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Enhancing Foundational Learning Numeracy and Early Intervention for Children with Disabilities

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ABSTRACT

The landscape of foundational learning and early intervention for children with disabilities in India highlights a predominance of NGOs with limited representation of individuals with disabilities or parents on boards. Geographically dispersed, there's an urban bias in resource distribution, exacerbating rural accessibility issues. Education is paramount, supplemented by holistic support services. However, challenges persist in delayed school enrolment, early identification, and pedagogy adaptation. Governance fragmentation hampers convergence, while data scarcity and gender disparities compound challenges. Recommendations include enhancing representation, addressing urban bias, strengthening support services, promoting collaboration, investing in early intervention, establishing specialized facilities, and empowering parents for inclusive education and holistic development of children with disabilities.

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INTRODUCTION

The history of disability in India dates back to Chandragupta Mauryan era of 3rd century B.C. There are many scriptures that go to suggest that disability used to be viewed as inauspicious monsters directly linked to the ill effect of *'Punar Janma'* (rebirth). It was believed that human beings go through different cycles of rebirth and each of the birth signifies the good or bad deeds, popularly known as *'Karma'*. The deformity seen in an individual used to be thought as a punishment of the ill deeds of previous birth. Thus, it was even thought that if an individual in their previous birth had done some heinous crime could then be born as animal in the next birth which could be a dog, pig, cat, frog or even insects. There are conflicting scriptures regarding disability in ancient Indian literatures; one demonizing them, such as in *'manusmriti'* and at the other end of spectrum as object of sympathy, pity and charity which is found in *'Vishnu Puran'*. There is yet another interesting aspect which is found in *'Kautalya's Arthashastra';* where Chanakya has used disabled persons as spy in Chandragupta Maurya's administration. However, we find two specific aspects within this history wherein the disabled persons were thought to be cunning, shrewd, and miscreant and on the other hand they were thought to be an object of pity who would never lie or never do anything wrong[1]. This conflicting history does not clearly tell us as to what reason *Kautalya* may have thought and engaged disabled person to be a good spy. However, in the later part of the history during Samrat Ashoka in the 2nd century B.C. and subsequently the golden age of Chandragupta II in the 4th century A.D., we find several mentions regarding the disabled people being object of sympathy who needed to be taken care through charity and alms giving by the state and public in general. The belief though continued to remain emphatic that disability occurs due to *Karma* of previous birth, though providing those help was a deed of *'Punya' (virtue).*[2] There was no change in the believe even in the whole of Sultanate and Mughal period but started showing some influence in the later part of 16th century through the influence of Elizabethan poor law of Britain. Not much change in the life of disabled people but homes for the disabled people were constructed to keep them isolated from the general public by providing and fulfilling their most rudimentary and basic needs such as food, clothing and shelter. In independent India, the scenario was marginally improved with the constitution declaring India as a welfare state. The intonation of all the government documents continued to remain charity and welfare oriented till mid-80s.

[1] Paramount history- Ramashankar Tripathi

[2] Encyclopedia of social work in India- Volume II (1987)

The first comprehensive document was released by the Justice Baharul Islam committee in the year 1989. The committee was formed on the basis of much needed resistance from the disabled community, the civil society organizations, academicians and a substantial group of intelligentsia who were also social activists. The disability scenario worldwide was rapidly changing and India had to respond to this change. By the turn of the millennium, 3 major institutional frameworks were drawn out by way of enacting Rehabilitation Council of India Act 1993, Persons with Disabilities Act 1995 and National Trust Act for the welfare of mentally challenged, cerebral palsy and autism in 1999.

The 3 landmark Acta were soon seen as relevant and its influence was noticed when the Indian parliament was one of the first government in the world to ratify United Nations Convention for Rights of People with Disabilities (UNCRPD) in 2007. The influence of UNCRPD brought in fundamental shift in the definition of disability from medical model to social model and from welfarism to rights-based perspective, 2016 witnessed the repealing of Persons with Disabilities act 1995 and the new act was born termed as Rights of Persons with Disabilities Act 2016. In subsequent chapters, we will briefly examine its impact in the larger context of society and deal the subject of disability in a life cycle approach viz., early intervention & foundational learning, education including higher education, livelihoods and family life, older adults and Persons with disabilities. This paper particularly would provide an in-depth analysis of the first point i.e. early intervention of childhood disability and foundational learning.

BACKGROUND

On the basis of above-mentioned historical perspective there has not been substantial perceptive changes in the disability sector that can be noticed even in the current era. While we see that there are sporadic changes at the govt. sector with the advent of the institutional frameworks, they have not made much impact in the overall spectrum of govt. functioning. At some stage, it needs to be appreciated that post 2016 Act, the govt. of India has established an exclusive department known as Department for Empowerment of Persons with Disabilities (DEPD). This is the nodal department which is supposed to coordinate with rest of the departments and ministries to ensure that all the provisions of the Act is appropriately adhere to within a stipulated time frame. Unfortunately, we do not see this and various departments continue to violate as well as overlook various mandatory provisions that needs to be strictly followed. Additionally, we also do not find any substantial change in the perception and attitude of public in general that should have been noticed after 28 years of enactment of the People with Disabilities Act in 1995. Obviously, there

has not been sufficient amount of effort put by the govt. in carrying out a positive campaign in mission mode. This could be lack of fund or lack of effort by the govt. machinery or both. It is therefore important to examine as to what has gone wrong and what kind of reform needs to be brought in so that there are changes that can be brought into the sector in time bound manner. Up till now, in India, major role in implementing various provisions of the disability development agenda have been played by the civil society organizations across the country. Unfortunately, the reach has been heavily biased towards urban areas, majority of who are operational in the metropolitan and capital cities. The scope of their operation mostly happens to be in early intervention and school education. Hence it is inevitable that the disability scenario needs a fresh look in a more comprehensive manner that demands a lifecycle approach and the plan should be worked out accordingly. Further, the govt. should understand and strategies appropriate for convergence amongst various departments to realize the lifecycle approach and funds be allocated in that manner.

In the light of what has been substantiated above, this paper is an effort to suggest reformatory measures that the govt. may like to consider.

In India, an estimated 7.8 million children and youth aged under 19 live with disabilities.[3] Three-fourths of the population of Children with Disabilities under 5 years of age, and one-fourth of the population of Children with Disabilities aged between 5 and 19 do not go to any educational institution. The proportion of children and youth with disabilities who are out of school is much higher than the overall proportion of out-of-school children at the national level. Thus, although the schemes and programs have brought children and youth with disabilities into schools, gaps remain.

METHODOLOGY

The two distinct components of the assignment are the rapid assessment and conducting of a round table post assessment results. The rapid assessment has been undertaken through a desk review and a stakeholder consultation, using a mixed method approach, combining primary and secondary research. The primary research included Interviews and Focus Group Discussions with Key Informants who were grouped into following categories – Government Respondents from both

[3]UNESCO. (2019). *The State of Education in India 2019* (p.13). https://en.unesco.org/news/n-nose-state-education-report-india-2019-children-disabilities (Accessed 10th May 2022)

National as well as selected State Governments, Civil Society organizations & NGOs working directly on Children with Disabilities issues, Academicians & Subject Experts, Teachers & Special Educators, Parents Groups, and Advocacy Groups. Virtual medium was used for the interviews and discussions. Each of the discussions on an average required 90-120 minutes. A total of 10 Key Informants Interviews (KIIs) were undertaken, across selected geographical locations. The secondary data research was conducted through a desk review of Government Reports, Data available on Government websites, Reports by International Agencies working in development sector, independent studies and research. Quantitative data was referred from two sources, Census of India 2011, and UDISE+ portal.

Additionally, structured questionnaire was sent to selected civil society organization working with Children with Disabilities and specializing in early intervention. The questionnaire had two distinct parts; the first being the identification and demographic section, and the second part was dedicated to technical questions related to early intervention and foundational learning of Children with Disabilities. Google format was used for receiving of the quick response. Almost 75% of the questionnaires were close-ended and the remaining 25% included responses in open ended category. Additionally, tertiary and impressionistic data also formed part of the methodology given the vast and firsthand experience of the principal investigator.

All the above combine together formed the source of information gathering for the reform paper to draw the inferences and analytical review of the situation of early intervention and foundation learning of children with disabilities in India as of today.

EARLY INTERVENTION - THE BASICS

How does it work?

Early intervention works to reduce the risk factors and increase the protective factors in a child's life.

We have an understanding of the risk factors that can threaten children's development, limit future social and economic opportunities, and increase the likelihood of mental and physical health problems, criminal involvement, substance misuse, or exploitation or abuse in later life. These factors exist at different levels within the child's environment – at the individual, family,

community and society level – and interact in complex ways.[4] Studies show that early intervention works best when it is made available to children on the basis of pre-identified risks.

What can early intervention achieve?

Early intervention approaches often focus on supporting four key aspects of child development – their physical, cognitive, behavioral, and social and emotional development – where it has the potential to make the biggest difference and provide benefits throughout a person's life.

- **Physical development** involves children's physical health, maturation and the presence or absence of a physical disability, and it provides the basis for positive development in all other areas. Physical outcomes targeted by early intervention activities include improving birth outcomes, reducing the incidence of infectious diseases and decreasing childhood obesity.
- **Cognitive development** includes children's acquisition of speech and language skills, their ability to read and write their numeracy capabilities and their understanding of logical problem-solving. Positive cognitive development is strongly associated with a child's success in school and entry into the workforce. Cognitive outcomes typically targeted by early intervention include performance on standardized tests, school achievement, and higher education and employment opportunities once they leave school.
- **Behavioral development** involves children's ability to monitor and regulate their own behaviour, attention and impulses. Children's self-regulatory skills are highly associated with their ability to form positive relationships with others, as well as their success in school. Behavioral self-regulation difficulties during childhood are highly predictive of children's involvement in criminal activity during the teenage years and adulthood. Behavioral outcomes frequently targeted by early intervention include reducing antisocial behaviour and crime, violence and aggression at school, and affiliation with antisocial peers.
- **Social and emotional development** involves children's awareness of their own emotional needs and the emotional needs of others. Social and emotional development also encompasses the development of children's self-esteem and their ability to manage

[4] https://www.eif.org.uk/why-it-matters/what-is-early-intervention

negative feelings. Social and emotional development is strongly associated with a child's ability to form positive relationships with others and a reduced risk of depression and other mental health outcomes. Daniel Goleman (1995) described emotional intelligence as an important aspect of human functioning. Emotional intelligence includes 5 components (Serrat, 2009:2-3)[5], namely self-awareness (emotional awareness, accurate self-assessment, self-confidence); self-regulation (self-control, trustworthiness, conscientiousness, adaptability, innovativeness): self-motivation (achievement drive, commitment, initiative, optimism); social awareness (empathy, service orientation, developing others, leveraging diversity, political awareness); and, Social skills (influence, communication, leadership, change catalyst, conflict management, building bonds, collaboration and cooperation, team capabilities). Early intervention lays the foundation for a few of the above skills. Early intervention outcomes associated with children's social and emotional development include increasing pro-social behaviour, improving self-esteem and reducing the incidence of clinically diagnosed mental health problems.

Early intervention also targets three key additional 'threats' to a child's development which are strongly associated with adverse outcomes during adolescence and adulthood: child maltreatment, high risk behaviours including substance misuse and unsafe sexual behavior.

EARLY INTERVENTION OF CHILDHOOD DISABILITIES IN INDIA

India is culturally a joint family society. Not so long ago it was customary that all brothers would live together and share the kitchen with distributed household chores. Therefore, when a baby was born in all likelihood the care of the baby also used to be a joint responsibility amongst all sisters in laws and various older siblings. Though there was a lack of scientific knowledge of what we understand the modern days early intervention inputs there would still be available caregivers that prevented neglect of a child and especially when it was a child with disability. Contrary to this, it was also noticed that in a large number of families a child with disability would be treated as curse in the family and thus both the mother and the child used to be isolated where the entire blame used to be on the women who has given birth to a deformed child. Thus, early intervention traditionally was a mixed bag. In either of the cases, whether it was love for the child by one set

[5] Serrat (2009) drew these components from the Emotional Competence Framework. Emotional Intelligence Consortium - Emotional Competence Framework (eiconsortium.org)

of family or hate by another, ignorance was the prime factor ruling both the minds. However, it was also a fact that there was an immense lack of information for the public in general in connection with the whole subject of early intervention. Thus, early intervention as a scientific knowledge which was put into practice was by the civil society organizations who were either working with child development or working for children with disabilities came in the for front, though it remained limited to urban metropolitan or mostly state capitals.

Early Intervention received a boost when the Ministry of Social Justice and Empowerment (Ministry of Social Welfare) promoted and funded various civil society organizations to take care of the Children with Disabilities from the pre-school stage and offer special education. Most of these schools started admitting Children with Disabilities as and when they came, even as late as 9 years and sometimes even more. Since these children never received any scientific inputs a large number of them were put under the early intervention programs in spite of crossing their age limit. Actually, most of the damage had been done, and was by and large permanent in nature. As the time progressed in urban areas however many parents who were able to accept the disability of their child understood the importance of early intervention. Hence in many such centers we find that some of the children are brought to these centers as early as 3 to 4 years of their age. Unfortunately, the rural areas still continue to remain grim and unserved.

In 1976, the government of India launched a nationwide program known as Integrated Child Development Scheme (ICDS). The ICDS was launched specifically to address the issue of early childhood care and education specifically targeting the poor rural masses as well as the urban slums. The ICDS scheme therefore not only targeted the children from 0 to 6 years (ECCE age) but also the pregnant women, lactating mothers and adolescent girls. However, we need to examine what role the Anganwadi Centers were designated and also examine to what extent these centers have fulfilled their roles specially in the context of children with disabilities.

UNDERSTANDING FLN OR ECCE STRUCTURE IN INDIA

In India, ECCE services have been managed under the Integrated Child Development Scheme (ICDS), under the aegis of Ministry of Women and Child Development. This includes non-formal pre-school education, nutrition care, early identification and referrals, through the Anganwadi Centers. For every population of 1000, an Anganwadi Centre is designated. In India, presently, there is a network of 1.38 million Anganwadi Centre across the country, through which the ECCE program is run.

Under the New Education Policy (NEP) 2020, the Anganwadi Centers have been designated as pre-school centers; hence they are the starting point of FLN for all children including Children with Disability. Early identification starts at 0-3 years, and is an essential pre-requisite for Children with Disability for their entry in Foundational Learning and Numeracy (FLN). Thus, Anganwadi Centers are an ideal place for early identification and intervention for Children with Disability, and therefore have a crucial role to play in the inclusion of Children with Disability. In urban areas, in addition to Anganwadi Centers, primary schools also have attached pre-primary sections (popularly known as *Balwadis*) which are the centers for imparting FLN.

Role of Anganwadi

Anganwadi's are run by Anganwadi Sevika's or Anganwadi workers (AWW). They are generally recruited as volunteers with basic minimum remuneration being provided under the Integrated Child Development Scheme, the parent department being Women and Child Development. AWW hail from the same village/ community and therefore are more acceptable since they know, speak as well as understand the local language in addition to being part of the same cultural milieu. This gives a unique opportunity for the AWW to have the best of rapport with the community and especially with the women folks. An Anganwadi center runs for 4 to 5 hours usually from 8 a.m. to 1 p.m. During this period, children from 0 to 6 years of age visit the centre for childcare, immunization, nutritional supplement and for the regular monitoring of their weight, height, etc. The AWW are trained for a period of 68 days over a period of 4 months. Following are the jobs assigned to AWW:

1. To produce community support and participation in operating the program.
2. To analyze the weight of each child every month, record the weight graphically on the growth card, use referral card for referring cases of mothers and children to the sub-centers, PHC and so forth, and preserve child cards for children below six years of age and produce these cards before visiting medical and para-medical personnel.
3. To conduct the survey of the mothers and children belonging to all the families, especially within the respective working area, once a year.
4. To organize non-formal pre-school education for the children within the age group of three to five years, in order to get them acquainted with the play and creative activities that are required for their growth and development.

5. To organize supplementary nutrition feeding for the children within the age group of 0-6 years and for expectant and nursing mothers on locally available food and also the adequate food preparation methods.
6. To provide health and nutrition education to the expectant and nursing mothers. Married women are also counsel on areas such as family planning and birth control measures.
7. AWW share all the information relating to births with the Panchayat secretary, or Gram Sevak, whoever has been notified as the Registrar or the Sub-Registrar in the village.
8. To make home visits to educate the parents in order to enable them to contribute towards effective growth and development of their children, with main emphasis put upon infants.
9. To maintain records, files and registers in an appropriate manner.
10. To assist the PHC staffs in the implementation of health components of the program, i.e. immunization, health check-up, ante-natal and post natal check etc.
11. To support ANM in the administration of IFA and Vitamin A by maintaining stock of the two medicines in the centre without the maintenance of the stock register as it would add to the administrative work which would affect the primary tasks under the scheme.
12. To share the information collected under the ICDS with the ANM.
13. If any work is required in the village, particularly if the work is relating to co-ordination of procedures with the different departments, then it has to be brought to the attention of the supervisors.
14. To maintain liaison with the other institutions and involve women school workers and girls of the primary and middle schools in the village which give recognition to the significance of their tasks.
15. To guide Accredited Social Health Activists (ASHA) involved under the National Rural Health Mission in the delivery of health care services and maintenance of the records under the ICDS scheme.
16. To contribute in the operation of the Kishori Shakti Yojana (KSY) and motivate and educate the adolescent girls, their parents and the community by the organization of the social awareness programs and campaigns.

17. AWW would also contribute in the implementation of Nutrition Program for Adolescent Girls (NPAG), this is in accordance to the guidelines of the scheme and it is vital to maintain such records as recommended under NPAG.
18. Anganwadi Workers can perform their job duties as depot holder for RCH Kit, contraceptives and disposable delivery kits. However, the concrete distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANM or ASHA as decided by the Ministry of Health & Family Welfare.
19. To identify disabilities amongst the children during home visits and referring the case to the nearby PHC or District Disability Rehabilitation Centre.
20. To assist in the organization of Pulse Polio Immunization (PPI) Drives.
21. To notify the ANM in case of any health problems or illnesses such as, diarrhea, cholera etc.

STATUS OF EDUCATION OF PEOPLE WITH DISABILITY

According to USAID factsheet on Disability and Education (2019)[6], '[A]pproximately 50 percent of the 150 million children with disabilities worldwide are out of school; 90 percent of those have never been in school.' The illiteracy rates for all People with Disability and for school-age disabled children remain much higher than the general population. Despite its significance, the educational outcomes for children with disabilities and adults with disabilities remain very poor (World Bank , 2009). Further, 'It is important to note that illiteracy levels are high across all categories of disability and extremely so for children with visual, multiple and mental disabilities (and for children with disabilities across all categories)' (Dawn, 2014). It must be noted that approximately, 2.4 million Children with Disability in India, are in age group of 0-9 years which is the early childhood period[7].

EARLY INTERVENTION AND FLN FOR CHILDREN WITH DISABILITY IN INDIA

The Desk Review used data from the Annual Status of Education Reports by Pratham which cover the overall status of education in India, including FLN levels for each State and rural district (which is the only annual source of information available on children's learning outcomes); and a

[6] https://www.usaid.gov/sites/default/files/documents/1865/FactSheet_Disability_7.31.19_FINAL.pdf (Accessed on 5 May 2022)
[7] Author derived projected population figure of Children with Disabilities by extrapolation of data from Census 2001 to Census 2011 considering decadal growth factor

recent report by the Economic Advisory Council to Prime Minister (EAC-PM) prepared by the Institute of Competitiveness entitled Report – State of Foundational Literacy and Numeracy in India (2021). However, neither of these studies captures the status of FLN for Children with Disability in India.

Understanding that Children with Disability have significant differences with respect to the type and severity of disability, from the data collected from KIIs the assessment found that the pedagogy of FLN needs to be designed keeping in mind the specific requirement of each Children with Disabilities in function of their physical, cognitive and emotional status. While such pedagogies have been put into practice in special schools run by civil society organizations, they were largely absent in primary schools under the Ministry of Education, despite the GOI's policy commitment to inclusive education. Also, the absence of pedagogies for Children with Disability in Early Childhood Care and Education (ECCE) programs leads to late enrolment of Children with Disability, and therefore there is delay in their growth and development. 'According to the NSSO 2018 data, only 10.1 % of persons with disabilities had ever attended a pre-school program.' (NCPEDP, 2021).

The appropriate ages for imparting FLN for Children with Disability and non-disabled peers differ due to delays in early identification, leading to a loss of several crucial early years of pre-school education in a child's life. Education in the early years of childhood is important for all children, especially for children with special needs. This age is a critical period when the brain and intellectual, physical, emotional, and behavioral processes develop rapidly. Further, there is research evidence on the benefits of ECCE for Children with Disability.

NEP 2020 AND NIPUN BHARAT INITIATIVE

The National Education Policy 2020, has laid a strong emphasis on foundational literacy and numeracy. To provide special focus and concerted effort the GOI's Ministry of Education has launched NIPUN Bharat Mission, which is also known as National Initiative for Proficiency in Reading with Understanding and Numeracy. NIPUN Bharat outlines learning outcomes which have been designed in a sequential and progressive manner from pre-school to grade three aiming at holistic development and learning in the foundational age. The administrative set-up of NIPUN Bharat initiative is based on a five-tier implementation structure at the NATIONAL-STATE-DISTRICT-BLOCK-SCHOOL levels. NIPUN Bharat has also recognized the importance of FLN

for Children with Disability and encourages some interventions for them, however, there is no clear policy directive spelling out the need for any study or research for FLN interventions for Children with Disability. In addition, it is observed that the language of the text appears to be tentative rather than emphatic with respect to interventions mentioned for Children with Disability.

ANALYSIS OF PRIMARY DATA

The analysis delves into the characteristics and practices of organizations working in the education sector for children with disabilities in India. The data provides insights into the types of organizations, representation of people with disabilities (People with Disability) in decision-making bodies, geographical distribution, primary focus areas, disabilities catered to, admissions trends, curriculum content, parental involvement, therapies provided, expected achievements, expectations from parents and government, and additional concerns and suggestions.

KEY FINDINGS:

Type of Organisation:

The majority of respondents (92.3%) are Non-Governmental Organizations (NGOs), indicating a strong presence of non-profit entities dedicated to promoting education for children with disabilities. However, there is limited representation from aided schools, suggesting potential gaps in formal educational institutions' involvement.

Representation of People with Disability or their parents among board members:

Around 46% of organizations do not have any representation of People with Disability or parents of children with disabilities on their boards, indicating a potential gap in inclusion. However, 15% of organizations have more than 4 individuals with disabilities or parents on their boards, showing a stronger commitment to inclusion.

Location of Organisations:

The organizations are primarily concentrated in urban centers, potentially leading to an urban bias in resource distribution. This may overlook the needs of children with disabilities in rural areas, highlighting the importance of addressing disparities in access to educational resources.

Primary Focus Area:

Education is the most common focus area, followed by livelihood and skill development programs, advocacy, healthcare, and social services. The variety of focus areas reflects a multifaceted approach to addressing the needs of children with disabilities.

Disabilities Catered to:

Multiple disabilities, intellectual disability, and a combination of various disabilities are the most common disabilities catered to. Some organizations cater to a wide range of disabilities, indicating a comprehensive approach to inclusion.

Number of Admissions:

The total number of admissions increases progressively from AY2021 to AY2023, reflecting potential growth or changes in organizational capacity or outreach efforts.

Average age at admission:

On average, children are admitted to the center/school at approximately 8 years of age, with a standard deviation of 4.78 years.

Duration of Enrolment:

Organizations report varying enrolment durations, with some children remaining enrolled for more than 15 years, indicating long-term engagement and support.

Parental Involvement:

Parental involvement varies across organizations, ranging from extensive participation in various activities to specific areas of involvement such as therapy and teaching.

Curriculum Content:

Organizations cover a wide range of content areas in their curriculum, emphasizing foundational skills, life skills, vocational education, and adapting the curriculum based on individual needs.

Teaching resources used:

Organizations utilize a variety of teaching aids and resources, including assistive technologies, sensory toys, and teacher-made materials, to support learning.

Therapies provided:

Organizations offer diverse therapies, including physiotherapy, occupational therapy, and speech therapy, to address the physical, cognitive, and sensory needs of children with disabilities.

Expected Achievements

Organizations focus on individualized learning goals, developmental milestones, and functional outcomes tailored to each child's needs and abilities.

Expectations from Parents:

Organizations expect parents to understand their child's needs, accept their disability positively, and actively engage in their education and rehabilitation process.

Expectations from the Government:

Organizations primarily expect funding support from the government, along with trained human resources and comprehensive assistance across various domains.

Additional concerns of organisations:

- Requirement of collaboration between government bodies and NGOs for enhanced funding support.
- Establishment of more residential institutes for children with high support needs.
- Active involvement of paediatricians in early intervention.
- Training initiatives for teachers, including retired teachers sharing expertise.
- Early identification and support services for children with disabilities.
- Specialized facilities such as old age homes for mentally challenged children.

DISCUSSION

The landscape of foundational learning and early intervention for children with disabilities in India reflects a dynamic and multifaceted ecosystem, characterized by the presence of various organizations dedicated to addressing the unique needs of this population. The majority of these organizations, approximately 92.3%, are Non-Governmental Organizations (NGOs), illustrating a strong commitment from non-profit entities towards promoting education for children with disabilities. However, there is limited representation of people with disabilities or parents of children with disabilities on the boards of these organizations, with only 15% reporting more than 4 individuals with disabilities or parents on their boards. This suggests a potential gap in incorporating diverse perspectives into decision-making processes.

Geographically, these organizations are distributed across different cities and towns in India, with a concentration in urban centres such as Ahmedabad and Pune. While this reflects a broad coverage of different regions, it also highlights a potential urban bias in the distribution of resources and services for children with disabilities, underscoring the need to address disparities between urban and rural areas.

Education emerges as the primary focus area for these organizations, with a strong emphasis on providing educational opportunities and support services. However, there is also a notable focus on livelihood and skill development programs, advocacy, healthcare, and social services, reflecting a holistic approach towards promoting the rights, well-being, and inclusion of people with disabilities in society.

In terms of disabilities catered to, the most common ones include Multiple Disability including Deaf blindness, Intellectual Disability, and a combination of various disabilities. Each organization's focus may vary based on their resources, expertise, and specific mission, but overall, there is a commitment to addressing the diverse needs outlined in the Rights of Persons with Disabilities Act 2016.

Regarding admissions, there is a progressive increase in the total number of admissions over the years, indicating potential growth or changes in capacity or outreach efforts. The average age at which children take admission is approximately 8 years, with variations across different age ranges and academic years. Additionally, children typically remain enrolled for more than 15 years in around 30% of organizations, indicating long-term engagement and continuity of services.

Parental involvement varies across organizations, with some reporting extensive involvement across various aspects of school activities, while others highlight specific areas such as therapy or teaching. This underscores the importance of fostering collaborative relationships between parents and schools to support the holistic development of children with disabilities.

Curriculum content covers a wide range of areas, including foundational literacy, numeracy, social-emotional learning, communication, and vocational training, reflecting a holistic approach to education. Special needs and resources utilized for teaching also vary, with organizations utilizing a wide range of resources and teaching aids to support learning.

Therapies provided include physiotherapy, occupational therapy, speech therapy, and a variety of specialized therapies, indicating a holistic approach to addressing the diverse needs of children with disabilities. Expected achievements from children within two, three, and five years also vary, with some organizations emphasizing individualized learning needs, while others focus on developmental milestones and functional outcomes.

Overall, while there are significant efforts being made to support foundational learning and early intervention for children with disabilities in India, there are gaps that require policy intervention. These include addressing the limited representation of people with disabilities in decision-making processes, addressing disparities in access to resources and services between urban and rural areas, and enhancing parental involvement and support. Additionally, there is a need for greater collaboration between government bodies and NGOs, increased focus on early identification and

intervention, and the establishment of specialized facilities to cater to the high support needs of children with disabilities. By addressing these gaps, policymakers can work towards creating a more inclusive and supportive environment for children with disabilities to thrive and reach their full potential.

CURRENT CHALLENGES

Delay in School Enrolment

The education of Children with Disability in India has always faced a major obstacle in terms of age-appropriate admission in the pre-schools as well as in the primary school. Parental ignorance and non-acceptance of their disabled child are crucial reasons for the delay in early interventions and in school enrolment. Parents in rural areas are not aware of disability issues; rural poverty also leads to neglect of the Children with Disability by parents who may be daily wage earners, also leading to delay in school enrolment. For children with multiple disabilities, lack of awareness can prevent the parents from realizing the unseen potential of their child, therefore there is little or no attempt to enroll their child in school. 'Only 29.47% of the schools across the country have children with disabilities enrolled in them in 2018- 19 and there is wide inter-state variation.' (NCPEDP, 2021). One of the basic challenges is to identify children with disabilities at an appropriate age and bring them to pre-school. It also must be noted that a large number of children with disabilities require early intervention which needs to begin even before the stipulated three years of age specified for FLN in NIPUN Bharat.

Early Identification and Intervention

Early intervention of childhood disabilities is a prerequisite to the developmental milestone of a Children with Disabilities that can lead to their entry into the stage of Foundational Learning and Numeracy (FLN). Early identification and intervention can be fruitfully realized at the Anganwadi Centre by appropriately capacitating the Anganwadi Centers with physical, financial and human resources.

Pedagogy

The method of transaction[8] as well as curriculum development for Children with Disability needs to specifically designed to cater to different nuances of different categories of disability and their severity. One of the reasons for the low participation of students with disabilities in education has

[8] *Transaction means the communication between teacher and student related to any subject that they are teaching in the classroom.*

been the lack of understanding of their requirements, learning levels and discussions on how to build robust systems that cater to diversity of their needs even after we have a strong supportive legislation in place.

The usual method of teaching Children with Disability includes preparing their Individual Education Plan (IEP) factoring in the specific challenges of the individual child. Presently, as Children with Disability enter education system at varied ages, the IEP focuses on each child as per their entry into the school and their basic assessment of being ready for school, therefore progress, improvement and learning outcomes for the Children with Disabilities becomes a subjective matter, in absence of any uniform guidelines or framework.

The Goals set by NIPUN Bharat Mission for FLN to be achieved by 2026-27, do not factor in the Children with Disability, and hence may remain unrealized. Hence, flexibility for curriculum adaptation, designing appropriate Teaching-Learning Material (TLM) for transacting with Children with Disability, and developing a guiding framework for the IEP needs to be considered.

Home Based Education – Multiple Disabilities

Home Based Education is an option for educating Children with Disability with severe disabilities under the Persons with Disabilities Act 1995 (People with Disabilities Act 1995); this policy has been upheld under The Rights of Persons with Disabilities Act 2016 (RPD Act 2016). Although the idea is to teach the child at doorstep and later prepare them to attend the inclusive school, currently there is no such data available regarding their transition from home to school. Further, discussions with the Key Informants (KI) suggest that the frequency of 'itinerant teachers' visiting home range from once in week to once in a month. Due to which Children with Disability under home-based education do not receive adequate and appropriate interventions in education. They also tend to miss on process of socialization including participation in games, sports and culture.

Human Resources – Inadequacy

'Inclusive schools'[9] are supported by a cadre of 'Special Educators'. These 'Special Educators' function as 'resource teachers' who are located at the Block Resource Centre (BRC), and as 'itinerant teachers' who travel around local mainstream schools and communities to offer support to Children with Disability, their parents and inclusive school teachers in inclusive schools. The itinerant teachers are allocated certain number of schools per teacher, who visit the schools and give lessons to the Children with Disability and also support the regular classroom teachers in

[9] *Inclusive school is the terminology used by the Ministry of Education though all regular schools are inclusive by definition*.

facilitating them in teaching the Children with Disability. This facilitation is possible when the inclusive school teachers have adequate knowledge and training to teach Children with Disability (who in a typical classroom situation would be from several different disability categories). The norm is that each itinerant teacher is allotted 10 schools irrespective of the number of Children with Disability in each school. However, on an average, it was stated by the teachers' group that they have to support up to 30 schools per itinerant teacher in addition to substantial administrative work. Often each of these schools are located at a distance, which additionally takes time. Thus, a child with disability in an inclusive school receives an extremely low share of the teachers' time for learning, which directly affects the learning outcomes. All the States have reported severe shortage of Special Educators.

Human Resources – Capacity Building

The overall facility for human resource development in the disability sector is primarily based with the eight National Institutes and few Universities in the country. Additionally, Rehabilitation Council of India (RCI) has recognized and entrusted several NGOs for conducting training courses for development of Human Resources. In spite of this, the overall supply of special educators and other rehabilitation professionals continues to remain much lower than the demand. Further, barring a few exceptions, there is a huge difference in the quality of knowledge and skills of special educators who have been trained by the National Institutes and Universities and those who have been trained by the Civil Society Organizations.

Additionally, it is extremely important that the inclusive school teachers have adequate knowledge about disability and teaching Children with Disability, so that the 'itinerant teacher' can work in a supporting role, Currently, the inclusive schools are almost completely dependent on the itinerant teachers for provision of education to Children with Disability. The all India average for teachers trained for teaching Children with Disability is as low as 8.85%, with Bihar (3.41%), Uttar Pradesh (3.80%), performing worse than Maharashtra (6.08%) and Telangana (8.62%). It needs to be noted that there is a huge gap in trained human resources for teaching Children with Disability in India. Thus, for this reason alone, achieving FLN goals by 2026-27 in the inclusive schools would be a serious challenge.

Human Resources – Status of Special Educators in Inclusive Schools

The Special Educators have undergone special training to teach Children with Disability specializing on single disability; hence they are best equipped to teach the Children with Disability. However, their status in inclusive schools as itinerant teacher or resource teacher remains low. They remain unaffiliated to any one school, and are seen as visiting teachers. They

are not made a part of the full time education cadre of any of the States and function as contract teachers, often with very low salary and no job security. With extremely low remuneration package, low social status the profession of Special Education in inclusive government schools remains unattractive.

School Infrastructure

There is a serious lack of basic school infrastructure conducive to Children with Disability in all levels of education in India. The accessibility parameters have not been appropriately understood and followed. The UDISE+ data captures only ramps, railings and accessible toilets at school level. While ramps and railings are found in a large number of schools, the percentage of accessible toilets is extremely low. All other features of accessibility as per norms defined by the Ministry of Social Justice and Empowerment need to be followed. This will facilitate the attendance and retention of Children with Disability in each school and prevent drop-outs. At the level of pre-schools, and Anganwadi Centers, the same should follow, where FLN begins.

Governance

In India, Education is a subject that falls in Concurrent List in the Constitution. This means that the Central Government is the primary policymaker and provides financial support to the State governments on a sharing basis on an agreed norm that may differ from scheme to scheme. However, the education of Children with Disability is handled by multiple agencies both in Central and State Government. While inclusive education is handled by the Ministry of Education, the special schools are managed by Ministry of Social Justice / Welfare.

Issue of Certification

The Disability Certificate is an extremely important entitlement for a People with Disabilities, which makes them eligible to access any and all Government benefits. Obtaining the certificate by a People with Disabilities or their parents, poses serious systemic challenges. Only government hospitals are authorized to issue these certificates. The main obstacles faced by People with Disability stem from lack of certifying specialists in a district and the time period allotted for evaluation of the People with Disabilities / Children with Disabilities. The time period is often very long and many a times the need for repetitive visits is a burden for the parents or the People with Disabilities themselves. This also adds to their financial constraints, as it may so happen that they need to travel long distances to the district hospitals, often losing their daily wage earning. It can lead parents to abandon their efforts to obtain the certificate.

Issue of Convergence

The education of Children with Disability requires the convergence of multiple agencies to provide a complete portfolio of services to Children with Disability. The Ministry of Education (MoE) for schooling; the Ministry of Health (MoH) for issuing certificates and providing adequate health facilities for therapy and handling special health conditions for certain categories of Children with Disability; the Ministry of Social Justice for provision of Assistive Devices, as well as social security; the Department of Public Works for accessible infrastructure; and the Department of ICDS for providing ECCE. Currently, there is little convergence among these departments. The convergence between the MoE and Department of ICDS is the most crucial for FLN. Additionally, due to lack of convergence between health and education, currently no inclusive schools have any facilities for therapeutic services. It is therefore, essential to strategize convergence among these five Ministries/Departments, so as to fulfill the goal of inclusive education.

Monitoring and Evaluation

In India, the National Human Rights Commission, National Commission for Protection of Child Rights, Chief Commissioner for Disability as well as their State counterparts are primarily the three monitoring agencies with respect to Children with Disability and People with Disability. They custodians of protecting the rights of Children with Disability and People with Disability. However, currently there are no clearly defined domains of the different agencies mentioned above and they have overlapping portfolios. It is recommended that the government defines the distinct functional role of each of these bodies related to disability so that there is no overlapping and one complements the other. Further indicators and monitoring framework for each of these agencies must be developed so that the domain is appropriately immersed in each of the systems.

Lack of Data

The desk review pointed out that there is no data available for FLN with respect to Children with Disability. Further, there is no single national comprehensive portal related to Children with Disability or People with Disability. The data is captured by multiple agencies for their specific domains, for example, Department of Health captures the People with Disabilities certification data, UDISE+ captures data related to school education and so on, without any convergence. There are a few States such as Andhra Pradesh, Telangana, and Uttar Pradesh, which have developed data portals for capturing data related to People with Disability. However, all these data portals only capture the People with Disability / Children with Disability who have received disability certificates. A vast majority of People with Disability and Children with Disability who are

otherwise eligible for government benefits but have not received the disability certificates do not figure in the data base, and therefore remain left out from any entitlements. There is also multiplicity and overlapping of data, and therefore overlapping use of resources. An appropriate convergence mechanism for the creation of a comprehensive database of People with Disability and Children with Disability will be crucial for any scientific planning of inclusion interventions.

Gender and Intersectionality

There is a larger neglect of a girl with disability in a family as compared to a male child with disability. Statistics show that enrolment of girls with disability is persistently lower than boys with disabilities. 'The persistently low participation of girls with disabilities in the general school system indicates that not enough attention and thought has gone to enabling their enrolment in education. The GPI (gender parity index) of children with disabilities from 2014-15 to 2018-19 indicates constant but low ratio of girls with disabilities to boys with disabilities. This ratio between the girls and boys with disabilities remains between 0.74-0.7 in school education.' (NCPEDP, 2021). The ASER 2018 Report states that the percentage of 'Girls out of School' has decreased over the years from 2008 to 2018. However, ASER does not capture data for children with disabilities, and therefore the status of Girls with Disabilities who are out of school could not be found. Though the learning outcome for girl children in India shows a positive trend, there is no data available for girls with disabilities, hence the same cannot be derived for them.

The girl child belonging to scheduled castes and scheduled tribes suffer from multiple, additional disadvantages. Firstly, they are disabled, secondly they are girls and thirdly that they belong to a lower caste or a tribal society. It may be noted there is no caste-wise enrolment data for Children with Disability available.

INNOVATIONS AND BEST PRACTICES

The best practices that have been included in the study have been shared by the Key Informants, and these are under practice in India. It was decided to limit the best practices documentation to the Indian context and the foundational learning space. Some of the best practices are summarized below;

Experiential learning through 'Total Communication' Approach

This approach is used to teach children with deaf-blindness. It focuses on experiential learning through which is activity based and is centered around a single focus activity. In this 'Total

communication' approach is used, where the intervener used a combination of communication methods and modes for the individual with deaf-blindness. The communicative methods and modes are specific to the individual so as to provide the best opportunity for understanding. This approach is being used by Helen Keller Institute for the deaf and deafblind, Mumbai.

Use of Multiple Intelligence Approach of Howard Gardener for transacting with children with intellectual disabilities.

Howard Gardener's 'Multiple Intelligence Theory' believes in the premise that learning occurs through many types of intelligences, and individuals have various levels of each. In this approach, the teacher identifies the multiple intelligence of each student and accordingly designs appropriate activities for their learning. This approach of Multiple Intelligence has been studied and researched in depth through exploratory method by Kamayani Prashikshan and Sanshodhan Society, Pune and it is being used to teach the children with intellectual disabilities.

RECOMMENDATIONS FOR DESIGN

School Enrolment

Large scale awareness generation at the community level related to disability. Awareness campaigns can be introduced at two levels, at one level targeting general community and other level it should target parents and caregivers.

Early identification and Intervention

The Anganwadi to become an effective FLN Centre needs to be equipped with appropriate infrastructure such as improvements of the built environment with proper accessibility features that includes accessible toilets, accessible Teaching –Learning Material and EII material.

Pedagogy

I. Flexibility needs to be provided for Curriculum Adaptation
II. 'Adaptive Communication' needs to be brought in for transacting with different categories of People with Disability. Adaptive communication will facilitate smooth entry of a Children with Disabilities towards FLN
III. Appropriate budgetary provisions in the annual budget need to be made for acquiring / replenishing / replacing TLM as per individual Children with Disabilities need.

HOME-BASED EDUCATION – MULTIPLE DISABILITIES

I. Due to reduced number of itinerant teachers, each child receives instruction by an itinerant teacher at best only once or twice a month. It is recommended that the recruitment of teachers should be done on the basis of actual statistics on the number of Children with Disability and their categories and degrees of disability. To start with, the department must fill up all the sanctioned posts and further work on recruiting more as may be required.
II. There should be support to increase the awareness of the parents and they should be given access to GOI income and livelihoods programs, such as the National Rural Livelihoods Mission and National Urban Livelihoods Mission.

Addressing Human Resource Inadequacy

It is recommended that the teacher training in the inclusive schools must be undertaken in mission mode with strict quality check by appropriate monitoring committee. The committee should

consist of representatives from government, NGOs, parents and People with Disability. This training should be part of NIPUN Bharat. Use of PM eVidya and Swayam Prabha TV channels that were used during covid to impart education.

Human Resource capacity building

The D.Ed. and B.Ed. degree requirements should include compulsory teaching on Children with Disabilities pedagogy since right to education of every child and inclusivity is part of fundamental right.

Human Resource capacity building - Status of Special Educators in the inclusive schools

All resource and itinerant teachers must enjoy the status as regular teacher and should be part of permanent cadre of State Education Departments.

School Infrastructure

I. It is highly recommended that accessibility audits be conducted in every public school by a qualified accredited access auditor.
II. Provision of appropriate therapeutic services for Children with Disability at the school complex should be ensured

Governance

ISSUE OF CERTIFICATION

A convenient centre could be opened up in a cluster of Panchayats with appropriate online facility for data entry into UDID portal.

ISSUE OF CONVERGENCE

I. Strategizing of convergence of the five key Ministries/Departments must be worked out at the District level. After preparation of the individual school plan it should be consolidated at the district level and the same should be available at the district level.
II. The District should have a district disability convergence plan developed through a workshop mode which should be prepared in Result Based Management (RBM) and accountability format. The plan preparation should be anchored by an appropriately qualified RBM expert.
III. Schools run by the Social Welfare Department should function as model resource school which should be assigned with certain number of inclusive schools for providing specialized inputs so that their best practices could be emulated. This will improve the functioning of inclusive schools and the parents would also be motivated to send their

child. This will bring appropriate functional convergence with social welfare department which is the nodal agency for disability.

IV. Appropriate awareness raising campaigns should be carried out for government functionaries in the five key Ministries/Departments. It should form part of regular training and upgrading programs so that the officials are regularly updated on disability issues.

DATA

I. Ensure regular update of Government websites and portals

II. The data should be made available (except sensitive data related to individual) in public domain for research and planning purpose at various levels.

III. A single-portal should be developed by respective State governments taking into consideration the requirement of all relevant departments related to disability. Each of the department should be given the password for accessing and updating their own domain only i.e. updating of the departmental data will be the right of that department only.

Gender and Intersectionality

I. While there is an incentive provided under Samagra Shiksha for girls with disabilities, efforts should be made to educate parents for treating girls with disabilities and boys with disabilities on equal terms. For this, ASHA Worker and Anganwadi Worker should be the vehicle for carrying out the awareness campaign and also constantly counseling the parents. Additionally, a conducive atmosphere needs to be brought in the overall community (both rural and urban) so that adequate attention and importance is given to a girl child.

II. For girls with disabilities, to continue education in school it is important that appropriate facility should be made available for their personal and the menstrual hygiene, their safety and dignity.

III. The Multi-Poverty Index Report jointly published by Oxford Poverty and Human Development Initiative, University of Oxford and United Nations Development Programme (UNDP) (Oxford Poverty and Human Development Initiative & UNDP, 2021) amply brings in fore the multi-dimensionality of poverty and therefore the deprivation. Intersectionality is a status where multidimensional poverty is apparent. It is recommended that special focus in planning should be given taking into consideration the intersectionality status of the community and the Children with Disability belonging to such intersectional milieu. For example, a special drive could be undertaken for bringing

girls with disabilities from scheduled caste or scheduled tribe community to school who often remain deprived.

IV. The NEP 2020 mandates every State government to prepare their own educational plan under the broad guidelines given by the policy and following the same its spirit. The State education plan must ensure that "Gender Inclusion Fund" is in place and that it should reflect in the district education plan as well. The 'gender inclusion fund' should be created keeping in view the gender parity index (GPI) and allocation of fund should be higher where GPI is low. District-wise GPI index should be made available to every district. While making this index, careful consideration must be made that the data related to Children with Disability is not left out.

ADDITIONAL RECOMMENDATIONS

Based on the analysis of primary data following are policy recommendations:

Enhancing Representation and Participation: Introduce policies and incentives to encourage greater representation of people with disabilities or parents of children with disabilities on the boards of organizations working in the education sector for children with disabilities. This can include setting quotas or providing financial incentives for organizations that demonstrate diverse representation in their governance structures.

Addressing Urban Bias and Regional Disparities: Implement measures to address the urban bias in the distribution of resources and services for children with disabilities by allocating additional resources to underserved rural areas. This can involve establishing satellite centres or mobile units to provide outreach services in remote areas and ensuring equitable access to education and support services across different regions.

Strengthening Focus Areas and Support Services: Provide financial support and capacity-building initiatives for organizations working in areas beyond education, such as livelihood and skill development programs, advocacy, healthcare, and social services. This can include grants, training programs, and technical assistance to enhance the quality and effectiveness of services provided to children with disabilities and their families.

Promoting Collaboration and Coordination: Foster collaboration between government bodies, NGOs, and other stakeholders involved in foundational learning and early intervention for children with disabilities. This can be achieved through the establishment of inter-agency coordination mechanisms, joint funding initiatives, and knowledge-sharing platforms to facilitate collaboration and maximize impact.

Investing in Early Identification and Intervention: Allocate resources towards early identification and intervention programs to ensure timely support for children with disabilities. This can involve training healthcare professionals, educators, and community workers to recognize early signs of disabilities and provide appropriate referrals and interventions.

Establishing Specialized Facilities and Services: Develop policies and funding mechanisms to support the establishment of specialized facilities, such as residential institutes and day care centres, to cater to the high support needs of children with disabilities. This can include providing capital grants, operational subsidies, and regulatory support to encourage the development of inclusive and accessible facilities.

Empowering Parents and Caregivers: Implement initiatives to empower parents and caregivers of children with disabilities by providing them with information, training, and support services. This can include organizing workshops, support groups, and counseling services to help parents navigate the challenges associated with raising a child with disabilities and actively participate in their education and development.

The Government of India can work towards creating a more inclusive and supportive environment for children with disabilities to thrive and reach their full potential in terms of foundational learning and early intervention.

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