CHAPTER – 6

REHABILITATION OF DISABLED IN KARNATAKA

Rehabilitation of disabled in Karnataka is taken place in various means and ways. Especially institutions which are government and non-government in this field have joined their hands in the rehabilitation process of disabled. Namely, Vocational Rehabilitation Centre for Handicapped (VRCH) of Central Government, District Disability Rehabilitation Center (DDRC) of Government of India, Directorate of Welfare of Disabled (DWD) of State Government of Karnataka, and NGOs like Association for the People of Disabled (APD), National Association for the blind (NAB), Dr. Chandrashekar Institute of Speech and Hearing (SISH), Association for Mentally Challenged (AMC), Sumanahally Leprosy Rehabilitation Centre (SLRC), and Mobility India (MI). All these institutions are working in the rehabilitation process of disabled in Karnataka.

6.1 PROFILES OF REHABILITATION CENTERS:

The detailed information of the above said institutions is shown in below deliberations. All such institutions are working in their limited capacity in the rehabilitation activity. The detailed interpretation of such institutions is helpful us to know the exact picture.

6.1.1: VOCATIONAL REHABILITATION CENTRE FOR HANDICAPPED (VRCH): Vocational Rehabilitation Centre for Handicapped is a Central Government
Agency. The following detail available on this institution is based on the "Brochure" published by the Government of India.

6.1.1.1: **History of the Centre:** The Government of India through the Ministry of Labor & Employment has been a pioneer in providing vocational rehabilitation services. Despite the good record of Special Employment Exchanges, it was felt that the placement of PWD would further improve if arrangements for proper assessment and adjustment training are made available to them. Accordingly, the Government of India, Directorate General of Employment & Training (DGE&T) opened two Vocational Rehabilitation Centers (VRCs) for Physically Handicapped at Bombay and Hyderabad to render assistance in the rehabilitation of such persons. The VRCHs have been silently serving the disabled since 1968. Now there are twenty such centers in the country. The Bangalore VRC established in 1980.

6.1.1.2: **Objectives of VRC:** Scientific and professional evaluation combined with vocational counseling is provided in VRCH and now extended to a variety of allied services. These Centers evaluate the residual capacities of the handicapped and provide them adjustment training, facilitating their early economic rehabilitation. Efforts are also made to assist them in obtaining other suitable rehabilitation services such as job placement, training for self-employment and in-plant training. The VRCH thus have a significant role in the country providing comprehensive rehabilitation services throughout India.

6.1.1.3: **Objectives of Skill Training Workshop (STW):** In order to facilitate speedy rehabilitation of the handicapped, 10 Skill Training Workshops have been set up at the VRCs in Ahmedabad, **Bangalore**, Chennai, Hyderabad, Kanpur, Mumbai, Una,
Srinagar, Pondicherry and Trivandrum. This facility is being extended to all the VRCs in a phased manner. Non-formal job oriented skill training is provided at these Centers. An agreement was signed between Government of India and the Government of USA and two VRCs, one at Bombay and other at Hyderabad were set up in 1968 to assess the vocational and psychological needs of the PWD and to render rehabilitation assistance to them. Some of the objectives are; to develop skills of the PWDs suited to their individual capacities; Design training modules and special training modules; Identify training needs with a view to start community based vocational training (CBVT) and develop suitable syllabi; Training of trainers of the disabled.

6.1.1.4: Process of rehabilitation in VRC: As discussed above the main activities to be rendered it has a particular process with the client. The client approaches the centre for any type of rehabilitation, first of all he should get registers his name in the centre. The centre conducts intake of the client by taking all the information of the client. This process is carried on by the Intake Assistants (Social Workers).

Thereafter the client will go to the workshop for the evaluation to plan out his rehabilitation. The evaluation unit has trade which assigns some work basing on his disability and education etc.

At this level, the client will undergo psychological test, performance test, adjustment test, suitability to the vocational training, etc in the trades. After completion of the evaluation, the client will be issued an evaluation certificate to that effect. If the client found suitable to the particular trade he will be counseled about the vocational training available in the centre on free of cost.
There are eight trades in the VR centre to arrange vocational training. They are, Electronics & Electrical, Refrigeration & Air conditioning, Printing and book binding, wood working, General Mechanic, Dress making and Secretarial Practice. The tenure of the courses is one year from the date of joining in the centre. After completion the client will be issued a certificate and arranges the economic rehabilitation. Another important
work of the VRC is submission under wage paid employment and self-employment. VRC has co-sponsorship power to submit the details of the registrants to the employer against notified vacancies keeping in view of the eligibility of the clients. This will be done in both sectors. Similarly, submits the applications of clients to the financial institutions under self-employment. All these works will be done through the referral section.

6.1.2: DISTRICT DISABILITY REHABILITATION CENTRE (DDRC):

This institution is a part of Government Hospital of Tumkur. The "Field Visit" enabled to get the details on this DDRC. This DDRC is one among the six DDRC which are functioning in Karnataka. An exclusive article entitled "Guidelines for setting up of DDRCs" makes convenient to give the following details.

6.1.2.1: History of DDRC: It is an initiative to facilitate comprehensive services to PWD in the rural areas. There are still a large number of districts in the country, which have no basic facilities for rehabilitation of PWD. The Ministry plans to facilitate creation of the infrastructure and capacity building at district level for awareness generation, rehabilitation, training, guiding of grassroots level functionaries, through setting up DDRC to provide comprehensive services to the PWD at the grass root level, in the un-served districts of the country.

The Ministry, in consultation with state government, will identify suitable district, set up the District Management Team (DMT) and also identify suitable registered GO/NGO/SHG amongst the existing ones for setting up DDRC and strengthen if necessary for effective transference after three years (Five years in case of North-Eastern states and Jammu and Kashmir). Subsequently the DDRC would be managed by the
implementing agency under the supervision of DMT. Funding for the scheme would continue on a tapering basis from the Deendayal Rehabilitation Scheme (DRS also called Umbrella Scheme) of Ministry.

6.1.2.2: **Objectives of DDRC:** Setting up of DDRC which would provide rehabilitation support to persons with disabilities through: Survey & identification of persons with disabilities through camp approach; Awareness Generation for encouraging and enhancing prevention of disabilities, early detection and intervention etc; Early Intervention; Assessment of need of assistive devices, provision/fitment of assistive devices, follow up/repair of assistive devices; Therapeutic Services for example, Physiotherapy, Speech Therapy etc. Facilitation of disability certificate, bus passes and other concession/facilities for PWD; Referral and arrangement of surgical correction through Govt. & Charitable institutes; Arrangement of loans for self-employment, through banks and other financial institutions; Counseling of the disabled, their parents and family members; Promotion of barrier-free environment; To provide supportive and complimentary services to promote education, vocational training and employment for PWD.

6.1.2.3: **Selection of Districts:** Selection of districts will be on the basis of need. As indicated earlier the Ministry now proposes to set up DDRC in the un-served Districts of the country only. As in such districts there may not be NGOs working in the field of disabilities hence for the initial period of three years, five years in case of J&K NE states the establishment of DDRC will be coordinated and guided by the Ministry with the active support of the state Government.
6.1.2.4: Monitoring and Coordination: Each DDRC is to be run under a DMT headed by the District Collector and having representatives from GOI (for the first 3/5 years) Departments of Health, Panchayat Raj, Rural Development, Welfare, Women & Child Development, Labor & Employment, and Education etc. Besides them the team is also to include a nodal officer from the implementing agency and representatives for reputed NGOs/ public representatives. This team will also be the custodian of assets of the centre. To facilitate better coordination it would be desirable that a nodal officer is identified among the district officials in the DMT to monitor and coordinate the activities of DDRC. This team may meet once in a month but not less than 4 times in a year.

6.1.2.5: Important functions of the DMT are: Selection of registered implementing agencies; Deployment of Manpower and finalizing their engagement conditions; Monitoring, coordination of activities of DDRC, even after handover; Convergence with other activities of the district; Fixing of charges for various services provided through DDRC and identifying other means of resource generation; Security of assets of DDRC and material received under ADIP (Assistance to Disabled Persons) etc.

6.1.2.6: Selection of Implementing Agency: As far as possible, DMT should identify a suitable agency for the new DDRC, right from inception. Implementing agencies should preferably be District Red Cross societies or registered societies of health department of the state government. If the above are defunct, any NGO of repute/ SHG could be selected. The DMT, through local publicity, could call for proposals from the interested registered organization and then identify the most appropriate among them in consultation with the Ministry.
6.1.2.7: **Admissible Manpower:** Each DDRC would have the Manpower with fixed honorarium and predetermined qualifications. The rehabilitation professional should preferably be registered with Rehabilitation Council of India (RCI)

6.1.2.8: **Equipment:** The equipment for fabrication and fitment of assistive devices related to all kinds of disabilities is to be purchased from this scheme. The equipment will range from an Electric oven, workshop anvil, physiotherapy equipment, clinical audiometer, speech trainer, workshop tools and some teaching material for the MR children. Nonrecurring expenses of Rs 5 lakhs per DDRC in the first year has been earmarked for equipment.

6.1.2.9: **Materials for Aids and Appliances:** The assistive devices and the material for fabrication of aids and appliances shall be supplied under the ADIP scheme of GOI. The DDRC should annually submit the proposals in the prescribed pro-forma along with utilization certificate, audited statement of expenditure, list of beneficiaries, details of aids and appliances and calendar of activities through The District Collector to the facilitating agency (National Institutes/ALIMCO)/Project Director, DRC scheme, GOI for availing grants under this scheme.

6.1.3: **DIRECTORATE OF WELFARE OF DISABLED & SENIOR CITIZENS (DWD):**

Directorate of Welfare of Disabled and Senior Citizens (DWD) is another important state government body in rehabilitation activity for disabled. The directorate is absolutely committed to the rehabilitation of disabled of Karnataka. The directorate has published "Angavikalara Ashadeepa." It is an important and informative booklet. The
following interpretation is based on the same booklet entitled, "Angavikalara Ashadeepa." The Government of India has passed a comprehensive legislation called "The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full participation) Act -1995".

6.1.3.1: **Introduction:** Government of Karnataka has taken serious view about disabled and has taken keen interest from the beginning to help the specially challenged persons and launched several welfare schemes for the welfare and benefit of the PWD. Understanding the need of this vulnerable section of the society the State Government has created separate department for the welfare of the disabled to provide all rehabilitation services, the Directorate of Welfare of Disabled was created as an independent Department in August 1988 and added the welfare of the Senior Citizens in the year 2003 to look into the programs of the PWD and Senior Citizens separately with the motto to serve and provide services to them only. A comprehensive Act called the Persons with Disabilities (Equal Opportunities, Protection of Rights & Full Participation) Act -1995 has come into force from 07-02-1996. The State Government has constituted the State Co-ordination Committee as per the Sec.13 of the Act. The State Government appointed the Secretary, Department of Women & Child Development as the Commissioner for PWDs as per Sec.60 of the Act. State Executive Committee is constituted as per the Sec. 19 of the Act. Action has taken to implement the Act, to bring the disabled persons to mainstream of the society.

6.1.3.2: **Rehabilitation Services:** The rehabilitation services of the Government of Karnataka can be classified as; Education Schemes; Employment and Training; Social Security Schemes; Recently Launched Schemes; Other Programs
6.1.3.2: Organization structure of DWD:

Figure: 06.02

Organization structure of DWD

State Level

Secretary, Women and Child Development
(Administrative Head - at the Secretariat)

Director

Joint Director (Senior Citizens)

Deputy Director (Schemes)

Deputy Director (Training)
(Posted at Mysore)

Assistant Director (Administration)

Office Manager
(Ministerial Staff)
Superintendent - 5
Stenographer - 1
FDAs - 10
SDA - 10
Typist - 2
Drivers - 3
Group 'D' - 3

Section Officer (Sr.Cit.)
Superintendents - 1
Stenographer - 1
FDAs - 10
SDA - 2
Computer Assistant - 1
Driver - 1
Group 'D' - 2

District level set up

Deputy Director (Women & Child Development)

District Disabled Welfare Officer

Program Assistant

Typist

Group - D

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6.1.4: ASSOCIATION FOR PERSONS WITH DISABILITIES (APD):

6.1.4.1: Introduction: APD is an NGO. It is in Bangalore. This NGO is famous in rendering rehabilitation services for the persons with disability in various categories in a systematic manner. This association is praised by even foreign social work experts like Jean Satterthwaite. She has written a wonderful book on this association entitled “Challenging Disability: Forty Years of an Indian NGO.” This book is worth to praise because of its’ information. She says “Beauty, calm and order meet you: cleverly laid-out gardens, flowers and great trees, benches and shades for rest and talk, and many people going about their business with design and concentration.” This word is entirely carried out in the book of each and every line. The Association for People with Disability (APD) is a Bangalore based organization working since 1959. Its coverage extends to Tumkur, Kolar, Koppal and Haveri districts.

6.1.4.2: History: It was the search for a three-wheeled scooter by a father for his 17 year old polio affected daughter that started it all. He tried everything. He contacted even the Army that made tricycles for paraplegic men of its armed forces. Yet, the simple but critical need of N S Hema, daughter of N S Ayyangar could not be met. Finally, it was the England based Uncle who got the tricycle to cross the seas and arrive in Bangalore. “Like the Rolls Royce of my life” is how Hema describes the moment. Meeting with Fatima Ismail, the mother of a polio affected daughter, who had started a Rehabilitation Centre for disabled in the name of Fellowship of the Physically Handicapped in Mumbai was the second inspiring moment for Hema. The mind of the young Hema began buzzing with dreams, hopes and ideas. To train and rehabilitate people with disability – bringing dignity and self-sufficiency in their life. Her return to
Bangalore only added fuel to her zeal as her father corresponded with N.D. Diwan, an ex-serviceman, and a wheelchair user, staying in Red Cross Home. They father daughter duo also met with Rev. I.L. Thomas (Principal of Bishop Cotton School) also a person using wheelchair and others to discuss the possibility of starting a Centre for helping the people with disability. Hema along with the support of others gave fulfillment to her dreams by founding APD.

6.1.4.3: **Founding principles are:** to enhance the self-esteem and productivity of people with disabilities; to integrate them at different levels of society and industry, and to create space for them in the socio-economic arena of the country and the world.

6.1.4.4: **Primary goals and objectives are:** capacitate and enable people with disabilities to towards self-sustainability and empowerment catalyzing mutually beneficial relationships with key stakeholders.

6.1.4.5: **Empowering methodologies are:** Education; Therapeutic counseling, services and provision of mobility aids; Vocational skills training and support in the placement of people with disabilities, with special focus on women and people with spinal cord injuries; and Networking and advocacy.

6.1.5: **NATIONAL ASSOCIATION FOR THE BLIND (NAB):**

6.1.5.1: **Introduction of NAB:** The NAB-KB is a Non-Governmental, Non-Profit Organization, affiliated to NAB (India), that focuses on Economic Rehabilitation of the Visually challenged persons. A one-of-a-kind organization, it provides the infrastructure as well as wide range of projects & services for the general welfare, education & training.
of the Visually Challenged (VC). They have rural projects, Deaf Blind Projects, Integrated Education Projects. They also conduct Eye Camps for the rural poor. Several Cataract & Cornea surgeries have been conducted in the past 10-12 years. Funds to an extent of about 30% come from Government of Karnataka & Government of India. Rest of the funds is through donations from general public, Schools & private/public sector organizations. Annual budget is approximately is Rs 120 Lakhs ($3,00,000). All donations are exempted under 80G of Income Tax Act of 1961. The main objective of this institution is to become “instrumental in holistic development of the blind through the establishment of various training centres.”

6.1.5.2: Vision and Mission of NAB: ‘To lead the visually challenged persons from darkness to light’ is its’ vision and the mission is ‘Make visually challenged equal member of society.’

6.1.5.3: Goals of NAB: Important goals of the NAB are; Self-reliance in mobility, Basic Education; Training in Vocational skills; Training in Technical Skills; Training in I.T; Rehabilitation in Rural areas; Employment Assistance.

6.1.5.4: Activities of NAB: Being Rehabilitation and Basic Training Center, conducting and providing CBR Programs, Mobility Training; Employment and Placement Services, Eye Care Services; Deaf & Blind Program; Computer Training; Technical Training.

Once again to impress the “objective of NAB (India) right from its inception has been to promote to welfare of blind people by providing them employment in normal
This objective will be achieved by the institution only through the proper efforts and commitment of the rehabilitation professionals.

6.1.6: Dr CHANDRA SHEKAR INSTITUTE OF SPEECH & HEARING:

6.1.6.1: Introduction: Dr. S. R. Chandrasekhar Institute of Speech and Hearing (Dr.SRCISH), Bangalore, is one of the leading clinical and academic rehabilitation Institutes in India. It was established in 1977.

6.1.6.2: History: Dr. S. R. Chandrasekhar is a reputed E.N.T. surgeon in Bangalore. In 1974, in his capacity as President of Lions Club of Bangalore East, he organized a Speech & Hearing Camp, at St. Martha’s Hall, Bangalore. The camp was an eye-opener as it brought to his attention the large percentage of population, which had speech and hearing problems. It also highlighted the dire need for speech and hearing services in Bangalore. This motivated the young doctor to start an Institute on Hennur Road in Bangalore, in 1977. The Institute has been his 'brain child' since its inception and he has nurtured the Institute to its present pre-eminent position with vision, single-minded devotion and commitment.

6.1.6.3: Vision: To enable individuals with speech and hearing problems to walk hand in hand with the rest of society is the vision.

6.1.6.4: Mission: To be recognized as a centre for excellence in evaluation, diagnosis and rehabilitation of the Speech & Hearing impaired.

6.1.6.5: Academic & Training Programs: "The field of communicative disorders provides exciting career opportunities for students. After successful completion of
training, they can work in a wide variety of settings as Speech Language Pathologists and/or Audiologists (SLPA). It is estimated that speech, language or hearing disorders constitute up to 8% of the total disorders/disabilities. Therefore, there is a growing need for trained professionals in varied clinical settings and in academic/research positions.

6.1.6.6: **Features of the diagnostic facilities at the Institute:** Technologically Advanced Audiometers: Extended frequency range useful in early detection of noise/drug induced hearing loss; Special audiological tests – useful in differential diagnosis; Free field testing and visual reinforcement Audiometry useful in testing infants and young children; Dichotic tests – useful in testing central auditory processing.

6.1.6.7: **Additional Features of Immitance Audiometers at the Institute:** Quick screen facility, conductance or susceptance and Acoustic reflex measures are additional features.

6.1.6.8: **Hearing aid repair workshop:** Here all types and makes of Hearing aids serviced and repaired and servicing and repairing done by a qualified person.

6.1.6.9: **Signers' World:** Signers' World is an association deaf and hearing persons interested in popularizing Sign language. It started with a handful of deaf persons who came to the Institute once a week to interact with students learning Sign language. Their numbers grew steadily and Signers' World was started in 2000. The members of Signers' world have taken several measures to create awareness about Sign language. These include articles in newspapers and magazines, and interacting with students.
6.1.6.10: **Aural Rehabilitation:** Aims at enhancing the communication skills of the HI using several rehabilitation techniques. Some of the main techniques used are given as: Amplification, Assistive listening devices, Cochlear Implant, Auditory Verbal Therapy, Speech Reading, Sign Language, Education of hearing impaired children and Mothers’ training program.

6.1.7: **THE ASSOCIATION FOR THE MENTALLY CHALLENGED (AMC):**

This institution is located at Hosur Road, Bangalore 560 029, India. This association is dedicated to the upliftment of mentally retarded children. The following interpretation is come out with the help of “Field Visit” done on a day.

6.1.7.1: **History:** Association for the Mentally Challenged was the idea of then Director of All India Institute of Mental Health (currently NIMHANS, Bangalore), the dynamic and dedicated Dr. D.L.N. Murthy Rao. The institution was started in 1960 under the presidency of Dr. D.L.N. Murthy Rao. Initially, it was started as a bi-weekly clinic in two rooms spared by the Central Social Welfare Board. Dr. Murthy Rao and his colleague doctors and psychologists helped in running the clinic. In 1963, the clinic was shifted to a building in the compound of Smt. Kotawala, the then Secretary of the institution, and the special school was started. One acre of land was granted by the State Government and part of the present building was constructed. The institution shifted to the new building in 1966. AMC is getting assistance and co-operation in all areas, including assessment, consultation and guidance from NIMHANS.

6.1.7.2: **Development:** The Association runs Akruti, a special school for mentally challenged children between 6 and 16. Besides classroom instruction, the school's
activities include painting, craft and dance. The AMC also runs Pragati, a multi-category vocational center for mentally challenged adolescents and adults. In addition, the Association runs Sanskriti, a sheltered workshop which offers gainful employment to mentally challenged adults who have acquired vocational skills at Pragati. The AMC also runs a child guidance clinic which is held three days a week. A team consisting of psychiatrists, psychologists and social workers provide comprehensive assessment and guidance. They address the needs of children undergoing special education, special teachers, vocational trainers and parents of special children. AMC participates in various National and International level competitions and have secured a number of prizes in these competitions.

AMC is a member of Federation for the Welfare of the Mentally Retarded (India), The National Trust and Pariwar. With the continued co-operation from the Central and State Government, Social Welfare Board and general public, AMC is expanding its services to serve more and more mentally challenged persons and their families.

6.1.7.3: **Activities:** There are several activities conducted every year. These are:
Annual day celebration; Sports day; Yoga Sessions; Laughter Therapy; Picnic; Visit to exhibitions; Cultural programs; Art/Painting Workshops; Celebration of festivals.

6.1.7.4: **New Initiatives: Samruddhi(2008):** Families are the chief support for mentally challenged persons. These families have continuous challenge of caring and supporting the mentally challenged throughout the life. Recognizing this need, the goal of SAMRUDHI is to strengthen and enrich the family life of mentally challenged persons.
6.1.8: SUMANAHALLI LEPROSY REHABILITATION CENTRE:

6.1.8.1: The Genesis of Sumanahalli: Thrilled by an inspiring sermon by one of the Redemptorist Fathers, on Good Friday of 1971, we the members of The Legion of Mary, Oliver Dooland and I, chose to visit the Central Leprosarium on Magadi Road. The first patients whom we met were all praise for us standing so close to them and talking to them, when their own wives had deserted them after they were afflicted with leprosy. That was an encounter.

These patients were from several slums in Bangalore: Magadi Rd., Sheshadri puram, East Station, Tilak Nagar, etc. We were visiting them in the slums, where we met others with similar interest: Brother Christudoss, a Holy Cross brother from St. Peter's Seminary, a few sisters from Mother Teresa's organization, and a certain Ms. Chris Saddler, a Britisher. There were days when after a hard day's work, I would join other friends in the colony and lay my head on the damp ground over a thin mat.... I understood for the first time what Communion is. In the wee hours of the early dawn I used to whisper in prayer "Lord, is there any place for them to grow more human?"

After attending the All India Leprosy Congress in Baroda, I reported back to His Grace Arokiaswamy. He brought in Dr. Marshall, Professor of Dermatology at St. John's Medical College, along with one medical student, Fr. Antonio Salafia, Fr. Michelangelo and Fr. Mario from the Montfort Fathers, Mother Marguritte (SJT). Work was on to run clinics for the patients in various slums.

Mr. J.C. Lynn, (later Chief Secretary to the Government of Karnataka) ushered in a token of financial help from the Beggar's Relief Fund for each leprosy patient who
would stop begging. A gesture of hope and faith extended by the Government. In May 1976 the Government asked us to put up a Leprosarium and offered land.

The Archbishop asked me to help draft an appeal to Mother Teresa to take up this task. Providence had other plans...Mother Teresa regretted her inability. With no plan, no project and no set-up funds, we just said "fiat" (we accept) to the Government.

Fr. Michel from the Servants of the Holy Spirit came with the first donation of Rs. 1 Lakh. The faith ministry began. The Sisters of St. Joseph's of Tarbes moved in to stay at Sumanahalli. This was followed by the Franciscan Sisters of Mary Immaculate. The Daughters of the Church and the Daughters of Wisdom also joined the SET (Survey, Education & Treatment) program.

With houses built, the patients from Sheshadripuram moved into Sumanahalli. Mr. Bonnie Mascarenhas joined as Technical advisor. Mr. Michelangelo took over the portfolio of Treasurer. Sr. Mary Mascarenhas began the rehabilitation activities. Volunteers from far and wide began to trickle in. The rest is history.

6.1.8.2: Partner Congregations: Sumanahalli, being a project of the Archdiocese of Bangalore, is under the chairmanship of His Excellency the Archbishop of Bangalore. This endeavour would not have been possible without the dedication of our partner congregations: The St. Joseph's of Tarbes (SJT), The Franciscan Sisters of The Immaculate (FSI), The Daughters of Wisdom (DW), The Daughters of The Church (FDCH), The Claretians (CMF).

6.1.8.3: Patrons and Partners: We have been blessed to receive great amounts of assistance and encouragement from a large number of our friends, benefactors and
volunteers. The Government, various departments, organizations, individuals and associations all came forward through the years to render their support. We express our sentiments of gratitude to all of them.

6.1.8.4: The Team: Sumanahalli is registered society with the government with His Grace Bernard Moras, Archbishop of Bangalore as the Chairman. We have a total number of 265 people working in the society in our different departments of survey, treatment, education, vocational training, production and rehabilitation.

6.1.8.5: The Governing Body Members:

1. His Grace Bernard Moras, Archbishop of Bangalore, Chairman
2. Rev. Fr. Xavier Manavath, cmf Claretian Provincial Vice Chairman
3. Mr. E.P. Jacob, Wood ways India Secretary
4. Fr. George Kannanthanam, Claretian Director & Treasurer
5. Mr. Cyriac Thomas, Advocate Member
6. Mr. Paul David Member
7. Sr. Laurent Marie, Montfort Sisters Member
8. Gracy, Daughters of the Church Member
9. Fr. Amaladas Maria Susai, Precious Blood Missionaries Member
10. Sr. Mary Mascarenhas, S.J.T. Member
11. Sr. Lucy Augustine Provincial, FSI Member
12. Mrs. Flavia Pinto Member
13. Fr. Joseph Thoompanal, Claretian Member
6.1.9: MOBILITY INDIA:

6.1.9.1: Introduction: “Mobility India” is another best NGO in Karnataka for disabled. Mobility is a birthright. Majority of people with disabilities have problems with mobility. To offer solutions to mobility problems they would require the interventions of Physiotherapist/ Occupational Therapist & Prosthetist / Orthotist to suggest assistive devices and make them. A wheelchair is another commonly used assistive device for people with disabilities to enhance mobility. Fundamental to all these issues is the approach to disability rehabilitation; through community based rehabilitation programs, an approach designed to enhance the quality of life for people with disabilities through community initiatives.

6.1.9.2: Magnitude: An estimated 10% of the world’s population approximately 650 million people, of which 200 million are children - experience some form of disability. 80% of people with disabilities live in low-income countries. Most are poor & have limited or no access to rehabilitation services. In India itself, there are 200 million people with disabilities who constitute 2.13 % of the total population.

6.1.9.3: Start up: In addition, natural disasters and man – made conflicts result in disabling conditions like loss of limbs and other disabilities require rehabilitation intervention. India has so far developed only 5% of the required human resource. Of the few professionals being trained in the country many choose to work abroad, at the national level & to some extent at the state level. Not many people prefer the district or the taluk level where most people with disabilities reside. India and other low–income countries of Asia & Africa require trained rehabilitation personnel.
Keeping in view of the above factor the Mobility India was set up in Bangalore, South India, in 1994 to reduce the wide gap between the need and availability of rehabilitation services in rural India and enable more organized work in the field of mobility appliances and to bring about a change in the disability field in general. Mr. Chapal Khasnabis, the founder Executive Director was instrumental in establishing and shaping Mobility India. His vision and determination are the guiding forces behind MI's success. MI promotes mobility for persons with disabilities, especially those in rural areas, who are poor especially women and children through awareness raising, training, improved services, advocacy, research and development, and all other activities towards an inclusive society where persons with disabilities have equal rights and a good quality of life.

6.1.9.4: Milestones: MI is the organisation that has a perfect blend of disability and non-disability at all levels - an innovative organisation of abilities and commitment and its approach to address the real need. Mobility India has come up in a big way since its inception. It has grown tremendously because of the need.

In 1995 continued to work with 12 partner organizations and started short training courses. In 1996 Mobile workshop launched. 10 disabled women identified to train as technicians in Research & Development. In the year Mobility India received National recognition- an award for Plastic Orthosis at the Orthotics & Prosthetics Society of India, (OPSI). In 1998 Mobility India's Regional Centre in Kolkata set up to provide and strengthen rehabilitation facilities in the Indian sub continent.

6.1.9.5: Mission: Enhance the quality of life of persons with disabilities and their families are the mission of this organization. Mobility is an essential human right.
People deprived of mobility require appropriate rehabilitation. Mobility India facilitates this process through its Rehabilitation Service.

6.1.9.6: **Aims and objectives:** To create awareness and understanding among the public of what a lack of personal mobility means to disabled people, and to provide the means to address this issue is the main objective of this organization.

6.1.9.7: **Support:** Mobility India reaches out to more number of people with disabilities in rural areas with focus on early identification and intervention because of its association with grass root partner organizations in rural India. Most of these organizations have roots in the community where no rehabilitation facilities exist. The rehabilitation team ensures that services are made available over large distances and definite changes ensured in the person’s life. Capacity Building could be reflected as the final output of the whole service. Key Areas of Support are - Support in setting up of Prosthetics and Orthotics facilities; Facilitating setting up repair and maintenance workshop for prosthetics and orthotic needs; Providing direct and mobile workshop services; Mobile workshop for organization; Setting up of a well-equipped therapy unit for an organization etc.

6.1.9.8: **Mobility India is governed by a board of 7 members:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth Thomas</td>
<td>President</td>
<td>Educationist</td>
</tr>
<tr>
<td>A. Satyavethi Shamshuddin</td>
<td>Vice President</td>
<td>Retired Principal</td>
</tr>
<tr>
<td>Philip DeCosta</td>
<td>Secretary</td>
<td>Retired Engineer</td>
</tr>
<tr>
<td>Anil Prabhu</td>
<td>Treasurer</td>
<td>Chief General Manager</td>
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<td></td>
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<td>State Bank (Retired)</td>
</tr>
<tr>
<td>Teresa Bhattacharya</td>
<td>Member</td>
<td>Retired I.A.S.</td>
</tr>
<tr>
<td>Ramesh Ramachandran</td>
<td>Member</td>
<td>Retired I.R.S.</td>
</tr>
<tr>
<td>Romola Joseph</td>
<td>Member</td>
<td>Social Worker</td>
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</tbody>
</table>
6.2: REHABILITATION SERVICES RENDERED BY GOVERNMENT OF INDIA:

6.2.1: THE SERVICES OF VRC:

6.2.1.1: Referral: By interviewing technique individual case histories of disabled persons are collected and recorded in detail by trained Social Workers. The Socio-economic assessment is then made by an experience Rehabilitation Officer. The various Rehabilitation services and facilities available at the Center are informed to every client. Vocational guidance and placement assistance are given to PWD regarding how to apply and secure jobs/technical and non-technical training/academic courses/self-employment ventures/activities, how to prepare for competitive examination and face interviews, etc.

6.2.1.2: Evaluation: Evaluation is a process through which the residual abilities, personal attributes of the PWD are scientifically qualified and quantified with reference to their physical, mental, social and vocational capacities to help the professional team to arrive at a suitable vocational diagnosis. The evaluation process involves: 1) physical/medical evaluation 2) Socio-economic evaluation 3) Psychological evaluation 4) Vocational evaluation.

6.2.1.3: Training: It has been observed both in the VRCH and the Special Employment Exchanges for the Handicapped that a majority of those approaching them for evaluation or job opportunities are not immediately ready or equipped for a job. A large number of them need training in various areas of work and work environment for performing and retention of the job: such as work adjustment, skill for the job and development of work personality to be acceptable to the employer. After a detailed evaluation of the abilities of the disabled an executable vocational plan is to be worked
out depending on the individual's physical, mental and vocational capacities and also appropriate to his socio-economic status. The types of training to be given to the PWD depend upon the residual abilities, skills and the immediate economic needs of the persons. They are divided into the following areas as Adjustment Training; Institutional Training; Apprenticeship Training; and Non-formal Training.

6.2.1.4: Wage paid employment: The ultimate goal of entire rehabilitation process in the VRC is integration of the PWD into the society. This is possible only through vocational rehabilitation, which includes vocational training, placement, and wage paid employment, self-employment or sheltered employment. Economic rehabilitation of the PWD is not only important from the point of view of making him economically independent, self-reliant and earning member of the society, which provides him quality life, but more importantly the job and feeling of working provides him happiness and security in life, dignity in society and sense of achievement in life. The VRCs in fact, take care of this aspect of Rehabilitation i.e., Vocational Rehabilitation.

6.2.1.5: Self-employment: Main objective of VRC is to extend all possible rehabilitation assistance towards the economic rehabilitation of the persons with disabilities. The registration in the VRCs consists of persons with different types and degrees of disability, different levels of educational background and different socio-economic conditions. Hence, there is a necessity to adopt multiplicity in approach to widen the scope of economic rehabilitation of the PWD. The scope of wage paid employment is increasingly becoming scarce in the employment market especially in the organized sector. Alternate methods of employment such as self-employment activities
are to be thought of for planning effective economic rehabilitation. VRC plays a vital role in promoting the self-employment activities. The VRC should equip itself with complete and exhaustive information about the different self-employment schemes and avenues available in the respective areas, the facilities and assistance provided by Government, non-Government agencies and financial institutions in the area.

6.2.1.6: **Physical Restoration:** Physical restoration or aids and appliances or supportive services like, artificial limbs, crutches, tricycles, wheel chairs, canes, Hearing aids, etc are arranged in association with the local NGO/GO to the disabled. The suitable persons are identified in the rural identification camps; rehabilitation camps and who approaches the VRC are referred to the other institutions.

6.2.1.7: **Other Services:** The other services of the VRC are as follows:

- It refers the client to the VRC attached medical board for the Standard format of Disability Certificate.
- It provides the counseling and guidance to the disabled with regard to the rehabilitation services available in the centre and elsewhere in the state.
- It conducts the rural identification camps, and rehabilitation camps in association with the District Employment Exchange or NGOs or local bodies.
- It provides almost all referral services which not available in the centre.

6.2.1.8: **Community Based Vocational Training (CBVT):** Majority of the disabled has no access to the Institutionalized training program due to distances, disability and destitution. The VRCH at Mumbai introduced an innovative CBVT program in remote villages and also urban areas situated over 100 kms away from Mumbai. The Centre initially identified about forty operations from out of the thirteen trades available at the centre. In the same manner, VRC Bangalore also conducts CBVT
trainings in Districts in association with the local NGO's. The main objective was to provide basic skills in one of the operations of an occupation depending on local employment market requirements. Syllabus was prepared with weekly and daily targets of skill to be attained. Almost the entire work performed by the VRC is community based, whether they are in the urban areas or the rural areas. The training whether institutional or non institutional are also community based. Even though there are several skill training programs that could be organized for shorter durations on a similar model, the name CBVT is assigned to a skill development program where the skill to be developed require not less than three months of training. As the name implies, the training program is designed to suit the local employment market and the training is provided at a central place accessible to the user, viz., and the rural disabled. It may be a central village or a place, to which transport arrives in the morning and the disabled persons are able to go back home by the evening.

6.2.2: SERVICES OF DDRC: Activities of DDRC should broadly be as follows

- Survey of the PWD and their needs in the districts at the rate of 10 – 15 villages per month
- Assessment camps at HQ – Twice a week ; At Civil hospital – once every week ( if required )
- Assessment-cum-distribution camps at villages- twice a month
- Awareness generation activities like visits to school, awareness camp in villages for different target groups, training program of grass root level functionaries – 4 times a month.
- Follow-up camps in villages – 4 times a month
6.2.2.1: **Assessment /Fitment of aids & appliances:** Actual fitment of assistive devices would be one of the major activities of DDRC. A blend of camp approach and institutional approach should be used in fitment of assistive devices. The expenditure on materials/ assistive devices should be met out of ADIP Scheme. The implementing agency would be responsible for exact arrangements and following proper procedure in keeping accounts as per the ADIP Scheme.

6.2.2.2: **Repair / Follow-up of assistive devices:**

a) The implementing agency must ensure proper repair through rigorous follow up of persons provided assistive devices

b) The district centre should provide for repair services, adjustment and follow up of assistive devices. A nominal charge for repair of assistive devices should be charged, and it can be different for different devices and types of repair.

c) PWD, provided with assistive devices, should be categorically informed of the follow up / repair / training services available at the district centers.

d) PWD may also be provided training for use of assistive devices and therapeutically services. They may also be given instructions in the local language through of a pamphlet having sketches / pictures for use and upkeep of the device (s).

6.2.2.3: **Prevention:** It has been promoted through various National Health Programs like Programs of Prevention of Blindness, Leprosy etc., as well as various immunizations like Pulse Polio. The orientation of these programs needs to focus not only on prevention of mortality, but also on disability. The
District Centers, therefore, need to modify the information dissemination on prevention to emphasize the linkage between health programs and schemes and prevention of disability. The District Centers should, therefore promote prevention.

6.2.2.4: **Early Intervention:** Early identification of disabilities and early intervention is very important for avoiding secondary disabilities and ensuring successful integration of children with disabilities. Hence each DDRC must set up an early intervention unit. Parents of children with disabilities must be encouraged to visit these. In addition, low cost intervention using locally available material should be suggested to them for continuing the intervention at their residence.

6.2.2.5: **Barrier-Free environment:** Provision of barrier-free environment is an important complement of assistive devices for providing accessibility to PWD. All new buildings, especially public sector and public utility like schools and hostels, panchayat and other Govt. buildings, hospitals, markets, bus stands, parks, public toilets are to be made barrier-free, as per the standard bye-laws circulated by Ministry of Urban Affairs and Employment. The basic responsibility lies with the local governments.

6.2.2.6: **Promoting Education, Vocational Training & Placement:** Education, training and employment are the important components of rehabilitation.

1. The implementing agency should organize orientation-training program for teachers / communities / families.
2. They may also provide information on suitable vocations, possible job placements and other facilities like soft credit through NHFDC, vocational training through VRC etc.
3. At least one orientation program of 3 to 7 days should be held once in 6 months.
6.3: REHABILITATION SERVICES RENDERED BY GOVERNMENT OF KARNATAKA: (DIRECTORATE OF WELFARE OF DISABLED & SENIOR CITIZENS)

6.3.1: (ADIP) Scheme for Purchase / fitting of Aids and Appliances: The scheme is centrally aided and implemented through the voluntary organizations. Aids and Appliances, Artificial limbs which do not cost less than Rs.50/- and more than Rs.6000/- are covered under this scheme. The full cost of the aid is given to those whose income is up to Rs.5000/- per month and 50% of the cost of the aid is given whose income is in between Rs.5000/- - 8000/- per month. Traveling, boarding and lodging cost of the beneficiaries are also met under this scheme. The implementing NGO has to apply for grants under this scheme through the Dist. Disabled Welfare Officer (DDWO) of the respective district.

6.3.2: Deendayal Rehabilitation Scheme: The Scheme of the MSJ&E, Government of India, simplifies and facilitates procedure for easy access to government support for NGOs with the aim to widen the scope and range of programs. It will address the unmet needs of the over 95% Indian citizens with disabilities who have not had access to services so far. Eligible NGOs who opt for financial assistance must submit the proposals through State Government. It will scrutiny the proposals and as per feasibility recommend for financial assistance. The present around 90 special schools / VTC are assistance under Central Grant-in-Aid.

6.3.3: Authority competent to issue disability certificates: The medical boards have been constituted at the State level, District level and Taluk level to assess the percentage of disability / the level of disability/ and then to issue disability certificates whose
disability is more than 40% and above. The composition of the Medical Board is in state, district as well as taluk level.

6.3.4: Special Schools: The Government of Karnataka has established 8 Special Schools for children with visual and hearing impairment. Out of 8 Special Schools 4 schools are for blind children and 4 schools are for children with hearing impairment. All the institutions are residential schools and free education is provided to all the children. Text Books in braille language are printed at the Government Braille Press, Mysore and supplied to Blind children studying in Government Schools and also in Private Schools free of cost besides providing clothing and medical facilities.

6.3.5: Scholarships: To encourage enrollment and to continue the studies of the PWD State Government extends scholarships in the following manner from Class 1 to University Level.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Monthly Scholarship</th>
<th>Scholarship for hostel students</th>
<th>Reading allowance for blind students</th>
<th>Conveyance allowance for physically disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>I to IV</td>
<td>50</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>VI to X</td>
<td>100</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>PUC</td>
<td>150</td>
<td>140</td>
<td>75</td>
<td>50</td>
</tr>
<tr>
<td>Degree/TCH</td>
<td>200</td>
<td>180</td>
<td>75</td>
<td>-</td>
</tr>
<tr>
<td>BE/MBBS/LLB</td>
<td>250</td>
<td>240</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>MA, M.Sc, M.Com, LLM, &amp; Equivalent</td>
<td>300</td>
<td>240</td>
<td>100</td>
<td>-</td>
</tr>
</tbody>
</table>

6.3.6: Incentive Award to Meritorious Disabled Students: The scheme provides one time Incentive Award to Meritorious disabled students who secure more than 60% of marks in public examinations.
Table: 06.02

Statement of Rate of Incentive Award to Meritorious Disabled Students

<table>
<thead>
<tr>
<th>Standard</th>
<th>Incentive award</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSLC</td>
<td>Rs.500/-</td>
</tr>
<tr>
<td>II year PUC</td>
<td>Rs.750/-</td>
</tr>
<tr>
<td>Degree</td>
<td>Rs.1000/-</td>
</tr>
<tr>
<td>Post Graduate Courses</td>
<td>Rs.1200/-</td>
</tr>
<tr>
<td>Degree in Agriculture, Engineering/Technology/vet.science/medicine</td>
<td>Rs.1500/-</td>
</tr>
</tbody>
</table>

6.3.7: Braille Press: Department runs a Braille Press at Mysore to cater to the needs of visual impaired students of the State. For blind students studying PUC and BA in humanities subjects 10 audio cassettes and a tape recorder is also provided free of cost by the State Government and help them to continue their studies.

6.3.8: Educational Concessions: vide Government Order No: ED 10 STB: 93 Bangalore dtd.2.1.2001 State Government has ordered for 3% reservation of seats in all educational institutions for PWD students and also preference in Hostel facilities. Facilities such as help of the scribe, extra time duration in public examination and selection of elective subjects are extended to visually impaired students. For Hearing Impaired children concession in studying 2nd and 3rd language and also one hour extra time for public examination is given. Special stickers are attached to the answer papers of the hearing impaired students in public examination.

6.3.9: Special teachers training centers: State Government runs 2 special teachers training centre at Mysore for the training of teachers in teaching visually impaired children and hearing impaired children respectively in collaboration with National Institutes with the intake capacity of 20 students per batch every year in each category. It
is a 2 years diploma course after PUC. Students with the minimum of 45 marks in PUC are eligible for entrance examination.

6.3.10: Reservation in Government Service: The Government has provided 3% reservation in A and B Post and 5% reservation in C and ‘D’ category of posts in all Government recruitments. The Government has also identified different kinds of jobs, which can be performed by disabled persons.

6.3.11: Industrial Training Centre, Mysore: State Government extends 100% financial assistance to Bangalore based NGO called NAB to run a centre to impart vocational training in light engineering, plastic molding, cane wiring etc. Visually impaired and hearing impaired students who have completed SSLC can take this course which helps them to find suitable job.

6.3.12: Employment and training for disabled persons: With an objective of enriching the skills and empowering of the disabled in getting placement in private sector, the Dept. has started a scheme called "Training and Employment to disabled Persons". The scheme envisages providing the following computer based training to the selected disabled persons at Dist. level, who have educational qualification of PUC and above. The non-matriculates are given 3 months training in vocational courses. Free hostel facility will be provided to the trainees during training period.

Table: 06.03

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Call Center</td>
<td>6 months</td>
</tr>
<tr>
<td>PC Hardware</td>
<td>6 months</td>
</tr>
<tr>
<td>DTP</td>
<td>3 months</td>
</tr>
<tr>
<td>Data Entry</td>
<td>3 months</td>
</tr>
<tr>
<td>DCAC</td>
<td>3 months</td>
</tr>
</tbody>
</table>
6.3.13: **Hostels for disabled employees and trainees:** The department runs 2 hostels for working and under trainee disabled persons separately for women and men at Bangalore. A person with disability whose income is less than 60,000 p.a. is eligible for seeking admission to these hostels. The intake capacity is 50 for each Hostel.

6.3.14: **Adhara:** Under this scheme financial assistance is given to eligible disabled persons to set up petty business. An amount of Rs.20000 is given as interest free loan as working capital and a Kiosk worth of Rs.15000 to setup business.

6.3.15: **Telephone Booths:** (G.O.No: m m a:433:PHP-96 dtd.23.3.97/ Telephone booths worth of Rs.12,000 are provided free of cost to enable the disabled persons to start self employment. The scheme is revised and present financial assistance is extended to buy metaphones to enable the disabled persons.

6.3.16: **Spoorthy Self Help Groups:** To cater to the needs of illiterate and semiliterate PWD, home based income generating activity needs to be encouraged and to motivate them for savings. The scheme has been implemented in all the 27 Districts @ one Taluk in each District where percentage of PWD is more. 10 Self Help Groups in each Taluk have been formed through NGOs.

6.3.17: **Rural Rehabilitation Project for Disabled persons:** (Revised NPRPD Scheme): Main aim of the scheme is “to deliver all Govt. services at the doorstep of the disabled persons.” Disabled persons will be appointed at Grama Panchayat Level and Taluk level as village level rehabilitation and multi purpose rehabilitation workers respectively.

6.3.18: **Aids and Appliances:** Aids and Appliances are provided to disabled persons whose families annual income is less than Rs.11,500 in Rural Areas and Rs.24,000 in Urban Areas.
6.3.19: Karnataka State Disability Medical Relief Scheme for corrective surgeries for the prevention of disabilities: The Scheme aims at providing financial assistance to undergo corrective surgeries. Financial assistance up to maximum of Rs.15000/- is extended for corrective surgeries. The said amount will be deposited directly in the concerned Hospitals.

6.3.20: Monthly Maintenance Allowance: Disabled person who is poor and not able to maintain himself with primary needs and could not meet other basic needs is given monthly maintenance allowance of Rs.400 per month.

6.3.21: Issue of Identity Cards: Identity cards are issued to disabled persons to enable them to avail the benefits extended to them under various governmental schemes.

6.3.22: Social Service Complex: This institution provides protection, care and shelter with food and health care to the aged / infirm and mentally retarded persons who are destitute.

6.3.23: Insurance Scheme for Mentally Retarded persons: Under this scheme, the parents / guardians of persons with mental retardation whose annual income is Rs.12,000/- or less per year, the DWD contributes the annual premium to LIC of India towards a specially designed group Insurance policy. Under this policy, after the demise of the parents / guardians of the mentally retarded person, the nominee will get a one time lump sum amount of Rs.20,000/- for the maintenance of the M.R person.

6.4: REHABILITATION SERVICES RENDERED BY NGOs: Non-governmental Organizations have relatively a long history. International Red Cross and Red Crescent movement is the World’s largest group of humanitarian NGOs. The International Committee of the Red Cross was founded in 1863. The era of ‘NGO came into use with
the establishment of the United Nations Organization (UNO) in 1945, with the provision under article-71 of chapter-10 of the UN charter for a consultative role for organizations that are neither governments nor member states. Globalization during the 20th century gave rise to the importance of NGOs. Many problems could not be solved within a nation. International treaties and International organizations such as the World Trade Organization (WTO) were perceived as being too centered on the interests of capitalist enterprises. In an attempt to counterbalance this trend, NGOs have developed to emphasize humanitarian issues, developmental aid and sustainable development. The role of NGOs in poverty alleviation, delivery of health care, spread of education, development of human resources, restoration and conservation of environment, awareness of population and other major social issues. Similarly, NGOs often work in areas and regions which are not generally covered by the governmental programs. Therefore, NGOs can be more efficient and effective in the use of resources and can provide support directly to people and community. NGOs have an important collaborative role in planning, implementation and evaluation of national social development programs.

(Rama Mani. D., 1988: "The Physically Handicapped in India Policy and Programme", New Delhi, Ashish Publishing House, P.8-9). The problems of the handicapped persons remained unsolved until after World War II, when the attention of the government and the public was drawn to the necessity of establishing centers for the rehabilitation and resettlement of the disable veterans of war. Only after Independence, did the problem of the civilian handicapped come into the limelight. As a result, several voluntary and government-subsidized welfare organizations have sprung up.
NGOs commonly refer themselves as ‘Voluntary Agencies’. It focuses on local ownership and use of local resources to meet local needs. It calls for economic & political democratization as the cornerstone of economic & political justice. The term ‘Third Sector’ appears to be gaining usage in both North and South of the World. In India too, like in many other countries, NGOs have become most important agents of change and social development. In recent decades NGOs have played a very important role in service-oriented activities. In Karnataka, NGOs have very actively worked in all spheres of service. In Bangalore, NGOs are working in all major fields. The following are the services rendered by various NGOs in Karnataka.

6.4.1: SERVICES OF APD:

6.4.1.1: The Community Health Work Program: It was initiated by APD in 1999 using the by-the-people and for-the-people approach. Its activities serve as a base for the holistic and long term development of the slum which in turn promotes better health for all. The Community Health Workers (CHWs) are the key functionaries of this Program and support the slum residents in addressing disabilities of different types – orthopaedic, speech and hearing, and mental retardation. They organize activities with regular guidance from APD. They are, Day and residential health camps, Health education and counseling on a range of issues including hygiene and immunization, Hospital referrals and follow ups, Regular interaction with families, especially women, Capacity building, Vocational skills training for people with different disabilities, Support in sourcing placement and self-employment for people with various types of disabilities. The health screening of new born babies is a valuable activity of this
program. It has led to the early detection of deformities and prompt corrective interventions among them.

6.4.1.2: Training on Children with Cerebral Palsy: In orientation with its philosophy to adopt collaborative approaches, APD organizes two day courses to prepare parents in *home therapy and care* for better caring for children with cerebral palsy.

6.4.1.3: Benefits of the course: Building capacities of parents is reflected in the gradual improvement in the mobility, movements and other functional activities of the child. This motivates the child to be part of recreational and educational activities.

6.4.1.4: Training in Community therapy aide: Therapy Aides are valuable service providers in Community Based Rehabilitation Program involving children and people with disabilities. Given the gradually increasing movement awareness in the country to improve the lives and conditions of people with disabilities especially children and women, trained therapy aides are much sought after.

6.4.1.5: Training in speech therapy: Useful for parents, family members of children with speech and hearing difficulties. The broad components are: Learning the sign language as part of speech training techniques, and Use and care of hearing aids.

6.4.1.6: Training for physiotherapy aide and communities: A slip on the floor, a tumble down the stairs or a fall from a tree or scaffolding, an accident on the road are the incidents we hear about very often or go through ourselves. Any of these can cripple or disable, temporarily or even for life, especially if the vulnerable spinal cord is affected. Various trainings are conducted by APD for families and community care givers. Useful
for families, Community Based Rehabilitation (CBR) workers, Anganwadi workers, teachers and nurses.

6.4.1.7: **Training and employment opportunity:** The course includes a ten month free course with a hands-on internship period. This is followed by a stipend attached work experience for a few more months. The residential training helps trainees to come out of their familial cocoon and learn to manage being on their own. The demand for trained personnel in Horticulture creates employment opportunities of PWDs. APD has customized short-term and mid-term courses to support families and communities to understand the world of a child or person with speech and hearing impairment and cerebral palsy.

6.4.1.8: **Income generating activity:** The potted plants and saplings cultivated by the trainees are sold as indoor and outdoor plants, rental at functions and for landscaping. PWDs are growing flowering plants and vegetables suited to kitchen gardens in residential spaces of all kinds.

6.4.1.9: **Medical interventions:** They are stepping stones towards enabling and empowering environment for disabled between 60% to 70% of PWD require medical and para-medical interventions. Subsequent to medical treatment, the improved functional ability and independent mobility make disabled more receptive to educational and empowering programs. Medical interventions include testing for disability, psychiatric counseling, physiotherapy or surgery, and support in rehabilitation help to address the different types of disability including cerebral palsy, speech or hearing impairments, and different types of locomotor disability.
6.4.1.10: **CBR Program:** APD’s capacity building programs for CBOs and NGOs prepare them to work effectively with PWDs in different age groups, especially women, in rural and semi-urban areas. The objective of Rural Community Based Rehabilitation was to make inroads in the provision of relevant support and services to children and young people with disability in the rural areas. This stemmed from the prevailing incidence of disability, lack of specific Government interventions, attitudes of stigma and discrimination due to lack of social perspectives, and the need to expand APD’s outreach.

6.4.1.11: **Disability Development Program:** It focuses on mainstreaming children and people with disability by up-scaling participation in home or formal educational programs, and training in vocational skills for income generations. These activities are subsequent to identification of medical treatment, and provision of mobility and other functional aids.

6.4.1.12: **Educational interventions:** The RCBR team interacts with children with disability and their families and networks with schools for enabling the child to learn either in home based programs or in classrooms. In the process, RCBR team identifies drop outs or students who have not passed their exams. Special attention can be given to them during the ten month course in the specially constituted residential school in the rural campus at Kamtampalli, Srinivasapura taluk, Kolar district.

APD’s customized Deaf Education Program focuses on children with hearing impairment, who are almost completely alienated from the educational system. It manages centre based activities for children between 6 to 18 years of age where they learn the sign language and other communication skills. Two week programs and
monthly workshops for severe and multiple disabled children and their families help to focus on critical medical needs including therapy, mobility and functional appliances, and management of living skills.

6.4.1.13: Vocational skills and livelihood opportunities: APD organizes a six-month residential program for up to 20 young women with disability in embroidery and tailoring skills. The experience of staying together gives them the opportunity to learn cooking, manage their personal chores, and live with individuals outside their family cocoon. This helps them to learn about division of responsibilities for maintenance the residential space, financial and time management.

6.4.1.14: People's organization and advocacy: An important pillar of APD's work in rural areas is the Disability Federation, developing and strengthened at the village, block and district level. These federations catalyze the process to change mind sets through formation of groups. These work to sensitize and access rights, highlight the responsibility of the various civil rights groups, access to social entitlements, and development of leadership and team to expand outreach. The Federations network with various Government departments, Panchayats and Civil Society groups regarding the implementation of the Disability Act provisions.

6.4.1.15: APD's interventions on mind set, perceptions and identity: There is now more interaction of PWDs with people around them, resulting also due to a newly developed enthusiasm within them. The networks help the people with disabilities, especially the girls, to open up and express their thoughts, ideas, anxieties, and desires. At times, after an accident, people often sustain partial or temporary damage to limbs or
spinal cord. Many accidents have also caused permanent damage causing disability in different degrees. Subsequent to such incidents, a need may be felt to re-orient the direction of life and adapt to a new life-style. APD organizes courses for not only the people requiring physiotherapy and skills in the appropriate use mobility aids, but also those who are working with such individuals. APD organizes courses in Therapeutic services, Technician courses, Community Based Rehabilitation, Education packages, Training and Employment packages, Horticulture training, Referrals, Academic affiliations and Supporting interventions of APD.

6.4.1.16: Spinal Cord Unit (SCU): The extent of spinal cord injury (SCI), sustained mostly after mishaps and accidents, vary from person to person. Medical interventions that usually include surgeries, often in emergency conditions, are complex and expensive. While hospitalization takes care of immediate urgencies, post medical therapy is required for healing the psychological damage. SCU’s rehabilitation interventions include support in medical care and therapy, psychological and vocational rehabilitation. This is done by:

6.4.1.17: Shradhanjali Integrated School (SIS): Established in 1973. It gives admission to children with cerebral palsy, speech and hearing impairments, muscular dystrophy, and locomotor disability. It teaches students from nursery to Class VII after which they are ready to study with students in regular schools. The exposure to this eventual mainstreaming begins from day one as 25% of SIS’s students are those with regular physical and mental abilities. Admissions take place on the basis of their mental and physical ability. SIS’s holistic approaches progress from parent counseling to medical interventions. If required, the children undergo surgeries.
6.4.1.18: Therapeutic interventions: APD's therapeutic interventions gradually improve the functional abilities and mobility of people. This change leads to self-confidence and pride, and slowly restoring the person's zeal to live life to his fullest. APD's therapy team assesses the disability, devises and implements a customized therapy schedule. This is supported with regular follow review of progress. APD provides training to care givers and families. These help the caregivers and family members the necessary hands on experience to support children and people with disabilities in a more efficient manner.

6.4.1.19: Industrial Training Centre (ITC): The Industrial Training Centre provides training to people both without and with disabilities so that the latter are prepared to blend in a mainstream environment at a later stage. It is affiliated to the National Council for Vocational Training (NCVT), and follows the curriculum defined by it for industrial training. This ensures that its certified training is at par with the industry requirements and standards. The courses help the participants to work as fitters, welders, electronic assemblers and draftsmen.

6.4.1.20: The Information Technology (IT) Training Unit: The IT Training unit offers both general and specialized computer education. These include short and long term courses in computer applications, desktop publishing, accounting software Tally, web designing and office management course.

6.4.1.21: Urban Slum Outreach Program (USOP): Families of children with disability are confronted with various interrelated social issues and problems. For these families, disability was only one among innumerable problems of everyday survival. By
adopting community based rehabilitation, the program. APD's Urban Slum Outreach Program, (USOP) established in 1984, is realizing the twin objectives of taking the reach of its services beyond the campus gates and impacting the lives of people with disabilities living in slums.

**Urban Slums:** It has appointed change agents by way of Community Based Rehabilitation Workers (CBRWs) who work at different levels to usher the dawn of hope, albeit gradually, in the lives of people with disabilities and their families. The CBRWs begin their work by identifying children and PWDs in different slums. They speak to the parents or respective families about APD, document the type of disability and then take forward the process of change. The dynamics of the slums, access to hospitals and schools, and attitudes are also taken into consideration. Together with volunteers, they work on holistic issues impacting the lives and livelihoods of PWDs. The activities include: **Education, Medical interventions, Vocational training and placement.**

**Rehabilitation of Women with Disability:** APD's program for Rehabilitation of Women with Disability is reversing attitudes through interactions and enabling training programs. The programs are especially significant to women with disability in the low income group. Its systematic approaches pave the way for women to face the future with zeal and enhanced capabilities.

**6.4.2: SERVICES OF NAB:**

**6.4.2.1: Rehabilitation and Basic Training Centre:** This was established in 1980, provides counseling and training to help the *visually handicapped*, especially those from the rural areas. The course is of 1 year duration. The students are trained in *basic*
skills of movement, domestic activities, light engineering, carpentry, cycle repair, pump repair and re-caning of chairs. The basic skills consist of Personal Grooming, daily living skills, communication skills, orientation & Mobility. While, in Vocational Skills: weaving, tailoring, carpentry, recaning of chairs, repairing of bicycles, light engineering and coir mat making. Visually Impaired men and women who are between 16 to 35 years are eligible for this course. Free boarding and lodging, uniforms are also provided for the trainees. Stipend will also be provided.

6.4.2.2: Community Based Rehabilitation Projects (CBR): CBR projects have been designed exclusively for the visually handicapped in rural areas in order to deliver rehabilitation services at their door step. NAB's field staff gives training to rural visually handicapped in their houses so that they are trained in their own surroundings and the immediate family and other members of the rural committee are also involved in the program. They are taught mobility, rehabilitation and the family trade or the local area trade to make them self sufficient and a useful member of the community. As 80% of the visually impaired are in rural areas and do not have access to Institutional-Based Services, NAB-KB attempts to reach out to this section in the rural areas of Karnataka.

In this project orientation and mobility, daily living skills and counseling will be given.

6.4.2.3: Mobility Training Center: To provide scientifically structured Orientation & Mobility Training to help the visually impaired to move about independently and confidently with the use of a white cane to identify the environment in which he/she is located and learnt to move one point to another point without a sighted guide. At NAB's exclusive Mobility Training Center, established in 1982, six weeks orientation and mobility training is given to the visually challenged in daily living skills,
developing self-confidence and in being mobile with the help of a white cane. Curriculum of this training is Orientation and Mobility with the help of a White Cane. Provides Training in Activities of Daily Living (ADL) and Personal Grooming for 6 weeks. Visually Impaired men and women who are physically fit are eligible for this training. Free boarding and lodging provided.

6.4.2.4: Employment and Placement Services: The Employment and Placement Service was established in Bangalore in the year 1977, since the inception of the NAB-KB, and as on date this centre placed over 1500 visually challenged young men and women in various organizations like Government, Public Sectors, Private Sectors, Small Scale Industries and Self Employment.

NAB believes that training without employment and placement leads to frustration and disappointment. This Centre has two Placement Officers who are qualified and professionally trained. Candidates have to register their names with the Department and seeing the suitability of the candidates i.e. matching the job requirement with the candidate's ability, the right candidates are selected for the right job. After identifying a suitable job, the placement officer selects the candidates to work with the industries by providing them complete orientation in his / her job at the site. The candidates are trained for a few days and a regular follow up is maintained. This constant follow up has helped build the confidence of the visually impaired worker and has encouraged him/her to work as an equal with other sighted employees.

6.4.2.5: Eye Care: In view of the importance of prevention of blindness, we have mounted, within our Limited resources, an Eye Care Program for children of poor and
low-income families. They conduct eye check up in rural projects as well as in slum areas and schools in Bangalore for the weaker sections of society. Under Proctor & Gamble's "Dhrishti" Project, females in the age group of 9 to 26 undergo Cornea grafting funded by them. It is important to have an Integrated Education Program for the sighted and the sightless children, so that they understand one another. Under this Program, blind children in rural and urban areas are encouraged to study alongside sighted children in Chikkaballapur, Kunigal, Gouribidanur, Malur, Kolar and Bangalore on a selective basis. Particularly heartwarming is the participation of the blind children in all school activities with enthusiasm and the acceptance by the others of the potentials of blind children.

6.4.2.6: Deaf Blind Project: In the year 2000, NAB (KB) set up a home based services program for deaf blind children. This program is being implemented in Bangalore city and rural areas with the support of Sense International India and NAB India. At present 5 deaf blind children are getting services from a special educator and assistant educator based on the individual need of children. The special educator trains the children in Sensory & Cognitive skills, ADL, Orientation & Mobility, Communication and Language, Prevocational skills & social skills and Counseling services to the child and family.

6.4.2.7: Computer Training Centre: Smt. Ratna Atmaram Rao Computer Training Centre offers Basic and Advance Programming Courses for the Visually Challenged people. On completion of training, NIIT conducts an examination and gives a certificate. The course consists of Ms-Word, MS-Excel, MS-Power Point, E-Mail and Internet.
Advance Computer Training: To integrate the visually challenged persons in IT Industry, The National Association for the Blind, Karnataka Branch have once again joined hands with The National Institute for Information Technology (NIIT) and started a course to impart training in Advance Programming which consists of Microsoft SQL Server 7.0, Programming Logic & Techniques, Visual Basic 6.0, Project Work. PUC with strong communication skills in English, Typing and Braille are eligible.

6.4.2.8: Technical Training Institute: To instill self-confidence in the visually impaired persons and train them technically. The curriculum of this training is Basic General Mechanic (Fitter's Trade), Injection Molding, Electronics. Minimum VIII class with knowledge of English & Reading and writing of Braille are eligible for this training. Free boarding, lodging and stipend will also be provided.

6.4.3: ACTIVITIES OF DR S.R. CHANDRASEKHAR INSTITUTE OF SPEECH AND HEARING:

6.4.3.1. Institute Based Services: These activities are the following types:

6.4.3.1.1: Clinical Activities:

1. Diagnostics Services:

Audiology, The institute having technologically advanced audiometers. There are other facilities such as Evoked Auditory Potential Measures. Most evoked potential tests do not require active subject participation. These tests (i.e., BERA, MLR, LLR, ASSR) measure electrical activity at various levels in the auditory nervous system and are a very useful diagnostic tool in both children and adults. It is useful in the following ways as,
Detection of hearing loss in neonates and infants, Diagnosis of Auditory disorders such as- Monitoring therapy progress in children with learning disability, Monitoring maturation of the auditory nervous system in children with cochlear implants, Medico legal cases. **Immitance Audiometry** is useful in assessment of, Middle ear functioning, Eustachian tube functioning, Inner ear functioning, VII and VIII cranial nerve functioning, Brainstem pathology, Monitoring recovery in middle ear disorders and facial nerve palsy. Acoustic reflex measures - latency, amplitude, and decay of the reflex tested, is useful in differential diagnosis.

2. **Speech-Language Pathology and Oto Acoustic Emissions:** OAEs are extremely soft sounds generated by most normal inner ears. They can be recorded in the ear canal. OAEs can be evoked and recorded using different sounds. The advantages are: Tool for assessing cochlear health; Tool for hearing screening in neonates / infants; Quick and non invasive test; Can monitor hearing status in persons; Undergoing treatment with ototoxic drugs ex. Cisplatin; Gentamycin; Exposed to loud noise; Helps in differential diagnosis.

3. **Clinical Psychology:** The following services are available in the department of psychology: I.Q. assessment, Personality tests, Assessment and Management of behavior problems, and Assessment and Management of Learning Disability.

6.4.3.1.2: **Therapy Services:**

1. **Aural Rehabilitation:** Aims at enhancing the communication skills of the HI using several rehabilitation techniques. These techniques are very important in the rehabilitation of the hearing impaired disabled. Some of the main techniques used are given below:
1.1 Amplification:

Hearing aid repair workshop:

- All types and makes of Hearing aids serviced and repaired
- Servicing and repairing done by a qualified person

Ear moulds - custom moulds, soft moulds:

- Regular moulds (for body level hearing aids), skeletal moulds (BTE's)
- Impressions for ITC and CIC also taken
- U.V Moulds
- Ear mould modification

1.2 Assistive listening devices: An Assistive Listening Device is not a hearing aid but a device designed to improve the ability of a person with HI to communicate and to function more fully. Assistive listening devices are of two types:

1. Devices that transmit the amplified sound more directly from its source to the listener such as FM systems, Infra red systems, Loop induction system, Telephone amplifiers.

2. Devices that transform sound into a visual or tactile signal which are Alarm clocks which use vibration or light as their signal, Telephone ring indicators, Door bells with visual indicators.

1.3. Auditory Verbal Therapy: Aims at providing listening training and verbal communication skills for persons with hearing impairment. This therapy is used mostly with young children, who have been fitted with appropriate hearing aids. This systematic therapy needs to be carried out for a long time to achieve good listening and speaking skills. Home training and parental involvement are essential for success of this therapy.
1.4. Cochlear Implant (CI) Program

- This program, headed by Ms. Madhuri Gore, was launched in 1996, and has been running successfully for the past 11 years at ISH. The Institute is fully equipped to assess and rehabilitate clients with cochlear implants.

- There are broadly two steps in the execution of the CI program. (1) Pre-surgical assessment for candidacy (2) Post-surgical rehabilitation, which includes customizing (mapping) the device and providing auditory verbal therapy (AVT).

1.5. Mothers' Training Program: Teaches the mothers how best to promote speech and language skills in their children with HI. Training sessions are conducted with both mother and child being present in the session and the therapist acting as a facilitator. These sessions are conducted daily at the Institute and provide significant benefit.

1.6. Sign Language: Basic sign language course is aimed at bridging the communication gap between the deaf and the hearing

   Signers' World: Signers' World is an association deaf and hearing persons interested in popularizing Sign language. It started with a handful of deaf persons who came to the Institute once a week to interact with students learning Sign language. Their numbers grew steadily and Signers' World was started in 2000. The members of Signers' world have taken several measures to create awareness about Sign language. These include articles in newspapers and magazines, and interacting with students.

1.7. Speech Reading: Speech reading (or lip-reading, as it is commonly known) refers to understanding of speech through the visual modality. To enable speech
comprehension, a person has to not only observe the movement of lips and tongue but also recognize gestural cues, facial expressions, body postures and environmental cues. Speech reading cannot be used as a substitute for auditory information. Majority of speech sounds are not visible and persons with hearing impairment may miss out on some information through the auditory modality also. However, with realistic expectations and speech reading instructions, persons with HI can derive significant benefits this technique. We provide speech reading instructions to persons with HI who get very little benefit from amplification.

2: Speech Language Therapy.

3: Psychological Services:

1. Parent and family counseling services offered to family/parents of patients with hearing/speech and language disorders, to improve their awareness of the patients' condition and also sensitize them to the needs of the patient.

2. Behavior modification therapy for children with autism, attention deficit hyperactivity disorder etc.

3. Learning Disabilities Clinic: aims at identifying children at risk for learning disabilities through school screening programs/camps and sensitizing teachers in the mainstream schools and providing remedial services.

1.4 Sunaad Kannada School for the Hearing Impaired: In 1987-88, the school began functioning in a rented building with 15 children and 2 teachers. In 1992, with matching grants from Lions Club International Foundation, the School building came up
inside the Institute campus and was named SUNAAD. The following are the objectives of school:

1. To provide primary and middle school education in Kannada and English medium for hearing impaired children
2. To provide special training in improving speech, language and listening skills
3. To provide guidance to parents of hearing impaired children on home training
4. To provide counseling for parents to handle the problems encountered in raising & educating a hearing impaired child.

(1) The Pre-School section [for young children with hearing impairment, aged 1-6 years]. The objective of this section is to provide intensive speech, language and listening training to children between 1-6 years so that after training, they can be integrated into a regular school at the same age as their hearing counterparts. The teacher to child ratio in the Pre-School section is 1:3. The age range of children in this section is 1-6 years. This low teacher-to-child ratio is maintained to ensure that the teacher is able to give individual attention to each child and also monitor his/her progress closely. The curriculum for the young children with hearing impairment in the Pre-School section revolves around intensive language and listening training. All our teachers have a diploma in Special Education [Hearing Impairment]. The involvement of the parents is crucial for the success of the training program, therefore mothers receive regular training and counseling on the follow up required at home.

(2) Nursery to 7th standard – for children older than 4 years. When hearing loss has been identified only after the age of 4 years, the child is admitted to the nursery section (not
pre-school) of the special school. Here, basic training in language and listening is given. After 3 years of training, the child is ready to go to the 1st standard and is able to cope with the regular school [state level] syllabus from the 1st standard to 10th standard. They appear for the 10th standard examination along with hearing children. The only concession hearing impaired children get is that they are exempted from learning the 2nd and 3rd languages. Integration is recommended depending on the child's ability but generally children remain in the school till the 10th standard. Apart from the prescribed syllabus, the children are given extra training for language development.

**Mainstreaming children:** Segregation of the children into high and low functioning groups is done based on parental involvement & support, severity of HI. The children in the high functioning group (i.e., those with mild to moderate HI) receive Auditory Verbal Therapy, where the main aim is to provide the children with basic communication skills required for mainstreaming into regular schools.

**Facilities:** The recommended teacher to child ratio is 1:8 in a special school. This is followed at Sunaad. Four of the classrooms have group amplification systems which help the children listen better. The school has a well equipped library with several books aimed at developing children’s language & reading skills. Science laboratory is equipped with all the materials prescribed by state board syllabus. Computer training is also provided for children from class 2 onwards.

**Extracurricular activities** – Students are encouraged to participate in various activities and inter-school competitions and our students have won many prizes. In addition, annual visits to different places of historical interest are planned for the
children, with the main aim of exposing them to different experiences and enriching their learning and communication skills.

1.5 Sign Language Training:

**Basic Courses in Sign Language Level I:** The objective of this course is to provide the individual with the basic skills necessary to communicate with the deaf.

**Basic Course in Sign Language- Level II:** The objective is to make the individual fluent in signing and train him/her to provide basic interpretation services for the deaf.

**Diploma Course in Interpretation:** The objective is to train the individual to become a professional interpreter for the deaf. The course is recognized by the Rehabilitation Council of India (RCI).

1.6 Communication DEALL: This is an early intervention program for children with developmental language disorders such as Autism/Pervasive Developmental disorders (PDD), Developmental Verbal Dyspraxia (DVD) and Specific Language Impairment (SLI) which aims at integrating such children in regular school after intensive preschool intervention.

**Objective:** To provide intensive stimulation and training (3 hours/day, 5 days/week, over an academic year) to small groups of preschool children with developmental disorders, in the areas of communication, cognition, behavior and socialization. The major thrust of the training module is on communication with due
consideration given to other aspects of the child's development also. The framework is largely developmental and the strategies and techniques eclectic.

1.7 Support Group Services:

- Stuttering Club:
- Laryngectomy Club:
- Post-Stroke/Aphasia Club:

1.8 ACADEMIC PROGRAMS:

- DIPLOMA COURSE IN SPECIAL EDUCATION (HEARING IMPAIRED) [D.S.E.],
- BACHELORS IN SPEECH LANGUAGE PATHOLOGY & AUDIOLOGY (BSLPA),
- MASTER IN AUDIOLOGY,
- MASTER IN SPEECH LANGUAGE PATHOLOGY,
- MASTER IN AUDIOLOGY AND SPEECH LANGUAGE PATHOLOGY,
- DOCTORAL PROGRAM IN SPEECH, LANGUAGE AND HEARING SCIENCES,
- SPECIAL EDUCATION CELL (NATIONAL INSTITUTE OF OPEN SCHOOLING-NIOS)

PRE-VOCATIONAL TRAINING PROGRAMS AND VOCATIONAL SKILLS TRAINING PROGRAMS. They are;

- Foundation course in English (100 hours)
- Sign Language and communication skills (80 hours)
- Typing skills (100 hours)
- Personality development (20 hours)

6.4.3.2: OUTREACH ACTIVITIES:

6.4.3.2.1: Clinical Services within Bangalore: Dr. SRCISH in collaboration with various hospitals, schools etc., provides clinical services at 17 different centres in Bangalore.

6.4.3.2.2: Speech & Hearing Camps: The Institute organizes Speech and Hearing Camps in various rural and semi-urban places with the collaboration of other voluntary agencies, to increase the awareness about speech and hearing disorders and provide
information about the services available. On an average, 5 camps are held every year and approximately 150 individuals are screened for speech/hearing impairments at each camp.

6.4.3.2.3: Correspondence Therapy Program: This is a unique program to help parents of children with special needs (i.e., HI and MR) that do not have access to clinical services. During these contact sessions, parents receive intensive training and in addition, receive regular lessons through the post.

6.4.3.2.4: Screening of School Children: The Institute staff screen school children for speech and hearing problems. These camps are organized through Lions and Rotary Clubs. Other voluntary agencies can also contact the Institute for conducting screening programs.

6.4.3.2.5: Neonatal Screening: The Institute provides audiological screening facilities for infants at high risk for hearing impairment (HI) at select hospitals.

6.4.3.2.6: Professional Support: The Institute also provides professional support to various special schools, hospitals and NGOs working for welfare of those with disabilities.

6.4.3.2.7: Hearing Conservation Programs: The Institute undertakes hearing conservation programs for industries and communities. The program involves measuring noise levels using sound level meters, suggestions for reducing noise levels, use of ear protective devices and periodically monitoring hearing.
6.4.3.2.8: **Public Awareness Campaigns:** There is an acute lack of awareness about speech and hearing problems, which constitute 8% of all disabilities/disorders, as well as about the various treatments available. The Institute has taken many steps to address this issue.

6.4.4: **SERVICES OF AMC:**

6.4.4.1: **Psychosocial counseling services:** Utilizing the services of trained clinical psychologists, psychiatric social workers and specially trained volunteer ‘counselors’, regular and committed services to address the psychological, social and income generating needs of the families and mentally challenged persons will be met.

- **Vocational support activities** for the family members of mentally challenged persons to increase their income and independence. This will use the Stree Sakthi program approaches.

- **Creation of a web based information resources** that are appropriate to different communities in their own language and using the socio-cultural beliefs and practices.

- **A series of short films** will be prepared to educate parents about daily care of mentally challenged persons.

- **Development of a directory of services** useful to families of mentally challenged. Initially it will cover services available in Bangalore; and later stage on the entire state of Karnataka.

- Formation of self-help groups in different parts of the city/state, as close to the places of living, so that it will be easy for the users to meet, share and support each other.
• **Community Radio** for interactive interaction with the users. Initially there will be a broadcast to the user community once a week for 30 minutes. It will cover some specific areas.

• **Linkage of the services** for mentally challenged persons and their families will be available at AMC through internet, self-help groups, community radio and voluntary organizations.

6.4.4.2: **Educational Services: Akruti:** It is a special education program which has about 80 children. The age of the children of the school ranges from 6 years to 16 years. Every child is examined and evaluated by a psychiatrist and clinical psychologist before admission. Clinical report of each child is maintained in the school. There is a regular follow up of the progress with the family members and the staff of AMC.

6.4.4.3: **Rehabilitation Services: Pragati:** It is a multi category vocational training center. AMC has kept pace by developing progressive programs for mentally challenged persons. In April 1975, the multi-category section was started. It is partially aided by the Government of India. The trainees are over 16 years of age. Here the adults with mentally retardation work happily alongside blind and with other physically handicapped, each helping the other. A few persons with hearing impairment form part of this group. There are a number of sections in the training centre.

6.4.4.4: **Sheltered Workshop: SANSKRITI,** the **Sheltered Workshop** scheme has 23 people. They are engaged in making various products under minimum supervision. The incentives given to them are ranging from Rs.1200/- to Rs. 300/- per month. There have been discussions with few organizations to introduce activities such as assembling, rolling, etc.
6.4.4.5: Day Care Center: The Day Care centre has 15 people with severe retardation. They are being looked after and cared by trained staff. They are engaged through occupational therapy related activities like paper cutting, planing and sanding the wood, creating balls of yarn and watering plants.

6.4.4.6: Clinic: Every Wednesday in the premises of the special school, the services of a multidisciplinary specialist team from NIMHANS (Bangalore) is available both for the children of AMC and those from the general public. Psychiatrists, clinical psychologists, psychiatrists, psychiatric social workers, psychiatric nurses from NIMHANS provide their services in the clinic.

6.4.4.7: Parent Self Help Group: During the last few years, parents of the children and adults utilizing the services of AMC have come together to form a parent self-help group. This group works to support each other parents.

6.4.5: SERVICES OF SUMANHALLY SOCIETY:

6.4.5.1: The Ave Maria Home for Leprosy Patients

The Rationale: To take care of the aged and young patients who need physical, medical, psychological and educational help. The vision is Rehabilitation of the young Leprosy affected persons and their settlement. Honourable care for the aged and protection of their dignity. The activities are common prayer, occupational therapy, group discussions and personal dialogue through which we teach self-dependence, Recreation: indoor and outdoor games and audiovisual programs, Cultural activities- patients participate in performances and recitals in Sumanahalli and outside.
Sumanahalli provides a live-in facility for 100 patients. The Ave Maria Home accommodates 60 patients, while 40 others, along with their families, are housed in the family quarters in campus. The future plan is to find jobs for all and to resettle them into society. A holistic approach towards education along with life-skills training is a vision.

6.4.5.2: **Education:** The inmates at Sumanahalli are shunned by their own families and the society at large. To pick up the pieces of their shattered lives and gain some independence, they need help with finding a livelihood of their own. Education is key here in establishing a sense of self-respect and pride.

**Methodology:** Coaching the children through songs, art, drama and games. We encourage our students to take part in public functions, competitions, drawing, painting and cultural programs on special occasions like World Disabled Day and other holidays. Sumanahalli invites educators and social workers to help widen the scope and scale of our educational activities.

**Results:** Some students who have completed their PUC have been provided jobs as nurses and some are Government employees as well. Boys who have completed SSLC have been sent for ITI training and are now gainfully employed.

6.4.5.3: **Vocational Training:** The aim of the Vocational Training Programs is to make the inmates economically self-sufficient. Sumanahalli has training programs in Leathercraft, Printing, Tailoring, Knitting, Mushroom cultivation, in addition to the manufacture of Orthopaedic Shoes, Candles, Paper Bags and Garments.

6.4.5.4: **Products:** Despite best efforts, integrating cured inmates into mainstream society is an uphill task. That's why they set up our own manufacturing units to provide
them a livelihood, a structured work setting and of course, crucially-needed income. Sumanahalli is proud of the fact that its inmates have received valuable training which helps them throughout their lives. Candles, paper bags, leather goods and garments are the products.

6.4.5.5: Rehabilitation

*Leprosy is more a social problem than a medical one*: The disease of Leprosy is never fatal, but it brings a fate oftentimes worse that death. Rehabilitation of Leprosy-cured patients is different from others. They need to be given back their lost human dignity by making them physically, mentally, vocationally, financially and socially sound. Ultimately, we want them to be fully reintegrated into mainstream society. The institution has vision for the Leprosy-cured is total integration into society through Light, Love and Life.

*From begging to a life of dignity*: We aim to wean affected persons away from a life of begging to a life of dignity and freedom, by enabling their livelihood. Through personal counseling they are made to accept their mental and physical situation, while giving them moral support and strength at every stage. Sumanahalli teaches them the dignity of labor.

*Vocational Training*: In addition to Agriculture, Sericulture and Cattle-farming, new trades such as Leather-craft, Printing, Knitting, Tailoring, Shoe-making, Candle-making, Jute and paper-bag making were introduced to suit individual ability and aptitude. Presently there are 9 vocational training programs at Sumanahalli.
Informal Education: Regular schools denied education to the leprosy-affected and their children. As a result, most of them were illiterate. Sumanahalli arranged to teach them various subjects including hygienic food habits, and Parenting skills as well as moral and spiritual values.

6.4.5.6: Treatment:

Through better awareness and medical intervention it is possible to ensure a complete cure for the Leprosy affected. The methods are, Imparting health education, Inculcating cleanliness and healthy habits, Teaching them to be responsible, Following proper guidelines to heal their ulcers. The activities are- Making MDT (Multi-Drug Treatment) available, Following up with patients to ensure regularity of treatment, Treatment of ulcers, Physiotherapy, Occupational therapy, Making greeting cards, plastic flowers, etc.

6.4.6: SERVICES OF MOBILITY INDIA:

6.4.6.1: MRRTC: Mobility India’s Rehabilitation Research and Training Centre – “Millennium Building on Disability” is a state of the art model disabled friendly building with various accessibility features for all. It is an ideal model of how a building can influence Changes in the Disability field and it houses all of Mobility India’s activities. It is also a Training centre to train and develop human resource especially persons with disabilities in the field of Orthotics, Prosthetics and Rehabilitation and also promotion of Community Based Rehabilitation. Students include persons from low-income groups in rural areas and urban slums, especially women and persons with
disabilities. It is envisaged that they will undergo the training and go back to their communities to work for persons with disabilities in their respective places.

6.4.6.2: Training: Set up in 1994, the organization has made a significant contribution to enhance the quality of rehabilitation services in rural and urban areas. Working in partnerships with NGO's having strong roots in communities of Southern, Eastern & North Eastern regions of India has facilitated provision of assistive devices and setting up rehabilitation workshops in these areas. To sustain these programs the organizations require trained personnel and Mobility India responded to the need by training the local staff through various short term programs in repair and maintenance of assistive devices. To address the larger picture of having trained personnel at the community level Mobility India started the training programs in 2002.

Networking with national & international agencies and regulatory bodies like the Rehabilitation Council of India (RCI), Orthotics & Prosthetics Society of India (OPSI), International Society for Prosthetics & Orthotics (ISPO), World health Organization (WHO) & Motivation, UK (specifically for Wheel Chair Courses) Mobility India has designed and developed various training programs

The training programs are aimed at creating professionals to work at the grass root levels, who can bring about a positive change in the disability scenario. The primary goal is to provide learning opportunities which promote basic knowledge, skills, values and behaviors that will enable them to implement tasks, under supervision and direction, within a variety of health care and community settings. The main focus of these programs
is in adopting a community-based approach that meets the needs of the people with
disability, especially from the urban slum areas, rural areas and low-income countries.

6.4.6.3: Courses currently offered

Long Term:

1. Prosthetics & Orthotics
2. Therapy

Short Term:

1. Wheelchair Provision
2. Community Based Rehabilitation

6.4.6.8: Physiotherapy: It focuses mobility and restoration of normal movement
and function and the alleviation of pain. Using a wide range of drug-free techniques to
relieve pain, restore function and movement and prevent further problems, physiotherapy
uses a combination of manual therapy, movement training and physical and
electrophysical agents. A personalized exercise program is prescribed, tailored to meet
individual's specific needs. Recognized as a significant contributor to the rehabilitation
sector, Mobility India's faculty have had extensive clinical and practical experience in
providing quality prosthetics, orthotics and rehabilitation services suitable to both urban
and rural settings. It has a well equipped Prosthetic/Orthotic Workshop and Therapy
Unit.

6.4.6.9: Rehabilitation services: For many years, an institutional approach
(rehabilitation centers and homes for disabled) was the common method to rehabilitation
of people with disabilities. The institutions are mostly city based, expensive, and hence
able to provide services to a small percentage of population. Community Based
Rehabilitation (CBR) is a better approach to extend rehabilitation services to a more number of people with disabilities. CBR is a community based rehabilitation strategy to reduce poverty, meeting basic needs and promoting QUALITY OF LIFE of persons with disabilities and their families.

**6.4.6.9.1: CBR:** It creates opportunities for people with disabilities to have access to health, education, livelihood, social & empowerment and ensure holistic development of individuals and their families within the community. To achieve this outcome, the activities revolve around building multi-sectoral linkages for a community based and inclusive development of people with disabilities. Mobility India currently has CBR programs running in urban slums of Bangalore as well as in Anekal taluk, Bangalore District and an outreach program in the slums of Kolkata.

The urban program was initiated in 1999 in the slums of Bangalore. The initial thrust was on education for children with disabilities, followed by formation and empowerment of the Self Help Groups, access to health and government welfare schemes. A new program has been initiated since January 2008 in Anekal Taluk, located in the south of Bangalore District. An outreach program covers 3 wards in the garden Reach slum pocket of Kolkata.

**6.4.6.10: RRC:** Set up in 1998, the Regional Resource Centre in Kolkata is making inroads into the Eastern & Northeastern regions of India. The core area of expertise is setting up workshops and building the capacities of the local organization in strengthening their rehabilitation services. In cases where organizations do not have a rehab facility, the RRC fabricates the assistive device and provides therapy services. Over the years it has added a Community Outreach program that covers 3 wards in the Garden Reach slum pocket of Kolkata. The program supports 120 children in medical
intervention and education. Community Outreach program covers 3 wards (133, 134, 135) in the Garden Reach slum pocket of Kolkata. The program supports 120 children in education, medical intervention & nutrition. The program will extend to another ward (136) where the initial survey is on. Key activities are Education support, Medical Intervention in the form of surgical referrals/ intervention, assistive devices, home based therapy, health check-ups, Nutrition, Initiated Groups Formation (Self Help Groups).

6.4.6.11: **Barrier Free Access:** It means able to be reached or used. Accessibility is an important issue for all concerned with the built environment, especially for disabled people and the increasing number of elderly people. An accessible environment is one, which allows people to move around safely, independently, and without restriction.

Mobility India’s Centre, a three-storied structure in the heart of Bangalore City, is a model for Accessibility equivalent to International standard. The building is completely accessible to all people with different kinds of disabilities to ensure it reflects the values of the organization.

6.4.7. **THE SERVICES OF ALIMCO:**

**THE ARTIFICIAL LIMBS MANUFACTURING CORPORATION OF INDIA (ALIMCO)**: In 1948 the first Artificial Limb Fitting Center was set up at Pune by the Indian Army. Today there are eleven centres which fit artificial limbs and manufacture them on a small scale without any standardization. Consequently a wide gap between demand and supply existed.

"The government of India was already alive to the problem. But this problem was accentuated in 1962, when the disabled military and paramilitary personnel had to
wait for a long time to obtain artificial limbs. The situation worsened in 1965 and more
so in 1971 during the wars with Pakistan. In 1963 a team of experts from WHO made a
detailed study of the country’s requirements of rehabilitation aids, prosthetic and orthotic
appliances. They recommended the setting up of an artificial limbs manufacturing unit at
Kanpur. The outcome of this is the setting up of ALIMCO at Kanpur, which is doing
noteworthy services for the orthopaedically handicapped in providing all sorts of
artificial limbs.\footnote{13}

Artificial Limbs Manufacturing Corporation of India (ALIMCO) is a non-profit
making organization, working under the aegis of Govt. of India, under the ministry of
Social Justice & Empowerment. It was incorporated in 1972 to take up manufacture and
supply of artificial limb components and rehabilitation aids for the benefit of the
physically handicapped and started production in 1976.

The ALIMCO besides manufacturing the required material 34 more limb fitting
centers have been established in collaboration with the State Governments during the
fifth five year plan period. These centers are providing rehabilitation, prosthetic and
orthotic fitting facilities to the disabled persons.

ALIMCO has finalized a scheme for providing a minimum of one limb fitting
center in each State and has set up a separate department of limbs fitting services. It
expects to set up 6 Regional Limb Fitting Centers at Jaipur, Madras, Nagpur, Calcutta,
Trivandrum and Cuttack besides 28 peripheral Limb Fitting Centers at various other
places. It has also been decided to set up a central institute of prosthetic and orthotic
training at Cuttack. This institute will impart training to orthotic and prosthetic technicians and engineers.

**Research & Development:** The Corporation is equipped with sophisticated machines and is backed by its own Research & Development. The design of products is constantly updated to maintain optimum efficiency level and to ensure high level of customer satisfaction. The products are manufactured under rigorous quality control so as to conform to international quality standard.

**Achievements:** Within the country, the Corporation is the premier agency supplying appliances for orthopaedically handicapped. It has helped establish 170 Limb Fitting Centres in various parts of the country to ensure proper fitting of aids and appliances. These Limb Fitting Centres provide necessary facilities for fitment of Orthotic and Prosthetic aids to the disabled people.

The Corporation also conducts camps in association with various voluntary agencies for fitting and distribution of aids and appliances in rural and semi urban areas of the country.

**Market Network & Exports:** The Corporation markets its products within the country through its offices at Delhi, Calcutta, Bhubneshwar, Chennai, Mumbai and with the help of an extensive distributor/dealer network to ensure availability near the important Limb Fitting Centres and customers. The major buyers of ALIMCO products are National Institute, Dealer Network, NGO Network and State Government.
The Corporation has also exported its products to Afghanistan, Sri Lanka, Bangladesh, Nepal, UAE, Jordan, Iraq, Angola, Cambodia, Uzbekistan etc. and the same have been well accepted in all these countries. UN agencies like UNICEF & WHO have also approved its products and are using these products for their programmes in certain countries.

The ALIMCO is being financed from the National Defence Fund. It will produce batter-operated when chairs and sophisticated items like hydraulic, pneumatic knee joints. When in full production in 1978-79 ALIMCO was having one lakh components worth Rs. 50 millions.

The basic equipments, raw materials, requirements of engineering and technology of production etc., are being met from indigenous services. There is no foreign technical collaboration.

Under the dynamic initiative and guidance of Smt Jayati Chandra IAS, Joint Secretary to Government of India, Ministry of Social Justice & Empowerment, the ALIMCO, Kanpur (UP) has set up a unique example before corporate world by setting up six numbers of ALIMCO ancillary units for persons with disabilities.

A tripartite agreement is signed between PWD entrepreneur, ALIMCO and NHFDC. The ALIMCO provides training, technical support for setting up ALIMCO ancillary unit, raw-material, marketing of finished product and timely repayment of NHFDC loan.
THE ACTIVITIES OF ARTIFICIAL LIMBS MANUFACTURING CORPORATION OF INDIA (ALIMCO): The Corporation produces 355 different types of quality aids and appliances required by orthopaedically, visually & hearing handicapped persons. ALIMCO has been in the forefront in providing innovative and appropriate solutions to the problems facing the disabled.

The product range includes Orthotic and Prosthetic appliances for Upper & Lower Extremities, Spinal Braces, Cervical Collars, Traction Kits, and Rehabilitation Aids like Wheel Chairs, Crutches and Tri Wheelers etc. The Corporation also provides special tools and equipments required for fitment of Orthotic & Prosthetic assemblies by the Limb Fitting Centers. For Orthopaedically Handicapped rehabilitation aids are; Lower limb orthotic (Calipers), Lower limb prosthetic (Artificial legs), Upper limb prosthetic (Artificial hands), Spinal orthotic (Braces for neck & back), Prosthetic supplies (stockinettes, socks and surgical boots); Mobility aids such as Wheel Chairs, Tricycles, Axilla & Elbow crutches and Walking Stick. For Visually Handicapped the products are Braille short hand machine, Braille slate, Walking cane & stick. For Hearing Impaired the product is Pocket type Hearing Aid.

The NHFDC provides financial support and PWD entrepreneurs manage the production unit. Initially, six PWDs have been placed successfully and earning net profit of Rs. 3500 to Rs 5000 per month. This multi-sectoral initiative is economically viable and feasible. The corporate world both, private and public sector should come forward in similar true spirit, so that many PWD entrepreneurs may set up ancillary units of corporate sector which will go a long way in empowering an mainstreaming the PWDs.
Table: 06.04
Statement of type of travel concessions & facilities that the respondents have availed

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bus</td>
<td>32</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Train</td>
<td>5</td>
<td>1.3</td>
<td>1.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Air</td>
<td>6</td>
<td>1.5</td>
<td>1.5</td>
<td>10.8</td>
</tr>
<tr>
<td>Disability identity card</td>
<td>44</td>
<td>11.0</td>
<td>11.0</td>
<td>21.8</td>
</tr>
<tr>
<td>Standard disability certificate</td>
<td>19</td>
<td>4.8</td>
<td>4.8</td>
<td>26.5</td>
</tr>
<tr>
<td>Disability pension</td>
<td>81</td>
<td>20.3</td>
<td>20.3</td>
<td>46.8</td>
</tr>
<tr>
<td>Housing site</td>
<td>5</td>
<td>1.3</td>
<td>1.3</td>
<td>48.0</td>
</tr>
<tr>
<td>Treatment expenditures</td>
<td>9</td>
<td>2.3</td>
<td>2.3</td>
<td>50.3</td>
</tr>
<tr>
<td>Supportive services</td>
<td>4</td>
<td>1.0</td>
<td>1.0</td>
<td>51.3</td>
</tr>
<tr>
<td>Some of them</td>
<td>152</td>
<td>38.0</td>
<td>38.0</td>
<td>89.3</td>
</tr>
<tr>
<td>All</td>
<td>17</td>
<td>4.3</td>
<td>4.3</td>
<td>93.5</td>
</tr>
<tr>
<td>None</td>
<td>12</td>
<td>3.0</td>
<td>3.0</td>
<td>96.5</td>
</tr>
<tr>
<td>Don't know</td>
<td>14</td>
<td>3.5</td>
<td>3.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

The disabled must be given some public benefits like traveling concessions, Housing, disability pension, supports services etc. The above table 06.04 indicates that more that 38% respondents availing more than one benefits as shown above.

Table: 06.05
Statement of awareness of respondents about rehabilitation services

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWD Act</td>
<td>41</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Rights of disabled</td>
<td>8</td>
<td>2.0</td>
<td>2.0</td>
<td>12.3</td>
</tr>
<tr>
<td>Information about disability</td>
<td>12</td>
<td>3.0</td>
<td>3.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Problems of disabled</td>
<td>72</td>
<td>18.0</td>
<td>18.0</td>
<td>33.3</td>
</tr>
<tr>
<td>Rehabilitation services in state</td>
<td>18</td>
<td>4.5</td>
<td>4.5</td>
<td>37.8</td>
</tr>
<tr>
<td>Safety and security of disabled</td>
<td>6</td>
<td>1.5</td>
<td>1.5</td>
<td>39.3</td>
</tr>
<tr>
<td>Others</td>
<td>18</td>
<td>4.0</td>
<td>4.0</td>
<td>43.3</td>
</tr>
<tr>
<td>Some</td>
<td>46</td>
<td>11.5</td>
<td>11.5</td>
<td>54.8</td>
</tr>
<tr>
<td>All</td>
<td>33</td>
<td>8.3</td>
<td>8.3</td>
<td>63.0</td>
</tr>
<tr>
<td>None</td>
<td>148</td>
<td>37.0</td>
<td>37.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Respondents have awareness on the following rehabilitation awareness related aspects. They are 1) PWD Act 2) rights of disabled people 3) information about disability 4) problems of disabled 5) rehabilitation services available in Karnataka 6) about safety and security of disabled, etc.

18% of the respondents have awareness on problems of disabled rehabilitation. 10% have awareness on PWD act. 11% have awareness on one or the other aspects. But 37% respondents have no awareness on any rehabilitation services. Therefore they must be educated in this aspect.

Table: 06.06
Statement on the suggestions of respondents about the rehabilitation services to disabled in Karnataka

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate ministry in</td>
<td>47</td>
<td>11.8</td>
<td>11.8</td>
<td>11.8</td>
</tr>
<tr>
<td>both govs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehab centers in</td>
<td>86</td>
<td>21.5</td>
<td>21.5</td>
<td>33.3</td>
</tr>
<tr>
<td>single place</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duplication of</td>
<td>49</td>
<td>12.3</td>
<td>12.3</td>
<td>45.5</td>
</tr>
<tr>
<td>services stopped</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility of all</td>
<td>17</td>
<td>4.3</td>
<td>4.3</td>
<td>49.8</td>
</tr>
<tr>
<td>Public places</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Countrywide</td>
<td>21</td>
<td>5.3</td>
<td>5.3</td>
<td>55.0</td>
</tr>
<tr>
<td>Standard procedure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lessen the</td>
<td>25</td>
<td>6.3</td>
<td>6.3</td>
<td>61.3</td>
</tr>
<tr>
<td>Documentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yearlong preventive</td>
<td>24</td>
<td>6.0</td>
<td>6.0</td>
<td>67.3</td>
</tr>
<tr>
<td>Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Versatile personality</td>
<td>38</td>
<td>9.5</td>
<td>9.5</td>
<td>76.8</td>
</tr>
<tr>
<td>of disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>93</td>
<td>23.3</td>
<td>23.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The above table 06.06 shows that the various suggestions of respondents with regard to rehabilitation services in Karnataka such as, A separate ministry should be opened in dual government (11.8%), all the rehabilitation centers should be in one single premises in every district (21.5%), duplication of services should be shunned (12.3%) all the public places should be accessible to all disabled in country (4.3%), etc.
6.5: Testing of hypotheses:

Hypothesis: “Rehabilitation or supportive services rather than sympathy and satisfaction of the disabled are related.”

Reformulated Hypothesis: “Discrimination is not high in rehabilitation services.”

Table: 06.07
Statement of respondents’ reaction on discrimination in rehabilitation services

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>Yes</td>
<td>191</td>
<td>47.8</td>
<td>47.8</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>209</td>
<td>52.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>400</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table: 06.08
Statement of respondents’ reaction on discrimination by the rehabilitation staff

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Thinks negatively</td>
<td>63</td>
<td>15.8</td>
<td>33.0</td>
<td>33.0</td>
</tr>
<tr>
<td>Simple avoidance</td>
<td>66</td>
<td>16.5</td>
<td>34.6</td>
<td>67.5</td>
</tr>
<tr>
<td>Reluctance to help</td>
<td>21</td>
<td>5.3</td>
<td>11.0</td>
<td>78.5</td>
</tr>
<tr>
<td>Doing negative activities</td>
<td>3</td>
<td>.8</td>
<td>1.6</td>
<td>80.1</td>
</tr>
<tr>
<td>Isolating me</td>
<td>7</td>
<td>1.8</td>
<td>3.7</td>
<td>83.8</td>
</tr>
<tr>
<td>Spoiling opportunities</td>
<td>6</td>
<td>1.5</td>
<td>3.1</td>
<td>86.9</td>
</tr>
<tr>
<td>Others</td>
<td>23</td>
<td>5.8</td>
<td>12.0</td>
<td>99.0</td>
</tr>
<tr>
<td>Can't say</td>
<td>2</td>
<td>.5</td>
<td>1.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>191</td>
<td>47.8</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table: 06.09
Statement of respondents’ reaction on discrimination by the rehabilitation staff versus categories of disability

<table>
<thead>
<tr>
<th></th>
<th>Disability</th>
<th>Freedom (LD)</th>
<th>Cured Leprosy (CL)</th>
<th>Visual Handicap ped (VH)</th>
<th>Hearing Handicap ped (HH)</th>
<th>Mentally Retarded (MI)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>discrimination in rehabilitation services</td>
<td>Yes</td>
<td>38</td>
<td>10</td>
<td>69</td>
<td>43</td>
<td>31</td>
<td>191</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>37</td>
<td>15</td>
<td>31</td>
<td>57</td>
<td>69</td>
<td>209</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>75</td>
<td>25</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>400</td>
</tr>
</tbody>
</table>

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Diagram: 06.01
Diagram of respondents’ reaction on discrimination by the rehabilitation staff versus categories of disability

Statistical equation test:

Table number 06.07, 06.08 and 06.09 and diagram number 06.01 supporting to conduct the statistical equation test. On the base of these 191 respondents that are 47.75% said that there is discrimination in rehabilitation services. Rest of the 209 (52.25%) respondents said that there is no discrimination in rehabilitation services rendered by the rehabilitation service centers. But it is significant to note that 47.75 percent respondents who are experiencing discrimination in rehabilitation service are not negligible. There is a need to correction in avoiding discrimination in rehabilitation services.

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6. Veena Rangnekar: BLIND WELFARE, National Association for the Blind, India, No. 11, Khan Abdul Gafar Khan Road, Worly Seaface, Mumbai- 30, Page: 03.
9. Details Based on Field Visit and Website i.e., www.sumanahalli.net