthalmologist.
- c. Acting as a link between the individuals and care specialists.
- d. Acting as a motivator and guide.
- e. Doing follow up of such cases.

4.5.4 Cure of Visual Impairment Process



4.5.5 Certification of Incurable Visual Impairment: Ensure that every visually impaired or partially visually impaired person identified in the project area is checked-up by a qualified ophthalmologist. Experience has proved that a significant percentage of "visually impaired" persons can regain sight through surgical intervention.

It is essential that every incurable visually impaired be certified by the appropriate authority as a visually impaired person. Such a certificate is essential for availing the travel concessions, scholarship, pension or any other social security benefits or facilities etc.

Such certificate should be issued in the prescribed proforma. As per the recently enacted "Persons with Disabilities Act, 1995", the disability certificate has to be issued by a "Medical Board" duly constituted by the State Government. In many States, such disability certificate is issued by the Civil Surgeon on the recommendation of the Ophthalmologist.

9. Extension of Services

After undertaking the door-to-door survey of the curable as well as incurable visually impaired persons in the clusters assigned, the Field Worker should carry out work as per the details given below:

9.1 Role of Field Worker

The Field Worker is the key functionary in the project. He or she has direct contact with the beneficiary. The success of the project depends upon performance, integrity, sincerity and devotion of the worker. The Field Worker is expected to perform the following functions:

9.1.1 Identification: The Field Worker should use the following

- a. Door-to-door survey in the prescribed format
- b. Vision screening by ophthalmic personnel
- c. Summary of vision screening
 - Curable cases
 - Incurable cases
 - Summary of baseline data
- c. Individual case file for each case
- d. Initial assessment form

9.1.2 Complete Proforma: Apart from various proforma used for identification of the target group, the Field Worker should also complete the following proforma:

- a. Daily Diary
- b. Weekly Visit Proforma

9.1.3 Extension of Direct Services

- a. Select and provide services to five cases at any point of time
- b. Schedule of services in the following sequence:
 - Individual and family counselling
 - Orientation & mobility
 - Daily living skills and home economics
 - Training in household work (for women)

- Concessions and facilities
- Training in rural crafts, household activities
- Monetary assistance as subsidy, launching grant etc.
- Any other need based services

- c. Seek community participation in all these activities
- d. Involve local administration in all the relevant activities
- d. Create public awareness about the project and achievements

9.1.4 Referral Services: Refer all the persons:

- with eye ailments to local eye care agency
- school age to the integrated education programmes.
- with other disabilities to concerned agencies.
- with multiple disabilities and deafblindness to residential institutes or programmes devoted to such persons.

9.2 Establishing Contact

The Field Worker should observe the following procedure of establishing contacts with the beneficiaries:

- a. Counselling: Approach visually impaired person and his family and convince them of his or her potentials
- b. Introduction of self & agency: Give a brief introduction of the project, Project Implementing Agency and himself.
- c. Explain the aims and objectives of the project and purpose of the visit to the home of the person.
- d. Give illustrations of successful cases of complete rehabilitation using visual aids and the print materials.
- e. Convince the family that the visually impaired person can do meaningful work and be independent by demonstration of work under blind-fold and giving relevant examples and information.
- f. Understand the socio-economic environment of individual.

9.3 Completing Initial Assessment Form

The Field Worker is required to complete the Initial Assessment Proforma for each incurable visually impaired person. He/she needs to compile the following details pertaining to the visually impaired person, his/her family and socio-economic environment:

- a. Personal details of name, address, age, sex, marital status, religion, caste, etc.
- b. Details of on-set of visual impairment, cause, nature and extent of visual impairment, nature of treatment, certification etc.
- c. Level of training, education, experience in craft etc.
- d. Details of family in terms of other such incidence, family occupation, income and number of family members.
- e. Extent of dependence in respect of mobility, self care, daily living skills, social acceptance and economic aspects.
- f. Availability of concessions and facilities.

- g. Economic status of the individual.
- h. Willingness of the individual to avail training.

The Field Worker must complete this proforma for every visually impaired person. The details should be verified by the Supervisor and the Project Director. This assessment should serve as a base for the planning of further extension of services.

9.4 Assignment of Initial Cases

The Project Director will collect the Initial Assessment Proforma and assign five beneficiaries for service delivery to each Field Worker. As a Field Worker is required to put in eight hours of field work daily, he/she can put in one and half hours for each beneficiary. These five cases should be selected on the basis of following criteria:

9.4.1 Proximity of Cases: The Field Worker would be able to effectively handle the cases if they are in proximity to each other. It would be best to first take up such persons in the Field Worker's own village as this helps him to begin in familiar surroundings.

9.4.2 Age-mix of Persons: To make an immediate impact, visually impaired persons from different age groups should be taken up first. Successful rehabilitation of these cases will have a demonstration effect and convince the villagers and other such persons of the bonafides of the project.

9.4.3 Taking up Challenging Cases: The challenging cases as given below should be taken up first:

- Persons who acquired visual impairment recently
- Young children
- Visually impaired housewives
- Persons in the working age group
- Educated persons

9.5 Scheduling of Services

On the basis of the individual felt needs of each visually impaired person, the Field Workers should prepare an individual plan for each person under the guidance of the Project Supervisor. The services should be provided in the following sequence:

9.5.1 Social Integration

- Training in orientation and mobility
- Training in activities of daily living
- Training in home economics particularly for females
- Family and individual counselling

9.5.2 Concessions: All visually impaired persons according to their eligibility should be provided the following concessions:

- Bus concession

- Railway concession
- Old age or disability pension
- Scholarship (in case of children)
- Monetary assistance like subsidy, launching grant etc.
- Other concession or facilities available in the area

9.5.3 Age-specific Services: After extending services of social integration and concessions to all the persons irrespective of age, further services should be extended as per age of the person:

- Integrated education for school age children (age 5 to 12 years)
- Economic rehabilitation for working age (18 to 65 years)
- Social rehabilitation for persons above 65 years age

9.5.4 Continue Rehabilitation Services: When any case out of these five cases is completed and rehabilitated completely according to his expressed needs, take up another case immediately. Do not wait for all first five cases to be completed to take up another set of five cases. The training must be a continuous process. The Field Worker must have at least five persons always who are being imparted individual need based training while ensuring follow-up of other cases.

While individualized services are being given, the other CBR services like filling of pension forms, community involvement, provision of assistive devices should go on also.

10. Social Integration and Concessions

Every incurable visually impaired person should be provided individual need based services of social integration as listed earlier. The nature of services would depend upon the age of the individual, sex, age of on-set of visual impairment, level of any earlier training and potential of the individual.

Most visually impaired persons need training in activities of daily living, orientation and mobility and personal grooming to be independent. The following services should be provided according to the felt-needs of the individual:

- Individual counselling
- Parent counselling
- Orientation & mobility training
- Daily living skills training
- Training in social graces and etiquette
- Vocational or occupational training
- Communication skills
- Provision of statutory benefits and concessions

The Field Workers need to be adequately trained for imparting such training to the individuals. Many a times, it is essential to avail services of experts, particularly in case of counselling and communication skills and to involve family members at all stages of such training.

The Field Workers should be provided age-specific training in

orientation & mobility as per details given in Chapters on O&M and Daily Living Skills. They also assist the beneficiaries to avail various support services and concessions etc.

10.1 Nature of Services

The project envisages assisting the visually impaired persons to obtain various travel concessions, monetary benefits and other facilities from the local administration, development agencies, and State as well as Central Governments. Enable a disabled person to avail concession on travel in the local buses to enhance his mobility and social esteem. Extension of such benefits also enhances acceptance of the project among the disabled individuals, their family members and the community.

10.2 Extent of Coverage

The Field Worker should provide information about various concessions, explain the procedure and help the individuals in completion of formalities. He may also need to involve the appropriate authorities and seek their cooperation in this respect.

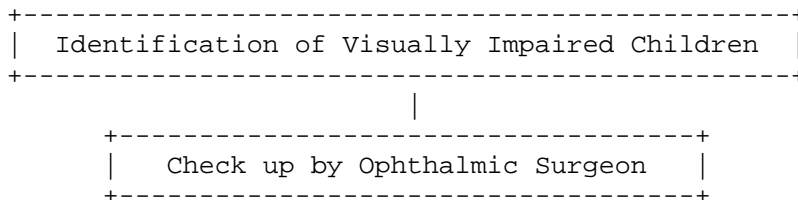
10.3 Type of Support Services

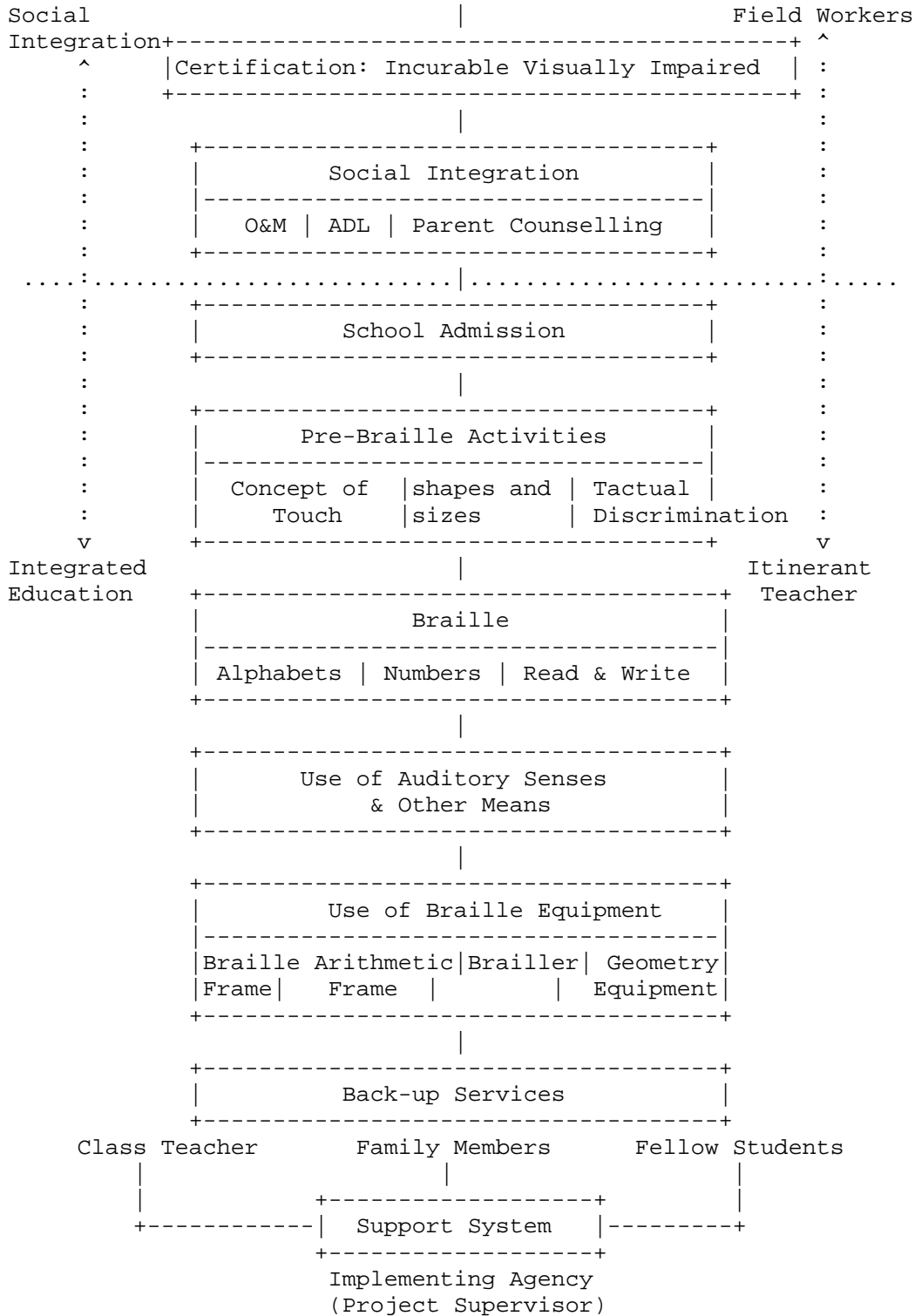
For enhancing social integration, reducing the cost incurred on account of disability, ensuring equality of opportunities, and promoting economic rehabilitation of the disabled, the Central Government, State Governments, local authorities and other instrumentalities of the Government have evolved a variety of schemes of extending concessions, benefits and support services to the disabled. The Field Workers must enable the visually impaired persons to avail the same. There may also be a few schemes which have been promoted by a particular State Government for a particular period. The Project Implementing Agency must keep a track and keep the field staff apprised of the same.

11. Integrated Education

On completion of social integration in terms of training in orientation and mobility, daily living skills and counselling, the incurable persons are divided into school-age and higher age groups. At this stage, the children are referred to agencies implementing integrated or semi-integrated education. Whereas other cases are taken up for further rehabilitation.

Integrated Education Process





Role of Field Staff: As integrated education needs specific inputs, the Field Workers should limit their role to:

- Identification of visually impaired children
- Their referral to the eye hospital

- Promoting their social rehabilitation, and
- Parent counselling.

With the admission of the child into the village school, the role of the Itinerant Teacher begins. (Refer to Chapter on Integrated Education for details)

12. Economic Rehabilitation

12.1 Explanation of the Term

The term economic rehabilitation does not mean a formal, secured or regular employment only. It also means:

- any trade, economic activity or profession,
- in the organized as well as unorganized sector,
- any trade that would provide with some monetary remuneration.

The term employment used by rehabilitation planners generally ignores a vital aspect that the community itself offers a wide spectrum of opportunities where visually impaired persons may be absorbed in gainful occupations. Rehabilitating a 50 year old lady in a remote village in India, for example, means making her a fully functional person in her own house and helping her to take care of her household activities as she used to perform prior to her visual impairment. Majority of women in rural areas are expected to perform the following activities:

- Cook meals for the family
- Perform household activities
- Take care of children and the elderly
- Fetch water and firewood
- Undertake rural occupations or the family trade.

If a visually impaired woman performs the above activities, she is directly helping in the running of the household and she enables the other family members to undertake income generating activities and in the process she contributes indirectly towards family earning.

If a visually impaired person is given the confidence and the training to undertake production activities which are essentially rural, where the raw material is available locally and a ready market is also available, he is directly contributing to the family income. This is what is meant by gainful occupation and thus economic rehabilitation.

12.2 Ultimate Goal

The economic rehabilitation should be the ultimate goal of a CBR programme. Every person who is otherwise eligible and capable should be provided such services to enable him to undertake an occupation and to contribute, in whatsoever way, to the family income. The main categories of vocational rehabilitation include:

- Traditional rural crafts and activities
- Small businesses and petty shops
- Small co-operatives
- Agriculture and horticulture
- Technical and professional activities
- Dairy and animal husbandry

12.3 Use of Community Resources

While imparting vocational training, every effort must be made to utilize the existing community services. It is recognized that the community resources will most likely have the ability to effectively assist the visually impaired persons. The Field Workers should play a crucial role in guiding and supervising community services to offer appropriate training to the individuals.

12.3.1 Examples of local resources are:

- Agriculture extension services
- Local craftsmen such as weavers, basket makers, potters
- Existing co-operatives of craftsmen
- Co-operatives banks and rural development banks
- Nationalized banks and other loan giving agencies
- National Handicapped Finance & Development Corporation
- Technical & craft training institutes
- Labour and employment agencies
- Community development, health and agriculture workers
- Various rural and community development and subsidy schemes

12.3.2 Illustration: Examples of various traditional rural crafts or activities currently being pursued by visually impaired persons around the country are:

- | | |
|--------------------------|----------------------------|
| - carpentry | - broom and basket making |
| - poultry keeping | - food processing |
| - farming | - knitting / sewing |
| - bread making | - dairy farming |
| - forestry | - brick making |
| - pottery / selling pots | - leaf plate making |
| - bone setting | - weaving |
| - rope making | - goat / sheep keeping |
| - preaching | - pump repairing |
| - bicycle repair | - fishnet making |
| - duck keeping | - petty shop-keeping, etc. |
| - foot-wear making | - inland fishing |
| - sericulture | - rice puffing |
| - rice husking | - bee keeping |
| - rice processing | - papad rolling |
| - water hut | - Wick making |
| - Hide processing | - skinning dead animals |
| - coir products | - fence fabrication |
| - vegetable selling | - incense stick making |
| - candle making | - mat weaving |

12.4 Role of the Field Worker

The Field Worker is expected to perform the following functions for expediting economic rehabilitation:

12.4.1 Selection of Activity: Most visually impaired persons would find the above mentioned activities appropriate. It is essential that the Field Worker makes a thorough assessment of the potentials, interest and capacity of the individual before deciding the suitability of the trade or the activity. It is also essential to consider the family background of the individual as many rural crafts are caste-oriented.

12.4.2 Training of Individuals: The Field Worker should organize training of the individual in the selected activity. The family should also be actively involved in such training. Also, the market must be researched to ensure that the activity is viable and income generating.

12.4.3 Organizing Inputs: The Field Worker should also assist the individual in availing:

- Bank loan
- Subsidy, and
- Other financial inputs for the activity.

It is essential that the Field Worker must not create any dependence upon himself/herself or undertake the responsibility for purchase of raw materials and sale of finished products. The trade must however be selected by the visually impaired person himself. These areas should be assigned to the individual or the family members.

The Field Worker may, however, assist:

- in compilation of relevant market information,
- in availing launching grants, monetary incentives, and
- in compiling market information.

12.5 Non-income Generative Activities

It is not always possible to find suitable formal or paid employment in the rural areas. The visually impaired should be taught the income generating tasks or gainful occupations undertaken by the household and save hiring a daily wager. The opportunity income should thus be considered a step towards economic rehabilitation.

In many instances, ability of a visually impaired women to manage and maintain the household is equally important to the survival of the family as is paid employment. Therefore, the Field Workers should make all efforts to encourage informal, unpaid and gainful employment of the individuals.

12.6 Facilities for Economic Rehabilitation

After the person is successfully trained in a particular trade, the objective should be to make him self-reliant by enabling him to get finance and other inputs. Some Government schemes for

training, credit and employment are listed below:

a. Bank loan: All nationalized banks are required to give loans to visually impaired persons at a differential interest rate of 4.5 percent upto Rs. 7,500.

b. Loan from NHFDC: The Ministry of Social Justice & Empowerment has constituted the National Handicapped Finance & Development Corporation for providing soft loan to persons with disabilities at minimal rate of interest. The NHFDC has appointed state level Agencies for processing the loan applications and for the disbursement and recovery of loan etc.

c. Subsidy: The IRDP (Integrated Rural Development Programme) has provision to give a subsidy upto 67 percent on loans given by nationalized banks and Government institutions to visually impaired persons. It has now become mandatory to ensure that at least 3 percent of the beneficiaries under IRDP are persons with disabilities.

d. Training: There are schemes like TRYSEM (Training of Rural Youth in Self Employment) which provides training in rural trades and handicrafts and helps in supply of tool kits to rural artisans. The visually impaired youth can be registered/ involved in such schemes.

d. Credit: The DWACRA (Development of Women and Children in Rural Areas) scheme helps in development of horticulture, pisciculture, sericulture and similar activities through support of formation of groups of 10 to 15 women, and supply of credit to undertake economic activities.

e. Employment promotion: The JRY (Jawahar Rojgar Yojna), an employment promotion scheme to generate additional gainful employment for unemployed and under-employed women and men in areas of watershed development, social forestry, construction of rural link roads and rural housing.

f. Most State Social Welfare Departments have loan schemes for the visually impaired. There are also schemes for the scheduled castes, schedule tribes and other backward classes. If the visually impaired person falls under these castes, loans can be availed under these schemes also.

g. Development agencies like the National Association for the Blind, foreign funding agencies like the DANIDA, OXFAM and Sight Savers International can be approached for obtaining assistance.

h. Local agencies like District Panchayat and Taluka Development Agencies, also have funds for disseminating the same to the visually impaired.

i. Service Clubs like the Lions, Lioness, Leo, Rotary, Rotaract, Inner Wheel, Round Table, Y's Men and Jaycees have sizable funds for promoting social work. These service clubs should be approached for obtaining financial assistance for the economic rehabilitation of the visually impaired.

j. Other sources: Donations can be raised from philanthropists, service-minded persons, and other agencies having funds for promoting economic rehabilitation.

13. Social Rehabilitation

As per the existing demographic pattern of the visually impaired, in 69 percent of cases, on-set of visual impairment is after the age of 60 years. Thus a large number of persons identified in the project area would be in the age groups 60 years and above. Generally for a person in this age group, it may not be possible to plan for any meaningful economic rehabilitation. In most of such cases, the only viable alternative may be to provide services of social rehabilitation.

As mentioned earlier, all the services of door-to-door survey, eye screening, ophthalmic inputs, initial assessment, training in orientation & mobility, counselling and activities of daily living, provision of travel concessions, pension etc. should be provided to the persons falling in the higher age group as well.

The persons in the higher group should also be provided the following additional services:

- Individual counselling
- Family counselling
- State disability or aged pension
- Other monetary assistance
- Health care

13.1 Individual Counselling

The persons in the higher age group need to be counselled in respect of accepting their visual impairment, supporting the family in the day to day activities, looking after their personal needs, managing their mobility and activities of daily living to the extent possible.

13.2 Orientation & Mobility (Refer to Chapter on O&M for specific O&M needs of this group).

13.3 Aged Pension

Most State Governments in India provide pension to the visually impaired in the range of Rs. 60 to Rs. 200 per month. The criteria, age, amount and procedure for availing such pension varies from State to State. Application has to be made in a prescribed form to the respective Social Welfare Department through the revenue authorities.

13.3.1 Role of the Field Worker

- Apprise the individual and family members about the scheme
- Compile required information from the family or village records
- Collect documents to be enclosed with the application
- Arrange photograph of the applicant, if required.

- Complete the application form and submit to concerned authorities
- Follow-up with the concerned authorities regularly
- Keep the family informed about the progress in this regard.

13.3.2 Role of Project Supervisor

- Compile the latest information about the pension scheme
- Collect the application forms
- Share information and distribute forms among the Field Workers
- Follow up the completion of application forms
- Approach the revenue authorities for follow up
- Verify the mode release of pension regularly.

13.3.3 Role of Project Director

- Motivate officials to cover more people and increase pension amount
- Make efforts for simplification of the procedure
- Ensure release of pension regularly
- Verify details of sanction, release and pending cases of pension
- Seek cooperation of revenue officials in processing applications
- Create public awareness about the scheme through mass media

13.4 Other Monetary Assistance

In some States, the aged persons are provided other assistance in cash or kind. For example, during drought in Gujarat, people were provided cash dole and grains etc.; in Haryana, every aged person irrespective of income is provided cash assistance; certain welfare agencies provide grains to helpless people, blankets and clothes to the needy during winter, milk powder to weak persons and other cash assistance to the needy and deserving persons. The Project Supervisor should compile such information and share the same with the Field Workers.

All efforts should be made to extend all these benefits to the aged persons. The similar procedure as in case of pension or the procedure as prescribed by the concerned agency should be followed.

13.5 Health Care

Most aged persons would require health check-up, diagnostic services, medical treatment or surgical intervention. The set objectives of the project do not encompass extension of general health care to the beneficiaries. The Project Implementing Agency may, however, tie up health care with other rural development or public health agencies. The Implementing Agency may not extend the health care on its own. It may, however, encourage referral of the individual to appropriate agencies.

The provision or referral for health care would establish credibility and enhance acceptance of the Project Implementing Agency in the area. It would be easier to seek cooperation of the community workers, opinion leaders or family members in the service delivery and the project implementation. The general health care would also achieve the objective of enhancing mobility and self care of the individual.

14. Case Completion

Due to financial constraints, large and scattered target group and other such factors, it is never going to be possible to provide intensive services to the same individual over many years. The envisaged CBR approach advocates category specific, need based and relevant services for each visually impaired person in the project area. After an individual has been provided need based services as explained earlier, he/she should be dropped as a completed case. The further services should, however, be provided by the family members and the community.

14.1 Check List

The Field Worker should use the following check-list for verifying whether the required services have been provided or not. The check-list should be completed in context of above noted age-specific individual need based services.

Table: Check list - rehabilitation services

Services/ Age Group	Medical Check-up	Orientation & mobility	Activities of daily living	Parent counselling	Bus pass	Pension
1	2	3	4	5	6	7
0-5 yrs	Yes	Training to parents	Yes	Yes	-	-
6-15 yrs	Yes	Yes	Yes	-	Yes	-
16-50 yrs	Yes	Yes	Yes	-	Yes	for those above 45 years
50 years and above	Yes	Yes	Yes	-	Yes	Yes
Scholarships	Eye restora- tion (if necessary)	Integrated education	Vocational training	Bank loans subsidy	Financial assistance	
8	9	10	11	12	13	
-	Yes	-	-	-	-	
Yes	Yes	Yes	Only, if necessary	-	-	
-	Yes	-	Yes	Yes	Yes	
-	Yes	-	-	if person is physically fit	-	

14.2 Procedure for Dropping Completed Cases

At a time, the Field Workers should cover at least five

individuals for providing individual need based intensive services. The number of persons to be taken up simultaneously would, however, depend upon the following factors:

- Geographical terrain
- Prevalence of visual impairment
- Demographic pattern of visual impairment
- Nature and extent of metal roads
- Availability of public transport
- Distance from the residence of the Field Worker
- Distance from the block headquarters
- Extent of involvement of family and community
- Mode of transport used by the Field Worker
- Experience of the field staff etc.

As explained earlier, the Project Supervisor should assist the Field Workers in deciding such cases to be taken up simultaneously. Using the above mentioned check list, the field staff should establish whether a particular beneficiary has been provided all the required services. Whenever any person has been provided these services, the same should be considered a completed case. And the next case from the same village or the adjoining village should be taken up.

Thus any particular Field Worker should cover a required number of cases (generally five) for providing intensive services. One must not wait for all the cases to be completed and dropped for covering the next batch of cases. Thus dropping of completed cases and taking up of new cases should be a continuous process.

14.3 Case Completion Report

Whenever any person has been dropped as a completed case, the proforma No. IX "Case Completion Report" should be completed. The Field Workers should record nature of services provided date of completion and such other relevant information. Details about the following services should be recorded in the proforma.

- a. Door-to-door survey
- b. Ophthalmic check-up
- c. Certificate of blindness
- d. Counselling: family, individual
- e. Nature of training: O & M, ADL, home economics
- f. Economic rehabilitation
- g. Type of support services
- h. School admission, scholarship etc.
- i. Any other assistance or services

This proforma should be completed by the Field Worker, checked by the Supervisor and verified by the Project Director. The proforma should be filed in the individual case file of each individual.

14.4 Follow-up

As mentioned earlier, on provision of individual need based services, the individual is considered a completed case under the

programme. Thus the programme encourages only individual specific intervention and provision of services. It is expected that the further services would be provided by the community and the family.

It is, however, desirable that periodic follow-up should be done by the Field Worker to ensure continuity of services and acceptance of the individual in the fold of the family. It is recommended that, in the beginning, the Field Worker should follow-up each case at least once a month. The frequency of follow up visit which depends upon the following factors may be reduced subsequently:

- Nature of rehabilitation
- Age of the individual
- Specific requirement of individual
- Cooperation and support of the family
- Interest of the individual
- Frequency of visit to the same village for providing services
- Location of the village

If the village is located on the route of the Field Worker, possibility of follow would be higher. Generally more frequent visits would be required in case of vocational rehabilitation as compared to the individuals who has been provided services of social rehabilitation only.

The family members and community should participate actively while planning individual services, imparting training, extending support services and evaluating the performance. The principle objective should be that community should accept the individual in its fold and continue extending further services and co-operation.

15. Monitoring of the Project

While block level administration of the project should be done by the Project Implementing Agencies, an effective system of project monitoring and control at the field level must be evolved.

15.1 Weekly Review Meetings

It is necessary to convene weekly review meetings of the field staff at the headquarters of the Project Implementing Agency. Performance of field staff with respect to rehabilitation, education and participation achieved during the preceding week should be discussed. Similarly, work allocation for the following week for each Field Worker should also be done. The problem faced by the field staff and their distinctive achievements should also be discussed in the meeting.

It is also advisable to involve the specialists who are providing support services for the programme. The Field Worker may discuss relevant problems and seek their advice. The Project Supervisor should be encouraged to maintain Minutes of the proceedings of each such meeting.

15.1.1 Persons who should attend the meetings

- Field Workers
- Project Supervisors
- Project Coordinator
- Project Director
- Representative of the National Coordinating Agency
- Concerned officials of local administration

15.1.2 Agenda for Weekly Review Meeting

- Review of previous week's performance and action taken
- Items discussed
- Decisions taken
- Plan for the next week
- Conclusion

15.2 Attendance Card

An attendance sheet as per proforma X will be kept at the home of incurable visually impaired person. The Field Worker should complete the following information in the proforma and hand over the same to the visually impaired person or the family members:

- Name of the beneficiary
- Serial number of the attendance sheet
- Name of the village
- Name of the cluster
- Name of the project
- Date of keeping the sheet at the home of the beneficiary

Whenever Field Worker, Supervisor, Project Director or other officials of the Project Implementing Agency visit the beneficiary, they should ask for the attendance sheet and sign the same after putting their name and the date of visit. Such visitors may also put any remark, if desired so, in the sheet.

The Project Supervisor should verify the date and time of visit of the Field Worker from the sheet. This sheet should be used as a document for the monitoring movement of the field staff.

15.3 Monthly Reports

The Project Implementing Agency should prepare a monthly report of physical as well as financial performance in the enclosed proforma. For evaluating physical performance of the project, all aspects of rehabilitation of each individual should be considered.

15.3.1 Physical Performance Report: The Project Implementing Agency is required to submit the physical performance report every month to the National Coordinating Agency or to the Funding Agencies as per the memorandum of understanding. The report should provide the following information:

15.3.1.1 Rehabilitation component: The proforma XV should be

used for preparing the monthly performance report in respect of rehabilitation component. This proforma should be completed based on the information provided in the physical performance register as per proforma XV. The monthly report should provide following information:

- General information about the project
- Details of review meetings held during the month
- The extent of awareness created during the month
- Baseline data about curable and incurable visual impairment
- Details of service delivery in terms of:
 - Certificate of blindness
 - Orientation and mobility
 - Daily living skills
 - Bus pass
 - Economic rehabilitation
 - Pension
 - Loan/subsidy
 - School admission
 - Any other

15.3.1.2 Integrated education: As integrated education requires intensive and systematic inputs, the monthly performance report in this respect should be more elaborate as suggested in proforma XV. A detailed report with the following parameters should be submitted for each visually impaired child:

- a. General information of the project
- b. Child wise report
 - Number of home and school visits
 - Individual training in O&M, ADL, braille
 - Supply of instruction material, braille books, large print, tactile material, recorded cassettes
 - Participation in co-curricular activities, holiday camp etc.
 - Other relevant information
- c. General report
 - Difficulties mentioned by teacher, parents, students
 - Details of visitors to the programme
 - Liaison with Government officials
 - Meetings with school staff, parents, fellow students
- d. Any efforts on public awareness

This information should be checked and authenticated by the Project Director. It should be submitted every month to the CCO, NAB Education Department or the Funding Agency etc.

15.3.2 Financial Report: The Project Implementing Agency is also required to submit the financial performance report every month in the prescribed proforma to the National Coordinating Agency or to the Funding Agencies as per the Memorandum of Understanding or the sanction letter. This report should provide the following information:

- Opening balance

- Receipt during the month
- Recurring & non-recurring expenditure during the month
- Closing balance

The Project Implementing Agency should submit separate financial reports regarding the rehabilitation as well as integrated education components. The monthly financial report of the CBR project as per proforma XVI and that of integrated education component as per proforma XVIII should be submitted to the CCO.

As the National Coordinating Agency follows the system of reimbursement of expenditure every month based on actual or admissible expenditure, it is essential to submit the monthly financial reports before the 5th of next month.

15.4 Reporting Formats

A variety of project monitoring and reporting formats have been developed for compiling information, analyzing the performance, maintaining records of progress of the project and for the purpose of submitting regular reports on physical and financial performance of the project.

15.4.1 Uniform Reporting Formats: From the experience of implementing CBR projects for the visually impaired across the country, it has been learnt that it is feasible and desirable to develop uniform reporting formats for the country as whole. Through the use of uniform formats, it would be possible to analyze these formats with the use of computer and it would be easy to compare inter project performance.

15.4.2 Easy Formats: It is, however, desirable that such formats must not be very cumbersome and time consuming. It should be possible for the Project Supervisor to complete all the formats within a few hours. In fact, wherever such formats are very cumbersome and time consuming, the biggest problem has been their timely completion. Many a times, this aspect becomes the biggest obstacle in the project administration.

15.4.3 Language: All the formats have already been evolved in English. All the formats as per paragraph 15.4.6.1 which are required to be used in the field by the Field Worker must be translated into the local language. The formats which are to be maintained at the headquarters of the Project Implementing Agency may be kept in English or the regional language depending upon the convenience of the Agency.

The formats which are to be completed and submitted every month to the National Coordinating Agency or the Funding Agency must be maintained in English only. As the CCO or Funding Agency has to receive and analyze these formats from across the country, it is essential that these reports are provided in English only.

15.4.4 Printed Formats: It is advisable to get the formats printed and distributed among the Project Implementing Agencies. It would ensure uniformity in completion of the formats. It is generally easier to record and analyze pre-planned and printed

formats. The agencies should be encouraged to complete the formats in every respect.

15.4.5 Flexibility in Reporting: It is generally never possible to evolve a programme which may be accepted in totality all over the country. There would definitely be regional modifications in the approach and nature of services. Hence there is adequate scope and flexibility for accommodating such modifications in the reporting formats also.

15.4.6 Recommended Formats: For effective monitoring of the programme, the following formats are essential. There are three categories of reporting formats. The first categories of formats would be used by the field staff for recording progress and performance of the project. The second category of formats would be used for maintaining records of the Project Implementing Agency. Whereas the third category of formats would be submitted to the National Coordinating Agency or to the Funding Agencies.

15.4.6.1 Field Level Formats

- a. Door-to-door survey
- b. Vision screening by ophthalmic personnel
- c. Individual case file
- d. Initial assessment form
- e. Diary of Field Worker
- f. Performance sheet for each client
- g. Attendance sheet: kept at the home of the beneficiary

15.4.6.2 Implementing Agency level Formats

- a. Summary of vision screening
- b. Baseline data - curable cases
- c. Baseline data -incurable visually impaired persons
- d. Summary of baseline data
- e. Weekly visit proforma
- f. Weekly review meetings
- g. Physical performance register
- h. Case completion report

15.4.6.3 Reports to be submitted to the CCO or Funding Agencies

- a. Monthly physical performance report: CBR
- b. Monthly financial performance report: CBR
- c. Monthly performance report for each child: IE
- d. Monthly financial performance report: IE
- e. Project completion report: CBR & IE

Wherever it is possible to use the formats in English, the same formats may be used. It is desirable that such reporting formats must consider regional modifications in the approach and programme implementation plan.

15.5 Case Studies

It has been established that the reporting formats may enable the Central Co-ordinating Agency to generate quantitative data and

statistical reports only. The report may be used effectively for the monitoring and evaluation of the performance of the programme. It is, however, not possible to generate qualitative reports from these formats.

As mentioned earlier, one of the principal objectives of the programme is to create public awareness. Thus the Project Implementing Agencies should prepare and submit human interest stories on the successful cases of complete rehabilitation. Such stories are generally more effective in projecting progress and achievement of the programme than just producing reports on quantitative and statistical analyses of the performance of the programme.

15.6 Individual Rehabilitation Plan (IRP)

For effective implementation of CBR, concept of individual planning, i.e. considering every individual a separate entity and planning comprehensive rehabilitation according to individual felt needs should be adopted. Our approach should be client centered and in consonance with socio-economic conditions of the area.

The service should not be delivered on the basis of pre-conceived notions and experience elsewhere. It is essential that the services should be area specific and as per felt needs of the individual. Thus the type of crafts, trades and remunerative occupations would depend upon the area and specific requirements and potential of the individual.

For this purpose, an individual case file for every individual with detailed information should be maintained. All the services as and when provided to the individuals should be recorded in the case file. The case file should contain the following information for each individual:

- a. General information of the individual
- b. It should have the following enclosures:
 - Assessment form
 - Certificate of blindness
 - Individual rehabilitation plan
 - Bus pa

Annexure I

Course Curricula: For the Training of the Field Workers

1. General Training

Duration.....	8 weeks
Working days	46 days
Field visits	4 days
Inauguration and concluding	1 day
Evaluation and feedback	1 day
Net working days	40 days
No. of hours each day	8 hours
Total hours	320 hours
Theory (3 hours daily).....	120 hours
Practicals (5 hours daily).....	200 hours

S. N.

Topic

1. Introduction of the project, location and target group
 - a. Introduction about the project
 - b. Details of the persons involved in the project
 - c. Explanation about the target group to be covered
2. Historical background of services for the visually impaired
 - a. Brief history about beginning of residential education in Paris during 1784
 - b. Establishing of the first school at Amritsar during 1887
 - c. Missionary approach to education and rehabilitation
 - d. Spread of institutional approach after 1947
 - e. Present status of education, training and rehabilitation
 - f. Beginning of CBR at Madurai, followed by Musiri and then Dholka approach
 - g. Beginning of integrated education during 1956 and itinerant model during 1981
 - h. Present status of integrated education and CBR
3. Need for implementation and promotion of CBR
 - a. Limited coverage of the existing institutional programmes
 - b. Demographic details and need for covering all age groups
 - c. Significance of involvement of family and community
 - d. Community participation
 - e. Comprehensive approach
 - f. Cost effectiveness
 - g. Vast community resources
 - h. Comprehensive approach
4. Statistical and demographical information pertaining to visually impaired
 - a. Major causes of visual impairment and effect on demographic pattern

- b. Estimated population of the visually impaired
- c. Distribution by age group
- d. Gender distribution and comparatively higher percentage of females
- e. Prevalence and incidence of visual impairment
- f. Significance of age of onset of visual impairment
- g. Geographical distribution
- h. Backlog of eye surgery and its implication
- i. Summary of findings of the National Sample Survey (1991)

5. Definition and types of visual impairments

- a. WHO definition
- b. Definition adopted by the Ministry of Welfare
- c. Summary of publication "Uniform Definition of Disabilities"
- d. Definition included in the "Persons with Disabilities Act"
- e. Introduction to E-Test
- f. Introduction to finger count
- g. Information about Curable and Incurable visual impairment
- h. Explanation of the term "Refraction" and "Acuity"

6. Physiology and anatomy of eye

- a. Structure and function
- b. Introduction to various parts of the eye
- c. Refractive errors

7. General causes of visual impairment & symptoms

- a. Major causes of visual impairment
- b. Simplest classification of causes
 - Ocular diseases and anomalies
 - General and systematic diseases
 - Injuries and accidents

c. Early intervention in case of:

- Xerophthalmia
- Cataract
- Trachoma
- Glaucoma

8. Introduction to eye care

- a. General
- b. Complaint, signs, causes, detection and treatment of:
 - Cataract
 - Glaucoma
 - Xerophthalmia
 - Trachoma
 - Eye infection
 - Foreign body
 - Injuries

9. Introduction to low vision aids
 - a. Demographical details of the target group for low vision
 - b. Need for low vision aids
 - c. Introduction to common Low Vision Aids
 - d. Referral to appropriate agencies in case of low vision
 - e. Details about such agencies
10. Psycho-social implications of visual impairment
 - a. Objective effects of visual impairment
 - b. Subjective variables & psychological implications
 - c. Social factors
 - d. Introduction to functional assessment
 - e. Importance of parent counselling
11. Acceptance of visual impairment, its need and importance
 - a. Need for individual and reference group counselling
 - b. Need for building up self confidence
 - c. Acceptance of disability
 - d. Case studies on adjustment, acceptance and self confidence
12. Meaning, importance, types and consequences of rehabilitation
 - a. ILO definition of rehabilitation
 - b. Modification of the definition in Indian Context
 - c. Socio-psychological implications of rehabilitation
 - d. Financial and economical implications
 - e. Types of rehabilitation:
 - Medical
 - Social
 - Educational
 - Vocational
 - Economical
13. Various models of rehabilitation prevailing in the country
 - a. Institutional approach
 - Sheltered workshop
 - Transitory employment
 - On-the-Job training
 - Homes for the aged blind
 - Special residential schools
 - b. Non-Institutional approach
 - Open employment
 - Home-bound programmes
 - Community-based rehabilitation
 - Integrated training
 - Inclusive education
 - Regular training
 - Professional training

c. Merits and limitations of these models

14. Survey methods

- a. Individual survey methods
- b. Need and importance of door to door survey
- c. Procedure of conducting door to door survey
- d. Recommended procedure of identifying the opinion leaders
- e. Details about initial survey forms

15. Meaning, definition and philosophy of CBR

- a. WHO definition of CBR
- b. E. Helander's definition of CBR
- c. Modification of definition in Indian context
- d. Components of CBR
- e. Need for encompassing all the components
- f. Community-based and not community-oriented
- g. Outcomes of CBR

16. Aims and objectives of CBR

- a. Complete integration of the individual
- b. Only viable approach
- c. Extensive coverage at low cost
- d. Demonstration to general public
- e. Attitudinal change through public awareness
- f. Active participation and involvement of community
- g. CBR: the most viable and result oriented approach

17. Components of CBR

a. Service delivery:

- Social rehabilitation
- Economic rehabilitation
- Support services
- Public awareness

b. Referral only:

- Prevention and cure of visual impairment
- Integrated education
- Other disabilities and multi-disabilities

18. Methodology of CBR

- a. Appointment of project implementing agency
- b. Selection of field staff
- c. Training of field staff
- d. Door-to-door survey
- e. Ophthalmic intervention - referral
- f. Detailed survey
- g. Social rehabilitation
- h. Integrated education - referral
- i. Support services
- j. Inputs for economic rehabilitation

- k. Method for creating public awareness
 - l. CBR process chart
19. Organizational structure of the project
- a. Various tiers of the structure
 - b. Role of central coordination office
 - c. Role of the project implementing agency
 - d. Details and roles of the persons involved in the project
 - e. Flow of funds, information and reports
20. Role of central coordinating agency
- a. Introductions of persons involved
 - b. Co-ordinating training of the field staff
 - c. Monitoring of working of the project
 - d. Creating public awareness through mass media
 - e. Involving Government as well as non-Government agencies
 - f. Advocacy in proliferation of the concept
 - g. Compiling and dissemination of information
 - h. Organizing refresher courses for the field staff
 - h. Adopting regional modification to the approach
 - j. Developing and publishing relevant materials
21. Role of project implementing agency
- a. Details of the Project Director
 - b. Details of the members of the project managing committee
 - c. Role of the implementing agency:
 - Implementation of the project
 - Providing office infrastructure
 - Providing space for weekly review meetings
 - Organizing referral in case of
 - * Ophthalmic inputs
 - * Integrated education
 - * Services for other disabled and multi-disabled persons
 - Involving local administration in the project
 - Tapping local media for public awareness
 - Monitoring of the project
 - Handling of the funds
 - Maintaining of the accounts
 - Submission of the reports in prescribed formats
 - Mobilizing resources from alternative sources
22. Need for involvement of local agencies
- a. For seeking participation of community in the programme
 - b. For utilizing the local resources to the fullest extent
 - c. For achieving permanency of the concept
 - d. For economizing the project
 - e. For extending generic services to the visually impaired
23. Roles and responsibilities of Field Workers
- a. Door-to-door survey
 - b. Referral for ophthalmic inputs

- c. Initial assessment
- d. Extending of individual need-based services
- e. Seeking participation of community at all stages
- f. Extending concessions and benefits to the individuals
- g. Maintaining all the individuals and group records
- h. Participating in the weekly review meetings
- i. Sharing progress, achievements and experience in the meeting
- i. Participating in the refresher courses
- j. Involving the local administration in service delivery

24. Roles of other field functionaries

a. Project supervisor

- Regular field visits
- Monitoring of the project
- Developing referral services in case of prevention and integrated education
- Working as a link between the implementing agency and the Field Workers
- Developing contacts with the local administrative authorities and welfare organizations
- Preparing monthly reports of physical as well as financial performance
- Conducting and guiding weekly review meetings
- Organizing field visits of the Project Director and other officials

b. Itinerant teachers:

- Preparing children for integrated education
- Providing inputs pertaining to plus curriculum
- Counselling the:
 - * Family members
 - * Peer group
 - * Class teacher
 - * Individual
- Supplying braille and other materials
- Monitoring progress of visually impaired children

25. Education and visually handicapped

- a. Need for integrated education
- b. Importance, merits and limits of integrated education
- c. Role of itinerant teachers in promoting such education
- d. Community participation
- e. Various requirements under the Central Scheme of Integrated Education of the Disabled

26. Models of education of the visually impaired

- a. History of education
- b. Models of education
 - Residential schools
 - Itinerant model

- Resource model
- Semi-integrated model
- Cooperative plan
- Inclusive education
- SPED centres

c. Their merits and limitation

27. Introduction to integrated education

- a. Need of integrated education
- b. Merits of such education
- c. Role of education system in promotion of such education
- d. Sources of funds
- e. Role of project implementing agency
- f. Salient features of integrated education scheme
- g. Needs for implementation of integrated education

28. Components of integrated education

a. Sequence of services:

- Child preparation
- Teacher and family counselling
- Orientation of school
- School admission
- Counselling of peer group
- Support services

b. Importance of acceptance of child into the school

- c. Only viable option for rural areas
- d. Production and supply of braille and talking material
- e. Scholarship scheme

29. Role of Field Workers in integrated education

- a. Role of field staff - limited only to referral
- b. Need for involvement of local education institutes
- c. Role of State Department of Education
- d. Details about successful experiments elsewhere
- e. Need for issuing of orders by the District Education Officer in respect of admission of blind children

30. Referral in case of prevention and cure of visual impairment

- a. Role of Field Workers in case of eye care - limited only to referral to Ophthalmologist or an eye care agency
- b. Importance of involving of Ophthalmologist in the project
- c. Need for screening of all cases with eye problems
- d. Certification of blindness before initiation of the rehabilitation components
- e. Role of Project Implementing Agency in prevention and cure of visual impairment

31. Concept of social rehabilitation

- a. Importance of daily living skills
- b. Need for independent mobility
- c. Concept of social integration
- d. Family counselling
- e. Need for extending travel concessions and other benefits
- f. Acceptance through demonstration of the abilities

32. Components of Social rehabilitation

- a. Independent mobility
- b. Confidence in personal care
- c. Effective home management
- d. Understanding of the environment
- e. Confidence building through counselling and training
- f. Extension of concessions and benefits under various schemes

33. Importance of orientation and mobility

a. Definitions:

- Orientation
- Mobility

b. Importance of O & M

- Safety of the individual
- Financial independence
- Step to comprehensive rehabilitation
- Mobility and sports

34. Techniques, methods and process of O & M

a. Mobility techniques

- Pre-cane skills
- Sighted guide techniques
- While approaching narrow ways
 - * Ascending and descending stairs
 - * Being helped to a chair
 - * Passing through doorways
- Walking along
 - * Trailing
 - * Protective techniques
- Upper arm and forearm techniques
- Lower hand and forearm techniques
 - * Locating dropped articles
 - * Using landmarks indoor
 - * Direction taking
- Long cane
 - * Importance

- * Right type of cane
- * Qualities of cane
- * Techniques of holding the cane
- * Grip
- * Hand position
- * Wrist movement
- * Arc
- * Rhythm
- * Using the cane
- * Adaptation of cane techniques for rural areas
- * Shorelining
- * Guide dogs

- Introduction of basis techniques
- Limitations in Indian conditions

b. Using other senses for orientation

- Hearing
- Touch
- Smell
- Temperature
- Kinesthetic Sense
- Taste

c. Orientation and mobility training in Indian conditions

- Adaptation of techniques
- Individual need-based training

35. Introduction to activities of daily living and home economics

a. Introduction to ADL

b. Training strategy

- Procedure for designing the daily living skills
- Specific rules for teaching the daily living skills

c. Training content

- Personal care
- Cooking skills
- House keeping skills
- Home economics

d. Training in individual activities

- Bathing
- Brushing teeth
- Shaving
- Washing clothes
- Money identifications
- Pouring liquids
- Lighting a kerosene lamp
- Lighting a sagdi (furnace)
- Making open fire
- Eating

- First aid in rural situation
 - c. Specific training in rural conditions
 - d. Special tips for Field Workers
36. Need and importance of parent counselling
- a. Explain project is community-based not community-oriented
 - b. Need for active involvement of parents/family
 - c. Approach to parent counselling
 - d. Parental involvement while imparting training
 - e. General motivational techniques
 - f. Role of parents in the programme
 - g. Role of community in the programme
37. Types of counselling
- a. Individual counselling
 - b. Group counselling
 - c. Counselling through demonstration
 - d. Counselling through narration of successful cases
 - e. Identification and involvement of opinion leaders
 - f. Role of Field Worker as a counsellor
38. Need for community involvement in the rehabilitation process
- a. Complete rehabilitation: responsibility of the community
 - b. Project is a short term intervention
 - c. Ultimate goal: acceptance of the individual in the fold of the family
 - d. Optimum utilization of the community resources
 - e. Rehabilitation from within the community
39. Concessions and facilities available to the visually impaired
- a. Travel concessions
 - Local buses
 - Railways
 - Air

Explain the procedures and help in availing such concessions. It may involve approaching the concerned authorities and convincing them to extend such concessions. The Field Workers may help the individuals to complete various formalities. Thus the procedure of availing such concessions should be explained in detail.

- b. State pension for the disabled
 - c. Subsidy on loan
 - d. Scholarship in case of students
 - e. Various educational and mobility aids and appliances
 - f. Cash assistance
 - g. Preference in housing schemes
 - h. Coverage under poverty alleviation schemes
 - i. Preference under rural development schemes
40. Process of economic rehabilitation and its importance

- a. Explanation of the term
 - b. Significance of income generating activities
 - c. Use of local resources
 - d. Examples of local crafts and activities
 - e. Examples of successful cases of economic rehabilitation
41. Introduction to local crafts, trades and occupations
- a. Listing of the crafts suitable for the visually impaired
 - b. Explaining any adaptation in the tasks or the equipment
 - c. Blind fold training in performing the tasks relevant to the craft prevailing in the area
 - d. Sharing information regarding the:
 - Sources of raw material
 - Production process
 - Costing
 - Profitability
 - Marketing information
42. Introduction to various inputs required for effective economic rehabilitation and completion of various formalities
- a. Selection of activity or craft
 - b. Training of the individual
 - c. Organizing material inputs
 - Bank loan
 - Subsidy
 - Other financial inputs
 - Information about sources of raw materials and avenues for the sale of finished products
 - d. Need for active involvement of community in the process
43. Reporting formats
- a. Need and importance of reporting
 - b. Introduction to various formats of reporting
 - c. Door to door survey form
 - d. Initial assessment form
 - e. Daily diary of Field Worker
 - f. Case file for each individual
 - g. Weekly tour programme
 - h. Log-book of different functionaries
 - i. Case completion report
 - j. Monthly financial performance report
 - k. Monthly physical performance report
 - l. Significance of maintaining individual case files
 - m. Importance of weekly review meetings
44. Resource mobilization and role of field staff
- a. Sources of funds
 - b. Listing of community resources
 - c. Importance of utilizing community resources
 - d. Introduction about various schemes of local administration

- e. Procedure of availing benefits under such schemes
- f. Roles of different field functionaries in resource mobilization

45. Introduction to braille

- a. Brief history of braille system
- b. Pre-Braille activities
- c. General introduction to six dot system
- d. System of braille reading
- e. Introduction of common writing devices

46. Importance of weekly review meetings and methods of conducting the same

- a. Need for such meetings
- b. Recommended agenda for such meetings
 - Review of performance during the last week
 - Discussion on every case under training
 - Planning for the next week
 - Finalization of the weekly tour programme
 - Finalization of any major activities, visits, camps etc. during the following week
 - Discussion with the Project Director, Ophthalmologist or other officials
- c. Maintaining minutes of the meetings
- d. Finalization of the travel vouchers, expenditure vouchers, monthly reports and payments of honorarium etc. during review held in the beginning of the month

47. Case closure and concept of complete rehabilitation

- a. Explanation of the term - case closure
- b. Need for moving from case to case
- c. Concept of short term intervention and then follow up
- d. Explanation of the chart of envisaged services for various age groups

48. Need for creating public awareness

- a. Need for creating public awareness
- b. Various modes of creating public awareness
- c. Examples of such efforts elsewhere
- d. Importance of area specific modes of creating awareness

49. Presentation of case studies and group discussion

- a. Successful cases of
 - Restoration of eye sight
 - Social Integration
 - Economic rehabilitation
 - Integrated education
 - Acceptance by the family
- b. Sharing information about the procedure followed in case of

these cases

- c. Discussion on hurdles in the process of rehabilitation
- d. Role of Field Worker in achieving success

50. Final evaluation and selection

- a. Theory and practical examination
- b. General performance in class and during practicals
- c. Regularity and sincerity during training
- d. Development of communication skills
- e. Understanding of the concepts
- f. General personality and oratory

2. Ophthalmic Training

The Field Workers are also given ophthalmic training to help them to identify simple eye ailments and understand the various causes of visual impairment. This will help to dispel their superstitions and equip them with the skills of explaining the same to the rural folk. Training is given in the following aspects in a class-room and hospital background by eminent ophthalmologists:

- a. General eye-care
- b. Pathology of the eye
- c. Introduction of common eye-ailments and allied diseases
- d. Prevention of preventable eye-ailments and blindness
- e. Introduction to prevailing eye-care programmes, etc.
- f. Procedure for organizing eye camps, availability of financial assistance, and extent of involvement of service clubs
- g. Causes of blindness and the existing prevention programmes
- h. Availability of visual aids
- i. Details of eye-care centres and services existing in the particular district

3. Practical Training

The field staff is imparted practical training for five hours everyday in the rural settings. The venue for providing such training will be model village with the following amenities:

- a. A temple or a place of public gathering
- b. A river or pond or any place for water collection or ablution
- c. Access with the highway and means of public transport
- d. Various types of houses, roads, etc.
- e. Post office, dispensary, school, panchayat office, etc.
- f. Dung pits, manure pits, farm machinery, and farm implements.

The concept of having a model village for imparting mobility training is to acquaint the Field Workers with the salient reference points found in a typical village. The field staff will get exposure to orientation and mobility training in a village setting so that more blind can be helped to be adequately rehabilitated.

The knowledge of getting the proper feel of the environment will enable the staff to understand the hazards and benefits of

blindness. As the training will be under blind fold, they will understand the blind better.

The field training is given in the following aspects:

- a. Methods of identifying rural blind, counselling the family, preparing case histories, reporting in the prescribed proforma, etc.
- b. Providing orientation and mobility training in a scientific and professional manner
- c. Training in home economics and daily living skills
- d. Practical exposure to realistic situations while under blindfold such as crossing a busy road, boarding buses, and negotiating traffic
- e. Intensive training in rural crafts and trades and agricultural operations of threshing, sowing, reaping, transplanting, operating, and repairing of farm machinery.

4. Various Personnel Needed for Training

Details of training	Faculty
1. Introduction of the project	Project Director
2. Socio-psychological aspects	Local faculty of Psychology
3. Education of visually impaired	Special Educator
4. O&M training	Trained O&M Instructor
5. Potentials of visually impaired	Occupational Therapist
6. Job adaptations	Vocational Counsellor Placement Officer
7. Community participation	Trained Social Worker
8. Aids & Appliances	Trained rehabilitation worker
9. Rehabilitation & agriculture	Agriculture Officer
10. Dairy & animal husbandry	Animal Husbandry Officer
11. Poultry	Poultry Officer
12. Rural crafts	Local Craft Instructor
13. Government participation	Social Welfare Officer
14. Ophthalmic training	Ophthalmologists
15. Project reporting	Project Director/coordinator

Annexure II

Course Curricula: Master Trainers

COURSE CURRICULA
for the Training of CBR Co-ordinators / Trainers

Duration	:	5 Months
Total Hours	:	750 hours
Theory	:	250 hours
Practicals	:	500 hours

The Project Coordinators are expected to perform a variety of role in respect of training the field staff, coordinate the functioning of various projects and to do general administration of the people, funds, information, infrastructure and the concept. Thus it is desirable to impart three pronged training to such personnel to enable them to work as Master Trainers, Project Coordinators and Administrators. Hence the training has been divided into three modules:

- a. As Master Trainers with focus on service delivery, individual needs and training components
- b. As Coordinator with focus project supervision, project monitoring, performance evaluation etc.
- c. As Administrators with emphasis on legal, administrative and financial aspects of managing the programme.

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S. N.            Topic  
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I. As Master Trainers

1. Disabled and disability

- a. Understanding disability and disabled
- b. The consequences of disease and disabling conditions

- The response to illness
- A unifying frame work
- Application of the concepts

- c. Causes of disability
- d. Prevention of disabilities
- e. The magnitude of disability
- f. Demographic details of the disabled

2. Disabled and society, community organization and urban and rural community development

- a. Special aspects of technological changes
- b. Indian society in transition
- c. Special legislation: The Persons with Disabilities Act
- d. Security schemes and their impact on service delivery
- e. Definition of community and community organization

- f. Importance of utilization of community resources
- g. Concept of purposeful intervention

3. Social case work and social group work

- a. Definition of social case work
 - b. Components of social case work
 - c. Concept of 'Person is a situation'
 - d. Material and human resources
 - e. Qualities of a case worker
 - f. Skills of interviewing and recording
4. Philosophy of disabled welfare

5. Human personality growth and behaviour development (special reference of visual disability)

- a. Nature, concept, dynamics and development of human behaviour
- b. Concept of growth and development
- c. Motivation of human behaviour
- d. Inner strength of an individual
- e. Developmental tasks in different stages of development

6. Society and disabled legislation

- a. Social legislation
- b. Legislative and constitutional provisions for the disabled
- c. The Persons with Disabilities Act, 1995
- d. Executive orders on job reservation
- e. Effectiveness of legislative provisions
- f. Merits and demerits of such provisions

7. Counselling psychology (with reference to visually impaired)

- a. Principles and definition of counselling psychology
- b. Introduction to behaviour modification
- c. Humanistic theory
- d. Behavioural theory
- e. Group counselling
- f. Guidance & counselling

8. Psychology of personal adjustment and personality theories

- a. Milestone developments of a visually handicapped child
- b. Socio-psychological aspect of visual disability
- c. Personality development
- d. Mannerism and blindness
- e. Adjustment process
- f. Visually impaired child and mental retardation

9. Causes and prevention of visual impairment

- a. Structure and functions of the eye
- b. Common eye ailments
- c. Refractive errors
- d. Major causes of visual impairment
- e. Early intervention

f. Prevention of visual impairment

10. Definition: visually impaired

- a. Broad definition
- b. WHO classification
- c. Explanation of various terms
- d. Definition adopted in the Persons with Disabilities Act
- e. Importance of disability certificate

11. Demographic details of the visually impaired

- a. Population of the visually impaired in india
- b. Demographic details of the visually impaired
- c. Incidence and prevalence of visual impairment
- d. Geographical distribution
- e. Summary of the findings of the National Sample Survey (1991)

12. Training of the field staff:

- a. Analysis of the course curricula
- b. Importance of involvement of local faculty
- c. Development of local human resources
- d. Procedure of selection of the field staff
- e. Method and duration of training

As Co-ordinators

1. Employment and placement of the visually impaired

- a. Importance
- b. Production potentials
- c. Avenues of employment
- d. Modern placement techniques
- e. Job reservation
- f. Incentives for the promotion of employment

2. Significance of economic rehabilitation

- a. Concept of economic rehabilitation
- b. Significance of unorganized sector
- c. Venues of self employment
- d. Role of community in expediting economic rehabilitation
- e. Group approach to rural occupations
- f. Schemes on self employment
- g. Incentives for self employment

3. Models and approaches to welfare of the visually impaired

- a. Institutional approach
- b. Transition from institution to community
- c. Community based rehabilitation and integrated education
- d. Inclusive training and education
- e. Provision of the Persons with Disabilities Act

4. Orientation & mobility and its importance

- a. Definitions
 - b. Importance of orientation and mobility
 - c. Mobility techniques
 - d. Use of other senses for orientation
 - e. Orientation & mobility training in indian conditions
5. Activities of daily living and home economics
- a. Introduction
 - b. Training strategy
 - c. Training content
 - d. Training in individual activities
 - e. Training in indian conditions
 - f. Special tips for rehabilitation functionaries
6. General introduction to braille
- a. Introduction
 - b. Braille reading and writing
 - c. Method of teaching braille
 - d. Availability of braille books and tactile material
7. Aids and appliances for the visually impaired
- a. Educational aids
 - b. Mobility aids
 - c. Vocational aids
 - d. Daily living aids
 - e. Low vision aids
 - f. Psychological tests
8. Education of the visually impaired
- a. Explanation of the term: education
 - b. Status of education
 - c. History of education
 - d. Residential schools
 - e. Integrated education
 - f. Inclusive education
 - f. Future of residential schools
 - g. Which system is better
 - h. Middle path approach
9. Central Scheme of Integrated Education of the Disabled
- a. Introduction of the scheme
 - b. Role of voluntary organizations in the scheme
 - c. Procedure of availing grant
 - d. Role of State Government in the scheme
10. Community based rehabilitation
- a. The existing scenario
 - b. Concept of CBR
 - c. Component of CBR
 - d. Implementation plan
 - e. Manpower requirement

- f. Tips for initiation of a CBR programme
- g. Roles and responsibilities of the implementation agencies in the programme
- h. Role and responsibilities of the co-ordinating agencies in the programme

12. Existing welfare programmes and the concessions

- a. Major schemes of the Ministry of Welfare
- b. National level Government programmes
- c. Addressees of:
 - concerned State Departments
 - Social Welfare Advisory Boards
 - Special Employment Exchanges
 - Major welfare organizations for the visually impaired
- d. Educational concessions
- e. State level schemes, programmes and concessions

As Project Administrators

1 Social welfare administration

- a. Social policies and social planning
- b. Administrative machinery and development planning
- c. Planning structure and process
- d. Monitoring of social welfare services
- e. Use of group process in social administration

2. Written analysis and communication

- a. Importance of effective communication
- b. Procedure for improving communication skills
- c. Report writing
- d. Reference to relevant published material
- e. Method of compilation, analysis and dissemination of information
- f. Method of preparing successful case studies

3. Survey methods

- a. Door-to-door survey
- b. Persons to be approached for seeking information
- c. Proforma for survey
- d. Proforma for baseline data
 - Curable cases
 - Incurable cases
- e. Initial assessment proforma
- f. Importance of base line data

4. Administration of CBR programmes

- a. Proper selection of the project implementing agency
- b. Effective training of the field staff
- c. Adequate and proper supervision of the staff

- d. Organizing and conducting weekly review meetings
 - e. Regular visits and supervision of performance
 - f. Importance of consistent motivation of the team
 - g. Recognition of good performers
 - h. Group approach to problem solving
5. Organization and administration of rural community development
 - a. Organizational flow chart from centre to the village
 - b. Type and character of administration work
 - c. Role of development administration
 - d. Responsibility areas
 - e. Role of field functionaries in project administration
6. Community based rehabilitation - implementation plan
 - a. Various components
 - b. Process chart
 - c. Role of various functionaries
 - d. Methods of community participation
7. System of project monitoring
 - a. At the local, co-ordinating agency and the Government level
 - b. Weekly review meetings
 - c. Reporting proforma
 - d. Monthly physical and financial performance reports
 - e. System of reimbursement of expenses
 - f. Field visits
8. Introduction to reporting formats, significance of reporting
 - a. Door to door survey
 - b. Initial assessment
 - c. Individual case file
 - d. Monthly physical performance report
 - e. Monthly physical performance report
 - f. Daily diary of field staff
 - g. Weekly review meetings
 - h. Physical performance register
 - i. Project completion report
 - j. Regularity and sincerity in reporting
 - k. Computer software for data storage and analysis
 - m. Management information system
9. Project evaluation
 - a. Need for evaluation
 - b. Methods of evaluation
 - c. Importance of current and periodic evaluation
 - d. Indicators for evaluation
 - Cost effectiveness
 - Unit cost of coverage
 - Social accountability
 - Extent of community participation
 - Replicability of the project
 - Sustainability

- Economic viability

e. Role of different agencies in evaluation

10. Procedure for availing grant-in-aid from the:

- a. Central Government
- b. State Governments
- c. Voluntary organizations
- d. Salient features of application for grant-in-aid
- e. List of enclosure to be enclosed
- f. Maintenance of various records etc.

11. Financial management and budget planning

- a. Budget allocation
- b. Admissible recurring and non-recurring expenditure
- c. Proforma for monthly financial report
- d. Authentication and approval of vouchers
- e. Economy in expenditure
- f. Procedure for reimbursement of expenditure
- g. Fund flow and cash flow
- h. Salient features of Foreign Contribution Regulation Act
- i. Provisions of Income Tax Act

12. Introduction to book keeping and accountancy

- a. Procedure for preparing vouchers
- b. Cash book
- c. Expenditure ledger
- d. Maintaining cash and bank balance
- e. Procedure of release of grant
- f. Trust law on accounting matters

13. Legal aspects of welfare organizations with reference to:

- a. Societies Registration Act
- b. Public Trust Act
- c. Foreign Contribution Regulation Act
- d. Indian Companies Act (Section 25 only)
- e. Income Tax Act (Sections 12, 35, 80 G)
- f. Employees Provident Fund Act
- g. Industrial Disputes Act
- h. The Persons with Disabilities Act, 1995

Practicals

- a. Orientation & mobility and movement science
- b. Daily living skills and home economics
- c. Auditory & tactile maps
- d. Introduction to braille
- e. Survey methods and approaches to rural development
- f. Use of educational and mobility aids
- g. Exposure to common eye ailments
- h. Case method of project handling, preparing of case studies
- i. Making of vouchers and checking of books of accounts
- j. Writing of reports and statistical analysis

Annexure
List of Various Agencies

I. Funding Agencies:

1. Ministry of Social Justice & Empowerment Government of India
`A' Wing, Shastri Bhawan
New Delhi 110 001

2. Ministry of Human Resource Development
(Department of Education)
Shastri Bhawan, `C' Wing
New Delhi-110 001.

3. Sight Savers International
A-3, Shiv Dham, Plot No.62
New Link Road
Malad (W)
Bombay - 400 064.

4. Christoffel Blindenmission
South Asia Regional Office (North)
YMCA, Cultural Central Building
1, Jaisingh Road,
New Delhi - 110 001.

5. Christoffel Blindenmission
South Asia Regional Office (South)
559, 11th Main Road
Hall II, Stage
Indiranagar
Banglore -560 008.

6. Danish International Development Agency (DANIDA)
A-148, Safdarjung Enclave,
New Delhi 110 029

7. OXFAM (INDIA)
C6/59, Safdarjung Development Area
New Delhi 110 016

8. South Asia Partnership (India) SAP
C. G. I Floor, Commercial Complex
Safdarjang Development Area
New Delhi

9. MISEREOR
C/O Indo-German Social Service Society
28, Lodhi Road, Institutional Area
New Delhi 110 003

10. World Blind Union
C/o CPB O.N.C.E.
La Coruna 18
28020 Madrid, Spain.

11. National Association for the Blind

11 Abdul Gaffar Khan Road
Worli Seaface, Bombay 400 025

- NAB Rural Activities Committee for rehabilitation
- NAB Education Committee for integrated education

12. State Bank of India
Community Banking Services Scheme
Nariman Point
Bombay.

13. Helpage India
TRDC, C-14, Qutab Institutional Area
South of IIT
New Delhi - 110 016.

14. Council for Advancement of People's
Action and Rural Technology (CAPART)
India Habitat Centre
Zone -V, 2nd Floor, Lodhi Road
New Delhi -110 001.

15. Manav Kalyan Trust
2nd Floor, Swapna Complex
Jawaharnagar Chowk
Maninagar, Ahmedabad -380 008.

II. CBR Project Implementing Agencies:

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S No      Project Location      Implementing Agency      Funding Agency  
1                      2                                      3                                      4  
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I. Andhra Pradesh

1	Hayathnagar	Mr. James David General Secretary NAB (AP) State Branch Durgabai Deshmukh Hospital Hydrabad	Sight Savers
2.	Kothagudem	Rotarians Community Services Foundation, Kothagudem, Dist. Khamam	Sight Savers

II. Bihar

3.	Sahpur	Dr. S.N. Upadhyay Bihar Blind People's Society 209, M.I.G. KankarBaugh Patna (Bihar) - 800 020 Ph. 52737	Sight Savers
4.	Devkulidham	General Secretary Kameshwari Priya Poor Home	Sight Savers

Darbhanga 846 004 Ph. 2593

III. Gujarat

5. Dholka Mr. Gautam Mazumdar Sight Savers
Secretary, Indian Red Cross Society
Atulaya Bhawan
Thaltej Tekra, Drive-in Road
Ahmedabad 380 054
6. Dhandhuka Mrs. Hiraben Modi Sight Savers
Modi Gin, Dhandhuka
Dist.: Ahmedabad Ph. 17
7. Patdi Mr. Kanubhai Gadhvi Sight Savers
8. Lakhtar Rashtriya Jagruti Mandal
Patdi, Dist. Surendranagar
9. Kankrej Mr. Lalubhai Prajapati Sight Savers
Principal: School for the Blind
Palanpur Shishushala
Balmandir & Education Trust
Palanpur - 385 501 Ph. 2057
10. Patan Prof. Ramnik Halari Sight Savers
--. Chanasama General Secretary
--. Sami NAB Mehsana District Branch
--. Harij Commercial Centre (South Wing),
Three Gates, Visnagar 384 315
Ph. 2710
11. Viramgam Dr. Ramilaben Jain State Bank of India
Sanjivani Hospital
Bordi Bazar
Viramgam 382 150 Ph. 130
12. Sanand Mr. Baldevbhai Dosabhai State Bank of India
President, Sanand Sarvajanic Trust
Eye Hospital, Sanand 380 110
13. Vijapur Dr. B. P. Chaudhary State Bank of India
Swami Ramanand Swarwati Trust
Shri Revabhai Valjibhai Nayee
General Hospital
Vijapur N.G.
14. Idar Prof. Bhaskar Y. Mehta OXFAM
15. Vijaynagar General Secretary
16. Khedbrahma NAB Sabarkantha Dist. Branch
--. Malpur "Yogendra Krupa" 7 Anand Nagar
Co. Society Ltd.
Behind Dhaneshwar Society
Idar - 383 430 Ph. 276
17. Prantij - do - Manav Kalyan Trust

18. Rapar	Mr. Dinesh Sanghvi Shri Gram Swaraj Sangh Post Nilpar Ta. Rapar Dist Kutch	OXFAM
19. Mendarda	Mr. Anil Patel	NAB
20. Bhesan	General Secretary NAB Junagarh Branch Swami Vivekanand School Premises Junagarh	
21. Lodhika	Mr. G. J. Vachhani General Secretary Rajkot Dist Branch, Bhaktinagar Society Opposite Stri Kanta Vikas Gruh Gondal Road, Rajkot	NAB
22. Nalakantha --. Limbdi --. Sayla --. Gandhinagar --. Daskroi --. Dehgam	Mrs. Nandini Rawal Project Director Blind Men's Association Vastrapur, Ahmedabad 380 015	Helpage, Manav Kalyan Trust, L. D. Jhaveri Foundation
23. Dhrangadhra	Mr. V. Rao Project Director Saurashtra Apang Mandal Near Nagarpalika Dhrangadhra.	Manav Kalyan Trust & Private Donors
24. Valsad	Mr. Rambhai patel Secretary NAB Valsad Branch Near Duttnagar Housing Society Civil Hospital Road Nanakvada, Valsad -369 001.	
25. Dahod	Shri Yusuf F. Kapadia Secretary National Association for the Blind Panchmahal Dist. Branch Borvani Road P.O. Chhapri, P.O. Box 39 Dahod -386 151.	
IV. Haryana		
26. Palwal	General Secretary	Sight Savers
27. Hodel	or Development Officer	
28. Mohindergarh	NAB Haryana State Branch	
29. Ballabgarh	Central Green, K. C. Road, N.I.T.	
30. Narnaul	Faridabad - 121 001 Ph. 81-24432, 81-24182	
31. Hathin	-do-	South Asia Partnership
--. Jatusana	-do-	NAB

V. Karnataka

32. Chikaballapur Mrs. Ratna Atmaram Rao Sight Savers
33. Siddlaghatta President,
34. Chintamani NAB Karnataka Branch
35. Malur 996 Hall II Stage
36. Gauribidanur Indiranagar
37. Kolar Bangalore 560 038
38. Kunigal -do- Ministry of Welfare
39. Koratagere -do- DANIDA
--. Chinhalli -do-
--. Tumkur -do-
--. Sira -do-
--. Madhugere -do-

VI. Kerala

40. Madathikonam Mr. P. George Sight Savers
41. Vellanad Project Director
NAB Kerala State Branch
II Floor, "Shalom Building" Pattom
Trivandrum - 695 004 Ph. 7129537
- . Varkala - Do - NAB

VI. Maharashtra

42. Shihur & Haveli Mr. Niranjan P. Pandya Sight Savers
43. Mulshi Executive Secretary
44. Sahyadri Valley Poona Blind Men's Association
45. Purander 82, Rasta Peth, Poona - 411 011
Ph. 33344
46. Loni Prof & Head - Eye Dept. Sight Savers
Rural Medical College
Pravara Medical Trust
Loni 413 713
Tal. Shrirampur,
Dist. Ahmednagar Ph. 42
47. Bhandara Dr. Manohar Golpelwar DANIDA
Director
Indian Institute of Youth Welfare
134, Shivaji Nagar, Nagpur 440 010

VII. Madhya Pradesh

48. Mhow General Secretary Sight Savers
49. Bhabra NAB M. P. State Branch
8, Bakshi Baugh Colony
Indore, Madhya Pradesh 452 006 Ph. 36866
50. Barbatpur President -do-

Swami Dayananda Saraswati (Shahpur)
Dist. Betul, M.P.

51. Chitrakoot Vice Chancellor Sight Savers
Chitrakoot Rural University
P.O. Chitrakoot Dist. Satna

VIII. Manipur

52. Lamsang Mr. Brijbidhu Singh Sight Savers
General Secretary
Rural Development Organization
Lamsang, Imphal

VIII. Orissa

53. Nimapada Mr. B. B. Sahoo Sight Savers
54. Nialli General Secretary
--. Kantapara Orissa Association for the Blind
Malgodown Road, Unit - 5
Bhubaneswar - 751 001 Ph. 5713248

55. Kalinga Mr. P.C. Misra Sight Savers
Director
Indian Institute of Youth Development
P.O. Kalinga Dist. Phulbani

56. Khajuripada Dr. B. Jena Sight Savers
Council for Tribal and Rural Development
314, Shahid Nagar
Bhubneshwar 751 007

IX. Rajasthan

57. Mandore Mr. G. M. Singhvi Sight Savers
58. Luni Director
Jai Bharat Sarva Kalyan Nyas
108, Nehru Park
Jodhpur Ph. 32208

59. Girva Dr. O. P. Mahatama Sight Savers
Gyan Health Institute
27, Premi Dwara,
Surajpole, Udaipur

--. Nathdwara - Do - NORAD

-- Dungarpur Mr. Vinod Doshi NAB
Secretary
Mahavir International
Dungarpur 314 001

X. Tamil Nadu

60. Arakkonam Mr. T. Asir Nallathambi Sight Savers
--. Walaja President

Tamilnadu Association for the Blind
P.B. No. 5520, Rattaikuli Street
Tondiarpet, Madras 600 081

61. Sankagiri -do- DANIDA
--. Mettur
--. Salem
--. Rasipuram
--. Namakkal
--. Attur
--. Omallur

XI. Uttar Pradesh

62. Basti Mr. Hanuman Prasad South Asia Partnership
Programme Coordinator
South Asia Partnership (SAP) India
C.6., 1st Floor Commercial Complex
Safdarjang Development Area
New Delhi - 110 016

63. Akrabad Mr. Ishtiaq Haider National Association f/t
General Secretary, NAB UP Branch Blind
C/O Ahmedi School for the Blind
Civil Lines, Aligarh 202 001 Ph. 459554

64. Bakshi Talab Dr. B. L. Jain National Association f/t
65. Chinhat Sukhanand Charitable Trust Blind
A-1020, Indiranagar
Lucknow-226 016

66. Basti Shri Gopala Krishna Agrawal DANIDA
--. Bahadurpur Secretary
--. Samghat Shikshit Yuva Seva Samiti ltd.
--. Sadar Pandey Bazar
--. Kudarha Basti- U.P. -272 002.

XII. West Bengal

67. Chowhatta Mr. Mohit Banerjee Sight Savers
Secretary
St. John Ambulance Association
Birbhum Dist. Centre
Rabindra Palli P.O. Suri - 731 101

68. Chamtagara Mr. Ananth Saren Sight Savers
--. Chhatna Vivekanand Adibasi Kalyan Samity
P.O. Chamtagara, Dist. Bankura

69. Baikunthpur Mr. S.S. Deb. Mahanta NAB
--. Ghatol Secretary
NIMBARK Math Seva Samiti Trust
Eva Samiti Trust
Village : Baikunthapur

P.O. Sankarpur
Dist: Midnapur -721 211.

XIII Delhi

70. Nazafgagh Mr. Jagdish Kapur World Blind Union
 President
 NAB Delhi Branch
 Sector V, Opp. House No.1628, R. K. Puram
 New Delhi 110 022 Ph. 602944

III. Training Institutes:

S.N.	Organization	Course Offered / Duration
1.	National Association for the Blind Rural Activities Committee C/O Blind Men's Association Vastrapur, Ahmedabad 380 015	Course for the 6 weeks CBR Field Workers
2.	National Association for the Blind Education Committee Rustom Alpaiwalla Complex, 124/127 Cotton Green, Cotton Depot Bombay - 400 064.	Course for the 3 Months Itinerant Teachers
3.	National Institute for the Visually Handicapped 116 Rajpur Road, Dehradun U.P - 248 001	a. Rehabilitation 6 Months Assistant b. Primary Teachers 1 Year c. Secondary Teachers 1 Yr.
4.	Ramakrishna Mission Vidyalaya P. O. Ramakrishna Mission Coimbatore	a. B. Ed (Special) 1 Year b. M. Ed (Special) 1 Year
5.	Kurukshetra University Kurukshetra Haryana	M. Ed (Special) 1 Year
6.	Chitrakoot Rural University Chitrakoot, Dist. Satna	B. Ed (Special) 1 Year
7.	Blind Relief Association Lal Bahadur Shastri Marg New Delhi	Secondary Teachers 1 Year Training Course
8.	Ramakrishna Mission Narendrapur, West Bengal	- do- 1 Year
9.	Holy Cross College Tiruchirapalli	a. B. R. Sc. 3 Years b. M. R. Sc. 2 Years
10.	Divine Light Trust for the Blind Whitefield, Bangalore	Itinerant Teacher 1 Year Training Course
11.	YMCA College of Physical Education	Course in Orientation

RECOMMENDED PUBLICATIONS

I. Books on CBR and Related Aspects

KEY: Author, Year of Publication, Title (*italic*), City and Address of Publisher, Pages, Price, ISBN

Bai, Radha K.; Koenig, Claudia; Joicy, P. M.; Shanmugam, L.; and Prabhakar, Immanuel S. (1995): *All Colours are there*, Tiruchiraplli: Holy Cross Service Society, 96B, Ettupattai Bungalow, Puthur, 620 017, Tamil Nadu, P. 375, on request

The book, a tribute to Mr. P. G. Michael for his devoted services of promoting eye care and rehabilitation of the visually impaired, is a compilation of a variety of articles pertaining to various aspects of eye care services, integration, rehabilitation and skill development. The articles have been authored by leading practioners of eye care, rehabilitation and education in South Asia. Four articles on CBR provide relevant information about various aspects of this approach.

Baine, David (1988): *Handicapped Children in Developing Countries: Assessment, Curriculum and Instruction*, Edmonton, Alberta: Department of Education Psychology, University of Alberta, Canada, P. 180, on request, ISBN 0-88864-934-7

The handbook is written for regular and special education teachers undergoing training. It is also a valuable resource for teachers subsequent to their training and for teacher trainers working in developing countries. It provides appropriate information pertaining to the following topics:

- a. Characteristics of curricula used in developing countries
- b. Problems arising from the adoption of western curricula
- c. Using ecological inventories to develop curricula
- d. Teaching methods
- e. Methods for teaching handicapped students in large, regular classrooms
- f. Teaching students with limited hearing
- g. Teaching students with limited vision
- h. Testing: problems, issues and recommendations
- i. Functional testing

This handbook is recommended for all organizations and individuals promoting education of disabled children.

Bhende, Asha A; and Upendra, Hema (1999): *Study of NAB Community Based Rehabilitation Programme for the Rural Blind*, Mumbai: National Association for the Blind, LBMRC, Rustom Alpaiwalla Complex, 124-127, Cotton Depot, Cotton Green, Mumbai 400 033, P. 145, on request

This publication is a critical assessment and appraisal of the CBR Programmes instituted by the National Association for the Blind. It deals at length with the impact the programme had on the rural visually impaired in improving their quality of life, their status and esteem in the family and community. It clearly shows that given the necessary training such a person can, to an extent, register a distinct improvement in his day-to-day life.

The publication enlists need for evaluation of concept, methodology of evaluation and limitations of study. It also provides details of characteristics of beneficiaries, responses of significant relatives and implementers' perspective in respect of implementation of CBR programme.

The study concludes that the CBR programme should be widely supported and adopted by further strengthening its positive features and by taking remedial actions with regard to its weaknesses.

CAPART (1996): Disability - A Strategy to Promote the Participation of People with Disabilities in Programmes for Rural Development, New Delhi: Council for Advancement of People's Action and Rural Technology, Zone IV, India Habitat Centre, Lodi Road, 110 003, P. 88, on request

In order to achieve the goal of full participation of persons with disabilities in all initiatives for rural development, it will be essential to mobilize the support of several groups at different levels. This document is, therefore, addressed not only to voluntary organizations working directly with disability, but also to organizations and community groups working with the rural poor, and to people's representatives and functionaries under Panchayati Raj, media persons from the official media and educators and trainers at the grassroot level. It covers the following topics:

- a. Disability in India
- b. Guiding principles, goals and focus areas
- c. Areas of focus of project proposals including social mobilization, capacity building, rural infrastructure development, indigenous technologies and networking
- d. Criteria for CAPART support.

It is a comprehensive document on CAPART's disability strategy.

District Rehabilitation Centre Scheme (1987): Training Manual: Village Rehabilitation Workers, New Delhi: Central Administrative And Coordination Unit, Ministry of Social Justice & Empowerment, Government of India, 4, Vihnu Digamber Marg, 110 002, P. 134, on request

This instructional manual brought out by the Central Cell of the DRC is the first in a series to cover the activities of Village Rehabilitation Workers, Multipurpose Rehabilitation Assistants,

Multipurpose Rehabilitation Therapists and Multipurpose Rehabilitation Technicians who are engaged in the DRC's field activities.

This useful instructional manual may also be used by the individuals promoting various disability development strategies. It is simple and concise, having been designed for the use of field workers who are generally not highly educated. The manual covers all the categories of disabilities.

The manual will also be useful to the parents and guardians of the disabled for timely identification of the onset of a disability, to prevent it from becoming an impairment and a handicap by providing for medical intervention at the appropriate time.

Is available in English and Hindi.

Easwar, R. (1999): Training Programme for Community Level Workers of the Rural Blind, in Fernandez, Gunawathy et al, See with the Blind, Bangalore: Christoffel Blindenmission, South Asia Regional Office (South), 559, 11th Main Road, HAL II Stage, Indiranagar, 500 008, P. 211-222, Rs. 200 9n India, ISBN: 81-87380-44-6

The article emphasises the important role a field worker has in extending CBR services to people with visual impairment and blindness. In addition to suggesting how to select the most suitable field workers, the author provides detailed information about training programmes for field workers (Editors).

Jaekle, Robert C. (1993): Mobility Skills for Blind People: A guide for use in rural areas, Bensheim 4: Christoffel Blindenmission e. V., Nibelungestrasse 124, D-6140, Germany; and West Sussex: Sight Savers International, P. O. Box 191, Haywards Heath, RH16 4YF United Kingdom, P. 72, on request

It is an excellent practical manual for parents of visually impaired children and adults, field workers in CBR programmes and others engaged in improving the quality of life for such people, especially in rural areas. Under the guidance of a trained O & M instructor, appropriate knowledge and skills can be easily transferred to a large number of service deliverers, both trained and laymen, to pass on to even greater number of visually impaired people (Bill Brohier, President, International Council for the People with Visual Impairment).

This guide manual has been presented in a narrative form by using "John" who narrates the transition in his life from the age of 10 years. Bob Jaekle, author of the manual and truly the "Father of CBR of the Visually Impaired" succeeds in ensuring that the user of the manual identifies immediately with the consumer, his visually impaired trainee. Systematically John proceeds from the simple to the more complex techniques of O & M; from familiar surroundings to the unknown, further and further afield, as he gains confidence and independence, both of which are particularly

important in the life of a visually impaired person (Based on Foreword by Mr. Bill Brohier).

This manual is a must for the CBR field workers, project supervisors, project implementing agencies and trainers of O&M.

Jaekle, Robert C. (1999): Community Based Rehabilitation for the Blind, in Fernandez, Gunawathy et al, See with the Blind, Bangalore: CBM, (Details given above), P. 197-210

The author provides an overview of the development of community based service for the visually impaired in a global context. He discusses the current trend to move from a single disability to a cross disability approach. Issues related to this trend in terms of service delivery and training at various levels of personnel for CBR are also discussed (Editors).

Helander, Einar; Mendis P.; Nelson G.; and Goerd A. (1989): Training in the Community for People with Disabilities, Geneva: World Health Organization, 1211 Geneva 27-Switzerland ISBN 92 4 1544015 (NLM Classification: WB320)

This manual has been prepared for people in the community who are planning, implementing or evaluating a CBR programme. It consists of 34 modules, 4 guides and 30 training packages. Each module can be used individually and the guides and training packages can be given to the people for whom they were written. The four guides are for members of the community who carry out special tasks for the CBR programme. They are:

- a. Guide for the Community Rehabilitation Committee - this is for the community committee that helps to manage the programme;
- b. Guide for Local Supervisors - this is for the community worker who implements the programme;
- c. Guide for People with Disabilities - this describes what people with disabilities can do for themselves and for other in the community;
- d. Guide for School Teachers - this will help teachers who have children with disabilities in their classes.

The training packages are for family members of people with different types of disabilities; seeing difficulties, hearing or speaking difficulties, moving difficulties, feeling difficulties, strange behaviour, fits, and learning difficulties. These packages provide information about the disabilities and about rehabilitation procedures that will help people with disabilities to do daily activities, such as eating, dressing, communicating, moving around, playing, going to school, and taking part in work and social activities. Family members can use these packages to train the disabled person to do these activities.

The individual training packages are for family members of people

who have difficulty in speaking and hearing or speaking, moving and have no feeling in the hands or feet, seeing, and learning. The training packages are also for the adults who show strange behaviour and the people who have fits. The manual also includes general training packages.

Helander, Einar (1993): Prejudice and Dignity - An Introduction to CBR, New York: Division of Public Affairs, United Nations Development Programme, One United Nations Plaza, N. Y. 10017, USA, P. 241, on request, ISBN: 92-1-126-32-9, Publication No. E93-III-B.3

The book was written and published as part of the UNDP Inter-regional Programme for Disabled People. The title of the book reflects the fact that many of the reasons behind the problems facing the disabled people can be found in deep-rooted prejudice; an immense effort will be needed to change that situation.

The book provides a description of CBR and covers definitions and basic concepts, prevalence, incidence and causes of disability and situation analysis. It proposes an alternative solution and explains the role of Government in programme development. It also proposes a plan of action as a future challenge.

It is an excellent reference material for the trainers of the field workers of the CBR programmes.

Horton, Kirk J. (1986): CBR of the Rural Blind - A Training Guide for Field Workers, New York: Director, Division of Education & Rehabilitation, Helen Keller International, 15 West 16th Street, 10011, P. 131, on request, ISBN: 0-915173-04-2

This is one of the most useful manual for the CBR field workers. It provides detailed information in simple, straight forward language through illustrations on all relevant topics viz.:

- a. Advantages of community based programmes
- b. Definitions of eye problems
- c. Orientation & mobility
- d. Activities of daily living
- e. Basic education
- f. Vocational skills

The training manual has grown out of the two decade long experience of Helen Keller International in the development and implementation of CBR programmes for visually impaired persons. While the manual is an outcome of the project that was carried out in Indonesia, the content is relevant and useful for all the developing countries. Every CBR field worker must have access to this manual.

Horton, Kirk J. (1987): Community Based Rehabilitation of the Rural Blind: A Training Guide for Field Workers, Syllabus for

Trainers, New York : Helen Keller International, 15 West 16th Street, 10011, P. 55, on request

This publication analyses the material needed for imparting training to the field workers of CBR Programmes, various achievement indicators which describe the level of proficiency the trainee will achieve in each of the major subject areas, general curriculum sequence and daily course contents etc.

It also provides braille work sheets, abacus worksheets and a diagram of the eye. This syllabus for the trainers should be used along with the training guide for the field workers published by the same author during 1986 (Referred above).

International Labour Office (1982): Community Based Rehabilitation Services for the Disabled, Geneva: ILO, on request

This is a report of the pilot experience on CBR for all categories of disabled in Indonesia. The report has been prepared for the Government of Indonesia by the International Labour Office acting as Executing Agency for the United Nations Development Programme.

The publication provides background to the Indonesian Rehabilitation Programme including objectives of the project, activities carried out and results achieved, achievements of immediate objectives and the significant confusions of this approach.

It also provides a set of recommendations regarding policy and administration of such projects, need for registration of the disabled, vocational training, mobilization of rehabilitation services and the role of the non-governmental organizations.

Jonsson, Ture (1994): Inclusive Education, Geneva, United Nations Development Programme, Interregional Programme for Disabled People, Palais des Nations, CH - 1211, P. 158, on request

The author lists various case studies explaining roles of Itinerant Teacher, Headmaster, District Education Officer and other functionaries in promotion of inclusive education. He also explains the philosophy, importance and distinguishing features of this mode of education. He concludes, "With careful planning, it should be possible to meet the unique needs of all students within one unified system of education - a system that recognizes and accommodates for differences"

Ministry of Social Justice & Empowerment (1998): Scheme to Promote Voluntary Action for Persons with Disabilities New Delhi: Disability Division, Shastri Bhawan, 110 001, P. 20, on request

This is first time that the Ministry of Social Justice & Empowerment has given due recognition to the concept of CBR in its major grant-in-aid scheme. The Scheme provides grant-in-aid

to the NGOs to the extent of 90 percent of the admissible expenses for promoting CBR. Application in the prescribed proforma should be made to the Department of Social Welfare of the concerned State Government under copy to the Director (Disability Development) of the Ministry. The grant-in-aid is released by the Ministry on the recommendation of the Department of Social Welfare of the concerned State Government directly in favour of the applicant organization.

Murthy, S. P.; and Gopalan, Lyn (1992): Work-Book on Community Based Rehabilitation Services, Bangalore: Karnataka Welfare Association for the Blind and ACTIONAID India, Disability Division, P. O. Box 5406, No. 3, Rest House Road, 560 001, India P. 135, on request

The workbook is intended to be a ready-reckoner for professionals and others who are interested in helping the disabled in various types of communities. It provides comprehensive information about the following aspects of CBR:

- a. Explanation of the term CBR
- b. Selection of project area
- c. Project planning, implementation and evaluation
- d. Project phasing and administration
- e. Client educational, vocational and employment information

According to Dr. Brian O'Toole, "There have been hundreds of CBR programmes across the continent that have gone no further than the pilot stage. In some respect after a decade of experience with formalized CBR projects, we may well be more aware of the limitations of the approach rather than possessing a coherent body of knowledge that may govern future initiatives. The manual, however, is one contribution towards redressing that imbalance".

Narasimhan, M. C.; and Mukherjee, A. K. (1986): Disability: A Continuing Challenge, New Delhi: Wiley Eastern Limited, 4835/24, Ansari Road, Daryaganj, 110 002, P. 127, Rs. 80

According to the authors, this book presents an up-to-date and comprehensive picture of the rehabilitation scenario to the professional as well as to the laymen. In this work, the relevant policies and programmes are examined to assess their relevance and suitability to a developing country like India. It provides an overview of relevant activities in other sectors of the economy related to rehabilitation - health, education, employment and social development. An effort has been made to understand the complete range of issues involved in tackling the problems presented to society in respect of nature and extent of disability, its causes and consequences, quality and implementation of existing services and crucial gaps in the service delivery system. The available rehabilitation models, both in developed and developing countries, are briefly described, and their relevance to our situation is broadly analyzed.

Ultimately, the essential features of an appropriate rehabilitation model suitable for developing countries has been identified which aims at reaching the largest sections of the disabled population for its all-round development and promoting rehabilitation services as a comprehensive package at grass-root level. It is hoped such a model will be equally helpful for many other developing nations in this region. With such a hope in mind, this book is an idealistic excursion into the future and projects the likely changes in India's rehabilitation scenario at the turn of the twentieth century.

National Forum of Organizations Working with the Disabled (1997):
Second South Asian Conference of CBR Network, Dhaka, Bangladesh,
8/12, Block-A, Lalmatia, P. 217, on request

The II South Asian Conference of the CBR Network evolved Dhaka Declaration on setting targets pertaining to promotion of CBR and listing ways and means of achieving these targets.

In this conference, country papers from Bangladesh, India, Nepal and Srilanka were presented on status of CBR and country plans for its further expansion were presented. The publication also includes presentations pertaining to participation of people in CBR, sustaining CBR, low cost models, human resource development and such other topics. It focusses upon promotion of cross disability CBR programmes with the active participation of family members and community.

National Institute of Public Cooperation and Child Development (1999): Rights of Children with Disabilities, New Delhi: NIPCCD, 5, Siri Institutional Area, Haus Khas, 110 016, P. 143, on request

This publication is based on the deliberations of the National Consultation Meet on Rights of Disabled Children and the papers presented by the experts during the Meet. It gives insight into the situation of disabled children in the country and provisions in the Convention on the Rights of the Child for the prevention and protection of childhood disabilities. It discusses in detail the lacunas in the Persons with Disabilities Act, 1995, enlists the role of voluntary organisations and the media in realising the rights of disabled children, and gives a comprehensive list of recommendations for preparing the Charter of the Rights of Disabled Children (Editor).

O'Toole, Brian John (1991); Guide to Community-Based Rehabilitation Services, Paris; UNESCO, 7 Place de Fontenoy, France, P.96, on request, ED-91/WS-6

The guide, which is part of a series of nine publications, is intended for teachers, parents and community workers, aims at stimulating discussions on basic knowledge, approaches and methods relevant to the education of persons with disabilities, and offer practical advice for action in this field.

It addresses a new approach to service development. CBR has received considerable attention during the Decade of Disabled Persons, in particular with the publication of the WHO Manual 'Training in the Community for People with Disabilities'.

Parallel to that the move away from institution-based rehabilitation prompted governments in developing countries to seek alternative approaches to reach disabled persons and their families.

The UNESCO Consultation on Special Education (1988) recognized integrated education and CBR as the two complementary approaches in providing cost-effective and meaningful education and training to disabled persons.

The guides are published in English, French, Spanish, Arabic and Chinese. The text can be freely reproduced or translated provided that mention is made of the author and source.

Pahwa Achala (Ed.) (1990): Manual on CBR - A Comprehensive Handbook for the Field Functionaries for Identification and Management of Disabilities at the Grass Roots Level, New Delhi: District Rehabilitation Centre Scheme, 4, Vishnu Digamber Marg, New Delhi 110 002, P. 429, on request

This instruction manual which covers all categories of disabilities has been developed for providing training to the Multipurpose Rehabilitation Workers and the Village Level Workers of the District Rehabilitation Centre Scheme of the Ministry of Social Justice & Empowerment. It provides information pertaining to causes and prevention of disabilities, demographic details, rehabilitation needs, specific needs, existing services, nature of aids and appliances, employment and placement, strategies for intervention, behavioural problems and basic emotional needs etc. The manual has already been translated into Hindi.

Pandey, R. S.; and Advani, Lal (1995): Perspectives in Disability and Rehabilitation, New Delhi: Vikas Publishing House Ltd. 576, Masjid Road, Jangpura, 110 014, P. 224, Rs. 250, ISBN 0-7069-9054-4

This book attempts to present a status of various services and possible areas of growth and development. This may be useful as a reference material for all those concerned with disability - professionals, parents, disabled persons, voluntary workers and policy makers. The book provides information pertaining to concept & definitions, extent of disability, physical and restrictive services, education, vocational rehabilitation and CBR, legislative support, strategies for awareness, role of media, voluntary sector and technology in rehabilitation.

Peter, A. Berman; and Sister Daniel, G. (1984): Rehabilitation of the Rural Blind: An Economic Assessment of a Project in the

Philippines: Helen Keller International Incorporated, 15 West 16th Street, 10011, on request

This study is the result of one of the first attempts by a private voluntary agency - Helen Keller International - to compare the cost-efficiency of two differently conceived programmes that have similar goals. Though it presents a close examination of particular programmes, the work provides a model that can be broadly applied to future economic assessments of all types of community services in the third world.

The authors compare the results of Helen Keller International's community-based services for the visually impaired in the Philippines with previously existing, urban-based centres for rehabilitating such adults.

Punani, (Dr.) Bhushan; and Rawal, Nandini (1996): CBR (Visually Impaired), Mumbai: Rural Activities Committee, National Association for the Blind, 11 Khan Abdul Gaffar Khan Road, Worli Seaface, 400 025, (also available at): NAB RAC, Vastrapur, Ahmedabad 380 015, P. 267

This is the basic manual of guidelines, popularly known as the "Green Manual" for the implementing agencies of the CBR projects promoted and coordinated by the NAB RAC. Every implementing agency is expected to follow the guidelines in respect of selection of project area, appointment of field staff, training curricula, delivery of services, monitoring of performance and reporting the progress to the NAB RAC as instructed in the manual. It advocates comprehensive approach to prevention/cure of visual impairment, integrated education, social integration, economic rehabilitation and support services.

It enlists the implementation plan for the initiation, implementation, monitoring and evaluation of a CBR project for the visually impaired. It also provides details of roles of the field workers, supervisors, implementing agencies and the coordinating agencies in the project implementation (Review by Vimal Thawani)

The Manual in your hand is third updated edition of the "Green Manual"

Punani, (Dr.) Bhushan; and Rawal, Nandini (1993): Handbook: Visual Impairment, Ahmedabad: Blind People's Association, Vastrapur, 380 015, P. 479, Rs. 60+Postage Rs. 10 for India.

The objective of the handbook is to provide a neat package of information, which would enable rehabilitation planners to formulate need based programmes keeping in mind the needs of the target group and the local conditions. The book is a practical guideline and would help the reader to acquaint himself with the most necessary aspects related to the field such as causes of visual impairment, losses consequent on visual impairment, training for compensating these losses and planning individual or

collective need-based rehabilitation. The handbook deals with alternative systems of educating persons with disabilities as well as different approaches to rehabilitation including vocational counselling, assessment, vocational training, employment and income generating activities. This updated version of earlier publication has devoted a full chapter to specific aspects of special need visually impaired persons including persons with low vision, deafblindness and multiple disabilities.

The chapter on CBR provides comprehensive information on modus operandi of CBR project implementation. It enlists various crafts and trades suitable for the visually impaired. It also provides details of existing Project Implementing Agencies, funding agencies and the training centres. The handbook also provides detailed information on various models of integrated education, activities of daily living and orientation & mobility. (Review by Jasmine Sajit)

Punani, (Dr.) Bhushan; and Rawal, Nandini (1995): W. Stein & Integrated Education, Ahmedabad: Blind People's Association, Vastrapur, 380 015, (Courtesy: Prof. Tirath Gupta Memorial Fund), P. 138, on request

The publication traces the history of special education, illustrates various models of education, defines integrated education, enlists advantages of integrated education, defines the role of a teacher and explains the process of integrated education. It also talks about parental involvement and importance of early intervention. The chapter on history and chronological development of education of the visually impaired has been meticulously documented.

The book explains the concept of "Rehabilitation - the Art of the Possible" - which is the reabsorption of a visually impaired into society in accordance with his capabilities and abilities to adjust to environment to the extent possible and with active involvement of the community (Review by: Akhil S. Paul).

Regional CBR Network (South Asia) (1996): First South Asian Regional Conference on CBR, Bangalore: 219, 4th B Main, 4th Phase, J. P. Nagar, 560 078, P. 32, in request

The aim of the conference was to provide a forum for sharing of news, views and experiences that will improve the quality of life of persons with disabilities and their families, through CBR approaches. National and international rehabilitation professionals, with long standing experiences in the disability field, facilitated discussion. They drew out exemplary practices, experiences and ideas from the participants. The conference evolved recommendations regarding strategies for CBR networking.

Rehabilitation Council of India (1995): Proceedings of the Regional Workshop: CBR, Ahmedabad: Blind People's Association, Vastrapur, 380 015, P. 55, on request

The Rehabilitation Council of India sponsored a regional workshop on CBR during 28-29 April, 1996 at Ahmedabad. A number of experts from all over India presented papers on various aspects of CBR for all categories of disabled people.

Srivastava (Dr.), R. K. (1997): Proceedings of Orientation Workshop of National Trainers for Medical Rehabilitation, New Delhi: Safdarjang Hospital, Ansari Nagar, New Delhi, P. 126, on request

The workshop oriented 18 National Trainers from different states on medical rehabilitation, CBR and related human resource development. These national trainers are equipped with knowledge and skill to organise training of state level Master Trainers for medical rehabilitation. The publication provides a reference material on medical rehabilitation for national trainers as well as state level Master Trainers for organising training workshops on medical rehabilitation. All presentation have been duly supported by charts, tables and sketches wherever necessary.

Taylor, Steven J.; Biklen, Douglas; and Knoll, James (Editors) (1987): Community Integration of People with Severe Disabilities, New York: Teacher College Press, Teacher College, Columbia University, N.Y. 10027, P. 231, ISBN 0-8077-2847-0

The publication demonstrates that Burton Blatt's goal of community integration for all is not merely realizable, but that it is being realized in countless, carefully planned and carefully monitored community projects which long since has ceased to be "experiments."

The editors advocate that it is time, however, to devote equal attention to the quality of life in community. The challenge today is not simply to open the doors of the institutions. The challenge is to help people with developmental disabilities, including those with the most challenging needs, to become part of community. The state of the art in community is moving rapidly. In this book, the editors try to capture the direction in which the state of art is moving and, together with colleagues, give the readers a sense of the issue today (Editors).

The Spastics Society of Tamil Nadu (SPASTN) (1997): Southern Region Seminar on CBR, Chennai: SPASTN, Opp. TTTI, Taramani Road, 600 113, P. 112, on request Email: spastn@md2.vsnl.net.in

A 2 days seminar was convened to arrive at a common understanding of the nature, need, applicability and relevance and potential of CBR. Its also aimed at promoting networking among individuals and groups already participating in and those planning to participate in CBR programmes. The seminar evolved a set of recommendations for promoting comprehensive CBR.

The Spastics Society of Tamil Nadu (SPASTN) (1997): Proceedings: Workshop on CBR Model and Training Viable for India, Chennai: Ibid, P. 70, on request

A 3 days workshop was organised in Chennai by the SPASTN and co-sponsored by the Rehabilitation Council of India and the UNICEF. A total of 72 professionals participated from all over India, Srilanka, Nepal, Canada and the United Kingdom. The publication provides information regarding approaches of RCI towards CBR, donor's role in promotion of CBR, situations in CBR, overview of CBR practices, CBR linkage model of early intervention, support groups etc.

Wadhwa (Dr.), Sanjay; and Athani (Dr.), B. D. (1998): Draft Action Programme for Inclusion of CBR in Health Care Delivery System for States in India, New Delhi: Department of Physical Medicine & Rehabilitation, All India Institute of Medical Sciences, Ansari Nagar, 110 029, P. 105, on request

The debates and discussions on CBR continue to be held and people working in the field of rehabilitation all over the world are trying to assimilate the idea, get the best out of it and learn from experiences and exchange ideas with each other. Bit by bit and piece by piece, the WHO-CBR concepts and other other rehabilitation programmes are being integrated in the approaches that suit the rehabilitation workers, the donor agencies, the politicians and hopefully, the people with disabilities and the caregivers.

This document provides contextual information to the policy makers and planners at the centre and the state levels for initiating 'action' in a phased manner as per the local needs and priorities commensurate with the resources available. It provides situational analysis of efforts made in respect inclusion of CBR in the health care delivery system. It explains the role of health sector in this respect and provides a Proposed Action Plan for inclusion of CBR in the existing three tier health care system from PHC to the District Hospitals.

Werner, David (1994): Disabled Village Children: A guide for community health workers, rehabilitation workers and families, Adapted for India by Radhika Alkazi and Vasanti Mirchandani under the supervision of Padam Khanna with Dr. Salai Pa Cin and Taposh Roy, New Delhi: Voluntary Health Association of India, Tong Swasthya Bhawan, 40, Institutional Area, South of IIT, Behind Qutab Hotel, 110 016, P. 797, Rs. 250, ISBN: 0-942364-06-6

This book was written from the "bottom up", working with disabled persons and their families. The authors believe that those with the most personal experience of disability should become leaders in resolving the needs of the disabled. In fact, the main author of the book (David Werner) and many of its contributors happen to be people with disabilities. The authors are neither proud nor ashamed of this. They do realize that in some way their

disabilities contribute to their abilities and strengths.

In this book, authors do not tell anyone what they must do. Instead they provide information, explanations, suggestions, examples, and ideas. They encourage an imaginative, adventurous, thoughtful, and even playful approach. After all, each disabled child is different and will be helped most by approaches and activities that are lovingly adapted to her specific abilities and needs.

The part I is devoted to working with the child and family and provides information on different disabilities; part II is devoted to working with the community and explains village involvement in the rehabilitation, social integration, and rights of children with disabilities; whereas part III focusses on working in the shop and explains rehabilitation aids and procedures.

Above all, the book helps to realize that most of the answers for meeting these children's needs can be found within the community, the family and the children themselves. It discusses ways of starting small community rehabilitation centres and workshops run by people with disabilities or the families of children with disabilities.

Over 4,000 line drawings and 200 photos help make the information clear even to those with little formal education. The book is a must for every organization devoted to working for the people with disabilities.

II. CBR Periodicals

ACTIONAID Disability News

Published by:
Disability Division
ACTIONAID-India, P. O. Box 5406
No. 3, Rest House Road,
Bangalore 560 001, India
Email: coblr@actionaidindia.org

Copies of newsletter are mailed free of cost on request.

Published biannually.

Focus: The major emphasis of the newsletter is on articles related to policy development, concept clarification, development of methodology in the areas of service delivery, training of manpower and programme development, and development of technology related to rehabilitation.

Asia Pacific Disability Rehabilitation Journal

Supported By:
Action for Disability

Hunters Moor Regional Rehabilitation Centre
Hunters Road, Newcastle upon Tyne NE2 4NR, UK

Edited by:

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Produced by:

Shree Ramana Maharishi Academy for the Blind
3rd Cross, 3rd Phase, J. P. Nagar
Bangalore 560 078, India`

Published biannually.

For private circulation only

BLIND WELFARE

Published by :

National Association for the Blind
11, Khan Abdul Gaffar Khan Road
Worli Sea Face
Mumbai -400 025, India.

Published thrice a year in April, August and December. Braille edition published simultaneously.

Annual Subscription rates:

Ink Print: India: Rs. 90; Asia: \$25; Europe: \$25; USA :\$25
Braille : : Rs. 20; : \$10; : \$10; :\$20

The Publication provides latest information on education, rehabilitation and innovations in the field of development of the visually impaired. The major coverage includes news rounder, achievers, felicitation, awards new technology, education, book review and opportunities. As NAB is the lead organization for the promotion of CBR and integrated education, it publishes articles on such projects regularly.

BMA Newsletter

Published by:

Blind People's Association
Vastrapur, Ahmedabad 380 015, India
Email: bpa@vsnl.com
Website: www.bpaindia.org

Copies of newsletter are mailed free of cost on request.

Published quarterly in English, Gujarati and Gujarati braille.

It is a newsletter registered with the Registrar of Newspapers. Its publication is supported by the Ministry of Social Justice &

Empowerment. It covers new items pertaining to recent developments in the field of development of visually impaired.

CBR NEWS

The international newsletter on CBR and the concern of disabled people.

Published by:
Healthlink Worldwide
***** (Address to be included)

Subscription free of charges for readers in developing countries and students from developing countries. The charges vary from \$12 to \$48 for readers from other countries.

CBR NEWS is published three times a year in English, including braille and cassette versions, and Hindi.

The braille edition is available on request from:

H. N. Makim NAB Regional Braille Press
C\O Blind People's Association
Vastrapur, Ahmedabad 380 015 India
Email: bpa@vsnl.com

The Hindi edition is available on request from:

Amar Jyoti
Kakardoona, Vikas Marg
Delhi

FRONTLINE DIGEST

Published by:
Regional Coordinator,
CBR Frontline Digest
No. 291, 4th B Main
J. P. Nagar IV Phase
Bangalore 560 078

Subscription: Rs. 65 per issue (India); US \$ 2 (South Asia);
Us \$ 3 (other countries)

Talking Digest priced at Rs. 90 each issue.

It is a quarterly Journal for Frontline Organizations involved in CBR. It revolves around various themes on CBR policy, research, advocacy and evaluation.

III. Other Useful Publications

1. UNICEF, Regional Office for South Central Asia, 73 Lodi Estate, New Delhi 110 003.

Their publications centre on children, disabled and non-disabled, as well as on women. They also have posters and other materials which would be useful for awareness and other community programmes.

2. ILO (International Labour Office), CH-1211, Geneva 22, Switzerland

A catalogue of their publications will be sent, free of charge, on request. Also, ask for their

- a. Quarterly newsletter
- b. Booklet; "From Community Based Rehabilitation to Community Integrated Programmes"

3. The Hesperian Foundation, P.O. Box 1692, Palo Alto, CA 94302, USA.

This organization has many useful publications, including

- David Werner: Disabled Village Children
- David Werner: Where There is no Doctor
- David Werner and Bill Bower: Helping Health Workers Learn
- Murray Dickson: Where There is no Dentist
- David Sanders: The Struggle for Health
- Christine Miles: Special Education for Mentally Handicapped Pupils: A Teaching Manual
- Mike Miles: Where There is no Rehab Plan

(These booklets are especially good for those involved in rehabilitation strategy)

Papers published and distributed by the Foundation are also useful, especially the one called "Child-to-Child Program". The Foundation also has slides/films.

4. Other useful Journals:

- a. The Indian Journal of Social Work
- b. Social Welfare
- c. Indian Journal of Disability and Rehabilitation
- d. Disability & Impairment
- e. Indian Journal of Special Education
- f. Ability

Annexure**Standard Application for Grant-in-Aid**

(Please fill in details of your own agency in the Questions Nos. 1-8)

1. Name and address of the organization

Name: _____

Address: _____

State: _____ Pin Code: _____

Tel. No.: _____ Fax No.: _____

Email: _____ Web: _____

2. Brief history of the organization, its objects and activities

a. History

b. Objects

c. Activities

3. Nature of the organization

4. Legal Status

S. N.	Particulars	Registration No./Date
a.	Public Charitable Trust Act	
b.	Societies' Registration Act, 1860	
c.	Non-profit Company under Indian Companies Act	
d.	Registration under Foreign Contribution (Regulation) Act, 1976	
e.	Registration under Persons with Disabilities Act, 1995	
f.	Registration under Income Tax Act	

- Section 12 A
- Section 80 G
- Section 35 CCA
- Section 35 I (ii)
- any other Section

Certified copies of the following documents to be furnished:

- a. Constitution of the organization or Memorandum of Association
- b. Registration Certificates under

- Public Charitable Trusts Act
- Societies Registration Acts, 1862
- Foreign Contribution (Regulation) Act, 1976
- Persons with Disabilities Act, 1995

c. A list of the members of the Executive Committee
 d. Audited Balance Sheets and Receipts & Payments Account for last 3 years

5. Whether recognized by the State Government:

6. Whether the organization is of all All India Character? If so, give the nature of its All India Activities:

7. Whether located in own/rented building:

8. Present number of beneficiaries:

S. N.	Nature of Activities	No. of Beneficiaries
-------	----------------------	----------------------

9. Details of the project for which grant is applied for :

Grant is requested for a project for the comprehensive rehabilitation of the rural persons with disabilities of all age groups and of all castes of the _____ villages of _____ Taluka, Dist. _____, _____ State. The main components of the Project are:

a. Prevention of preventable disability and cure of curable disability

b. Survey, screening, early identification and assessment of persons with disabilities

c. Provision of corrective surgery, medical evaluation, and diagnostic

d. Provision of assistive devices, ortho-prosthetic devices, mobility, educational and rehabilitation devices.

f. Social integration of persons with disabilities and creation of public awareness

g. Economic rehabilitation or income generation or gainful occupation of the adult persons with disabilities

h. Appropriate education of children with disabilities in regular village schools or special schools.

i. Support services of scholarship, bus pass, railway pass, launching grant, loan, pension etc.

10. Likely date of commencement and completion of the project

The project will commence after receipt of assurance of financial commitment.

The project will be an ongoing activity. Each taluka will need financial assistance for five years. At the end of five years another taluka will be taken up for implementation.

11. Whether the project is likely to be assisted by some other source: No.

12. Justification of the project indicating outstanding features which entitle it to financial assistance:

a. The Rural Bias

It has been empirically studied that 83 per cent of the total population of persons with disabilities in India lives in rural areas. Assuming the total population of persons with disabilities to be 40 million, 31.2 million persons with disabilities reside in villages. Programmes for such persons are confined to institutional programmes in cities. A handful of urban institutions cannot rehabilitate the teeming rural millions.

b. The Old Age Syndrome

It has also been observed that majority of disability in India occurs after the age of forty-five years due to a variety of senile causes. Thus majority of such persons with disabilities have lived a large part of their lives as sighted persons. All they need is adjustment training for getting used to disability. Moreover training institutions give training only to persons with disabilities in the age group of 14-45 years. Thus blind persons above this age will have nowhere to go. Moreover a person who has acquired disability after forty-five does not need to learn traditional crafts like weaving, canning etc.

c. Education - A Prime Need

The few hundred schools for children with disabilities cannot reach out to the thousands of such children in the rural areas. Moreover, parents are reluctant to send their children to residential schools. Our rural Project will enable children with disabilities to be educated in their own village school, in familiar surroundings while living with the family. This is the only way of providing education to such children in the rural areas.

d. Importance Prevention and Cure of Impairment

Health services do not reach the grass - root level due to the absence of an intermediate machinery and the general level of ignorance and apathy.

The Project Implementing Agency will deal with medical checkup of all persons with eye problems and provide medicines, corrective surgery and the necessary eye health care facilities. Thus

health services will permeate to the lowest level and help prevent further disability.

e. Very Low Per Unit Cost of Rehabilitation

Institutional projects cover around 200 persons with disabilities and the cost of the building and other services totals 20-25 lakhs including an equal amount in opportunity costs and other invisible costs, thus the per capita cost of rehabilitating one persons with disabilities works out to be Rs. 12,000 per annum. Whereas in this project around 1000 persons with disabilities would be covered at a very low cost of less than Rs. 1,000 as there is no capital investment in building or infrastructure. Moreover these persons will remain with their families and thus help to accelerate the process of social change as per the Government policy.

f. Innovative Project

Most projects dealing with the rehabilitation of persons with disabilities believe in institutionalizing them and thus isolating them from their families and society. This will be a unique step in the sense that such persons will be provided services in the form of a field project in their own homes.

g. Rehabilitative services at the Door Steps of Beneficiaries

Due to the large field staff, this projects will enable rehabilitative services to be provided at the homes of persons with disabilities, thus ensuring prompt and regular care, follow-up and counselling services, the time, money and physical discomfort of such persons will be spared. Since the chosen field workers will be from the villages of the project itself, rapport will be easily established. This philosophy has also been propagated in the District Rehabilitation Centres (DRC) Scheme and other community intervention programmes.

8. Social Awakening

The rural persons with disabilities will be provided rehabilitative services at their door-steps, thus the neighbourhood and the society will be involved in the process of rehabilitation. The home will be rendered the centre of rehabilitation and society the setting. People will become aware of the needs and potentials such persons, will be exposed to rehabilitative services and thus there will be social awareness and awakening. The community based project will thus unite the village.

9. Availability of Infrastructural Facilities

The Project will be implemented by the ----- which has ----- years experience in blind and disabled welfare.

The organization has a strong infrastructure of schools, libraries, artificial limbs making units etc. All these services will be used for the project. This infrastructure will help the

persons with disabilities to be provided better services.

10. Availability of Training Facilities

The Applicant organization has a very strong core staff with persons of various disciplines. The staff is well acquainted with modern principles of management and rehabilitation. This core staff will give its honorary services for providing the intensive six-week training for the field staff.

13. Total Estimated Expenditure on the Project :

S. N.	Staff	No.	Honorarium per month	Per Annum
I. Recurring				
A. Staff				
1.	Field Supervisor	1	2,500	30,000
2.	Field Workers	8	1,000	96,000
			Sub Total (A)	1,26,000
B. Travel				
1.	Field Supervisor	1	500	6,000
2.	Field Workers	8	250	24,000
			Sub Total (B)	30,000
C.	Administrative Expenditure		500 p.m.	6,000
	Total Recurring (A+B+C)			1,62,000
II. Non Recurring				
1.	Motor cycle (1)			40,000
2.	Cycles (8)			10,000
	Total Non-recurring			50,000
Total Cost :				
	I Recurring			1,62,000
	II Non-Recurring			50,000
	T O T A L			2,12,000
14. A. Total grant requested at the rate of 90 percent				
	Recurring @ 90%			1,45,300
	Non-Recurring @ 90%			45,000
	Total Grant Requested			1,90,800
B. Matching contribution at the rate of 10 percent				
	Recurring @ 10%			16,200
	Non-Recurring @ 10%			5,000
	Total Matching Contribution			21,200

Applicant organization will arrange for office premises, office infra-structure etc.

15. Period for which maintenance and non-recurring assistance is required: Recurring expenditure for two years, non-recurring for first year only

16. Whether necessary land for the proposed building is available: Not Applicable

17. Details of the plinth area to be constructed in relation the number of students/persons for whom construction to be undertaken

N. A.

18. Whether the trained staff and other suitable, if so, give details:

The staff required for the Project is given above. However, the other core staff of the organization will be available for expert advice.

18. Whether the organization is in a position to meet with the balance expenditure? If so, indicate the source:

The balance of expenditure i.e. 10 percent will be met through donations.

19. List of Papers to the enclosed in duplicate:

a. Prospectus of aims and objects of the organization.

b. Constitution of the organization

c. Constitution of the board of management with particulars of each member

d. Latest available Annual Report

e. Audited accounts for the last two years along with a copy of the certified balance sheet for the previous three years

f. A statement giving details (year, purpose, amount etc.) of assistance received during the last five years from Central/State Govt./Central Social Welfare board/Local bodies or any other quasi Govt. Institutions including requests made thereof to anyone of these or any other project.

g. A statement giving item-wise and year-wise details of estimated recurring and non-recurring expenditure on the project.

h. A copy of the site plan of proposed building (a rough sketch giving broad indicating of the building to be constructed and area to be covered) and estimated cost.

i. A statement indicating the equipments, accurate furniture,

library books etc. (by number of details whichever is possible already available)

20. List of Additional Papers, if any :

- a. Road map of the project area
- b. List of villages in the project area
- c. List of officials to be involved in project implementation

Proforma I

Door to Door Survey

Name of Field Worker:
Cluster :

Date:

In each house ask whether any person has any eye problem. If "NO", move to next house. If "YES", then record details below:

S.N. Village Name of Address Names: persons Sex Age Remarks
Name Head of with eye problem (M/F) (Yrs)
Family

1.
2.
3.
4.
5.
|
++
20.

Signatures:

Project Supervisor

Field Worker

Date:

Original: to be kept by FW

Duplicate: to be kept by IA

Proforma II

Vision Screening by Ophthalmic Personnel

Name of Field Worker:

Cluster: Covering duration: From: To:

S.N.	Village	Name of Client	Address	Sex (M/F)	Age (Yrs.)	Curable	Incurable
1.							
2.							
3.							
4.							
5.							
++							
20.							

Signatures: Project Supervisor Field Worker Ophthalmic Personnel
 Original: with FW Duplicate: Screening Camp Triplicate: with IA

Proforma III

Summary of Vision Screening

Date:

Covering survey duration: From: To:

Project Location :

	Name of Field Worker	Cluster	No. of persons with eye problems			Total
			M	F	C	
1.	Mr./Mrs.					
2.						
3.						
++						
8.						

Signature: Project Director Field Supervisor

Date:

Original: with IA Copies to: NAB RAC

Proforma IV

Baseline Data - Curable Cases

Project:

Name of Field Worker:

Cluster:

S.N.	No. on screening list	Name	Address	Sex	Age	Date of Recommendation	Action taken
------	-----------------------	------	---------	-----	-----	------------------------	--------------

- 1.
- 2.
- 3.
- 4.
- |
- ++
- 20.

Signature: Field Supervisor Field Worker Project Director

Date :

Original: with Field Worker

Duplicate: with IA

Proforma V

Baseline Data - Incurably Visually Impaired

Project :

Name of Field Worker:

Cluster:

S.N.	No. on screening list	Name	Address	Sex	Age	Age of onset	Type of blindness	Cause	Treatment availed
------	-----------------------	------	---------	-----	-----	--------------	-------------------	-------	-------------------

- 1.
- 2.
- 3.
- 4.
- |
- ++
- 20.

Signature: Project Director Project Supervisor Field Worker

Date :

Original: with Field Worker

Duplicate: with IA

Proforma VI

Summary of Baseline Data
Distribution of Visually Impaired After Screening

Weekly : To be prepared weekly and discussed at weekly meetings

Monthly: To be prepared monthly and sent to NAB RAC

Name of Implementing Agency:

Project Location:

Population: Project Area: Covered so far:

Duration of survey: From: To:

Date: Screening: Report:

Age Group (in years)	Curable			Incurable		
	Male	Female	Total	Male	Female	Total
0-4						
5-12						
13-45						
46-65						
65 & above						
Total						

Signature: Project Director Field Supervisor Field Worker

Date :

Original: IA

Copies to: NAB RAC

Proforma VII

Individual Case File

I. Title of case file: Name of Field Worker :
 Name of the Client : S. N. :
 Address :
 Village : Cluster : Sex : Age :
 Dates of : Identification Ophthalmic Check-up :
 Initiation of training : Case completion :

II. Contents of case file :
 (a) Assessment form (b) Certificate of blindness
 (c) Rehabilitation plan (d) Bus pass/travel concession
 (e) Copy of pension form (f) Details of bank loan/subsidy

III. Rehabilitation Plan:

S. N.	Nature of Service	Date of	Hours	Achievement
-------	-------------------	---------	-------	-------------

Initiation completion spent

-
1. Ophthalmic inputs
 - (a) Eye screening
 - (b) Refraction
 - (c) Eye surgery
 - (d) Low vision aids
 2. Counselling
 - (a) Family
 - (b) Individual
 - (c) Peer group
 - (c) Community
 3. Individual training
 - (a) O & M
 - (b) A.D.L
 - (c) Home economics
 5. Economic Rehabilitation
 - (a) Nature of trade
 - (b) Training
 - (c) Inputs
 - (d) Bank loan subsidy
 6. Bus pass/travel concession
 7. State pension
 8. School admission
 9. Scholarship

IV. Status at case closure :

V. Remarks by Field Worker :

VI. Verification & comments (with date and signature)

Signature Project Director Project Supervisor
Date :

Proforma VIII

Initial Assessment Form
(In case of incurable visually impaired persons only)

Name of Implementing Agency : Project Code:
Project : Cluster : Village :
Name of Field Worker: Date of assessment :
1. Name of Client : S. N.:
2. Address :
3. Age : Yrs. 4. Male/Female 5. Single/Married
6. Religion: 7. Caste 8. Age of onset of blindness :
9. Cause of blindness: Congenital/disease/ accident/others
10. Nature of blindness: Total/Visually Impaired/Low Vision
11. Whether examined and treated by Ophthalmologist: Yes/No
12. Certificate of blindness issued: Yes/No % of blindness:

Performance Sheet
(Use separate sheet for each client)

Name of client: Village: Cluster:

Date of visit	Time From	To	Services provided	Other activities	Remarks
---------------	-----------	----	-------------------	------------------	---------

Signature: Project Supervisor: Field Worker:

Date :

Proforma X
Weekly Visit Programme

Name of Field Worker:

Date Village Time Name of client Envisaged activities

Signature: Project Supervisor Field Worker

Date :

Original - FW

Duplicate - Project Supervisor

Proforma XII

Physical Performance Register
(To be maintained by and at the Project Implementing Agency)

Part A: Logbook of Visitors (From Coordinator/Director onwards)

Date	Name of visitor	Designation	Clusters visited	No. clients seen	Remarks offered	Action taken
------	-----------------	-------------	------------------	------------------	-----------------	--------------

|
++

Part B: Logbook of Field Supervisor

Name of Field Supervisor:

Date seen	Villages visited Advice given	Name of Field Worker Name of Field Worker	No. of clients taken	Observations Advice given	Action taken
-----------	----------------------------------	--	----------------------	------------------------------	--------------

|
++

Part C: Physical Performance Register
(To be maintained by the Project Implementing Agency)
Separate Sheet for each Field Worker

- Name of Field Worker:
- Cluster:
- No. of villages:
- Population covered:
- Coverage

	Male	Female	Total
(I) Curable Blind Identified:			
(a) Totally blind:			
(b) Partially blind:			
(c) With multi-disabilities			
Total (a+b+c):			

a. Part (i): Coverage

Month Year	No. of villages covered	Curable			Incurable		
		Checked & treated	Operated	Total	Training completed	Under Trng	To be covered

|
++

Part (ii) Service Delivery

Month	Cert. of	O&M	ADL	Voc	Bus	Pension	Bank	School	Case
-------	----------	-----	-----	-----	-----	---------	------	--------	------

Others

Total Expenditure (i+ii+iii)

d. Closing balance: (Op. Balance + Receipts - Admissible Expenses)
(a) + (c) - (d)

This is to certify that information given above is true and correct to the best of my knowledge and belief.

Place: Signature :
Date : Name :
Designation :
(Seal of the organization)

Proforma XV

Monthly Performance Report for Each Child
Enrolled under Integrated Education

1. Project Area.....
2. State.....
3. Name of the Resource/Itinerant Teacher.....
4. Source of Funds: Sight Saver/ Any Other (Please Specify).....

S.N. of the Child --> 1 2 3 4 5 6 7 8
First Name of Child -->
Standard studying in-->

Part I Child wise Report

1. No. of home visits
2. No. of school visits
3. Training in ADL (Yes/No)
4. Exposure to Early Learning Kit (Yes/No)
5. Training in O & M (Yes/No)
6. Stage of braille learning
(Refer to standard List I)
7. Whether instructional material prepared (Yes/No)
8. Supply of braille books (Yes/No)
If yes, specify subjects
9. Supply of tactile material (Yes/No)
10. Supply of large print material (Yes/No)
11. Supply of aids & appliances
(Refer to Standard List I)
12. Aids & Appliances to be Supplied
(Refer to Standard List I)
13. Supply of recorded material (Yes/No)
If Yes, specify books
14. Participation in co-curricular activities (Yes/No)
15. Participation in holiday camp (Yes/No)
16. No. of visits of the child to resource centre
17. Parent counselling (Yes/No)
18. Academic achievements of the child
19. Any other relevant information

Part II General Report

1. Difficulties mentioned by:
 - a. Class teacher
 - b. Headmaster
 - c. Parents
 - d. Fellow students
 - e. Children
2. Comments of the Itinerant Teacher
3. Any visitors to the programme (yes/no)
If Yes, tick mark the children the visitor met
4. Liaison with Govt. officials(yes/no)
If yes, please give details
5. Meetings with Yes/No Date No. of Participants Details
 - a. Headmasters
 - b. Teachers
 - c. Parents
 - d. Review meetings
- 6 . Any News Articles published (yes/no)
If yes, attach xerox copies
28. Any other information

Authentication:

This is to certify that the information given in the format is true to the best of my knowledge and belief. I have personally verified the information from the records and from the concerned persons.

Name of the Project Director.....
Designation

Place:

Date:

Signature
(Seal of the Organization)

Standard List I

Stages of Braille Learning

Stage	Details
I	Pre Braille Activities
II	Introduction to six dots on peg board
III a.	Introduction through flash cards
b.	Reading of braille words
c.	Reading of braille sentences

- d. Reading of braille text
- IV a. Writing of words in braille
- b. Writing of sentences in braille
- c. Writing of braille text
- V a. Reading & writing of simple braille
- b. Reading & writing of abbreviated / contracted braille

Standard List II

Aids and Equipment generally Available with the Child

S.N.	Item	Abbreviation	Remarks
1.	Braille Writing Slate (Board with a sliding guide)	Slate	
2.	Braille Writing Frame (Two flap Board without sliding guide)	Frame	
3.	Arithmetic Taylor Frame	Taylor F	
4.	Arithmetic Type	A-Type	
5.	Algebraic Type	B-Type	
6.	Bonham Geometric Device	Bonham	
7.	Geometry Box	Geo-Box	
8.	Braille Paper	Paper	
9.	Braille Kit	Kit	
10.	Rubber Mat	Mat	
11.	Plastic Sheet	Sheet	
12.	Spur Wheel	Wheel	
13.	Early Learning Kit	ELK	
14.	Braille Pocket Frame	P-Frame	
15.	Signature Guide	S-Guide	
16.	Abacus	Aba	
17.	Measuring Tape	Tape	
18.	Stylus	Stylus	
19.	Foot Ruler	Ruler	
20.	Brailler	Br.	
21.	Any Other (Please Specify)		

Proforma XVI

Monthly Report (Financial)
Integrated Education

1. Project Area..... 2. State.....
3. Report for the month.....year.....4.Source.....

I. Details of Admissible Expenses

A. Opening Balance for the Month:

B. Receipt During the Month: Amount:

Draft No..... Date.....

C. Admissible Recurring Expenses

S.N.	Details	Teacher I	Teacher II	Total
------	---------	-----------	------------	-------

1. Salary
2. Conveyance
3. Cycle maintenance
4. Vehicle maintenance
5. Books & consumables
6. Reader allowance
7. Orientation programme

- 8. Salary substitute teacher
- 9. Stipend - deputed teacher
- 10. Others (specify)

Total

D. Closing Balance of the Month:
 (Opening Balance + Receipts - Admissible Payments)

Endorsement :

This is to certify that information given above is true and correct to the best of my knowledge and belief. I have personally verified books of account, vouchers and bills etc.

Place : (Signature)
(Seal of the Organization)
 Date : Name:

II. Overall Report: (For the preceeding Years-for a year as a whole)

This report is to be submitted only once a year during the beginning of the financial year

Year	Opening Balance	Receipt Amount	Admissible Expenditure	Closing Balance

III. Admissible Non-Recurring Expenses

This report is to be submitted only when the capital items for the project have been purchased.

