AN EXPLORATORY STUDY
OF HOME BASED EDUCATION
PRACTICES
DRAFT REPORT

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Executive Summary

Introduction

“While the RTE Act mandates inclusion of children with special needs (CwSN), some children with special needs are unable to attend school despite specific interventions designed for their education. The amendment of RTE Act (in August 2012) has included CwSN in the definition of disadvantaged groups. It includes children with severe - multiple disabilities with the right to Home Based Education (HBE), thus creating an enabling environment for the children”

Samagra Shiksa: Framework

HBE as mentioned above was considered as an important programme under the SSA serving as a bridge to inclusive schooling for CwSN. SSA adopted a zero rejection policy for all children and for achieving this, it followed a multi- option model for Children with Disabilities (CWD)\(^1\). According to SSA (2006)\(^2\), no child having special needs should be deprived of the right to education and to be taught in an environment, which is best suited to her/his learning needs. These include special schools, Education Guarantee Scheme (E.G.S.), Alternative and Innovative Education (A.I.E) or even HBE. SSA (2006) defined HBE in the following way:

“Generally home-based education is defined as the education of children with severe intellectual/physical disabilities, who can be educated in the combination of home-based and alternate educational settings to enable them to achieve independent living skills. Home-based education aims at school preparedness and preparation for life. Alternate educational settings provide opportunities for learning of social skills, vocational skills and implementation of life skills”.

The following are the merits of HBE as proposed by SSA\(^3\)

- Families are full participants in all aspects of the planning, delivery, and evaluation of services;

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Increased emphasis on early identification and intervention services;
Children and families have access to a comprehensive and well-coordinated array of services that address the child and families’ physical, emotional, social, and special needs
Once a child develops the basic Activities of Daily Living- ADL, services could be extended to the regular schools
Services should be integrated with all other child-serving programmes, agencies, and systems
Services are provided keeping in mind the linguistic needs, socio-cultural norms and values of each child and family.

In the year 2015-16, household surveys and special surveys have been conducted by all states to identify CWSN. 27.79 lakh CWSN have been identified. 25.03 lakh CWSN (89.53% of those identified) are enrolled in schools in 2015-16. Further 69,881 children with special needs are being covered through School Readiness Programme and 1.16 lakh CWSN are being provided HBE. In all 96.18% of the identified CWSN have been covered through various strategies.

Although data shows that total number of children under the HBE programme have been decreasing over the years, the present study was conducted to ascertain the benefits being derived from this scheme to meet the high support needs of children under HBE. In light of the HBE being included under the RTE, 2009, it is expected that increased support in the form of special education services from schools would serve to improve the HBE experiences of many students with disabilities. In addition, it is expected that improved relationships between neighbourhood schools and families of children with disabilities would result in parents choosing HBE for the right reasons—not as an only option available for their children.

**Methodology**

**Objectives**
The study explored how the presence of CWD under home education practices affect the parents, teachers/resource teachers, schools and community members in remote tribal, and urban slum areas and the resources are being provided for meeting their needs? Specifically the objectives of the present study are:

1. To assess how the tribal and poor backgrounds effect the provisions and other factors related to the family, teachers and community members of a CWD under the HBE programme.

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2. To analyze views and perspectives of resource teachers, parents and community members regarding the implementation of home based practices over the years and about the provisions especially after its inclusion under the RTE Act.

Sample
The sample for this exploratory study was 5 students living in the remote Scheduled tribe dominated areas and from slums of Maharashtra. Various houses where children were under the HBE in remote areas in the State were visited and the final sample for case studies was selected on the basis of number of factors like: identifying children staying in tribal areas and enrolled under HBE, willingness of the Parents to participate in the study, accessibility of the home through public transport and provisions for staying overnight by the programme coordinator in the village for observation and intense interactions with the stakeholders. Interactions were held with parents of 20 households before 5 students were selected for preparing case studies. The places visited for selecting the children were: Chandrapur and Gadchiroli Districts in Nagpur, Pune, Shahpur town in Thane District, Igatpuri in Nashik District, Jawhar and Palghar district, Alibag, a municipal council in Raigad District and Dharavi and Ghatkopar slums in Mumbai.

Methodological Strategy

- A focused literature review was conducted to provide a policy and legislative context for the supports available for CWD under HBE in Maharashtra;
- Various SC/ST concentrated Districts were visited and out of 20 children visited, 5 were selected for deeper case studies;
- Case Study semi structured interview schedules based on the various components under the SSA and literature review were formulated utilising questions designed to elicit a rich description of the participants’ experience for parents, teachers and community members (See Annexure 1). Data was also collected through the combination on different levels of techniques, methods, strategies, like focus group discussions and observations and from secondary sources. An observation checklist was also prepared;
- The case studies were written based on a thematic analysis of all the interview content was performed;
- Information gathered under the case studies was also validated from secondary sources.
- A road map for further action/interventions was prepared and discussed with States for implementation.
Procedure
Participants in the case study were selected after taking consent of the parents. Semi structured interviews were conducted and also video graphed. The interviews with the participants who were parents, teachers in the school and community members lasted for nearly 45 minutes. Following each interview, the reflections and impressions were documented to assist in analysis.

Findings
The families that were visited for in-depth case studies were very poor, parents were illiterate and barely had money to make two ends meet. The findings that emerged from the analysis of 5 case studies including the tribal children are:

The Children
- Four of the children were delivered at home by a non medical person due to either lack of medical facilities, ignorance or lack of finances. All the children suffered severe infections after birth and the parents’ attribute their disability condition to the birth trauma suffered by these children;
- All the children were diagnosed late, around 5-10 years after birth. As a result, they were deprived of early intervention services like daily living skills, speech development, physiotherapy for bodily movements etc.;
- All five children appeared to be in poor health, malnourished, badly dressed or not dressed at all and dirty. They are living in serious unhygienic conditions and prone to multiple infections;
- All these children are enrolled in regular schools post RTE Act. Even if they do not attend the school they are promoted to higher classes because of no detention policy;
- All the children are dependent on a family member for their daily living especially the mother. Since the mother remains busy with house work and in looking after the other siblings, this child is generally neglected. As observed, these children are just kept alive and the parents have no time for doing anything more than this.
- All these children in addition the physical disability were also considered to be intellectually disabled without any proper diagnosis.
**The House**

- The houses of tribal children are located in small hamlets with physical environments which support them and determine their economic activity. Nearly all of the houses are similar in the hamlet with thatched roofs and mud walls. The houses visited had limited furniture like a chair or a bed. Most of the tribals like to stay outdoors most of the time;
- The children in urban slum areas are staying in small houses with limited space. There is no provision for attached kitchen or bathroom especially in the slum area of Dharavi where there is no water connection and toilet;
- The houses are dark and dingy with a number of family members inhabiting the house. The child in these houses is placed at one point and since she is unable to get up lies at the same place throughout the day.

**The family**

- In all the case studies it was observed that the mother was the person solely responsible for the child. This is true for both tribal and urban areas. She was also explicitly blamed for the child’s condition in two houses (Dharavi and Kamathi village and appeared to be very unhappy;
- The parents of the children under the study were illiterate and employed (or self employed) in low wages. The families were hard pressed for money and wanted the Government to help them with finances;
- In 4 out of 5 case studies it was observed that there is a marital discord between the parents. The reason for this constant fights is attributed to irritability due to excessive work or burden of responsibility;
- There was explicit gender discrimination even amongst children with disability. Being a boy with disability had more advantages and acceptance than being a girl with disability;
- The parents had no training for looking after the special needs of their child. They were ignorant about the kind of techniques they need to use with their child to even develop the daily living skills;
- All the parents complained about lack of resources for looking after the needs of their child. They had no money even for medical interventions and as a result the child had deteriorated over the years. They felt the need for a physiotherapist speech therapist etc. to be made available at home.
- Most of resources are available at the BRC level which was around 20-40 kms away from the houses except in Dharavi slums where it was almost next door. Carrying a severely disabled child on a motor bicycle or cycle was a herculean task and therefore the
children had no access to resource support. Even if the parents did attempt to take them to BRCs, these visits were not frequent and the continuous support needed was not available;

- All the parents interviewed had tried a number of religious and spiritual ways to treat their children like taking to a particular shrine, leaving them in missionaries. Especially, the tribal children were exposed to a lot of attempts of miracle cure.

The School

The primary school is located in the village while the upper primary schools are a few kilometers away. In the existing scenario, after the RTE Act, all children under the HBE programme are enrolled in the schools. As a result, regular schools are responsible for their education. However, when the teachers were interviewed and the school was visited, the following findings emerged:

- The regular schools, especially in the rural areas are not equipped with any facilities for CWD. Even in the city, there are a few government schools having the resource centre;
- The CWD occasionally come to school carried by their mothers for mid day meal. Even that becomes difficult as the children grow and are heavier and the wheel chair given is not suitable;
- There is no transport available for bringing these children to school. Even if parents manage that, there is no caretaker appointed to take the child to school. It then becomes the responsibility of the parent to accompany the child to school, sit there throughout the school timings and bring the child back home. The scenario is worse in upper primary schools as these are far from the house;
- The parents need to be highly motivated to take their child to school in the absence of facilities. With low expectations from the child, parents are happy to let him/her stay at home and keep him/her alive;
- Parents of other children sometimes complaint regarding the CWD studying with their children. They feel that this can affect their children both physically and mentally;
- There is no training both at in-service and pre-service levels that equips these teachers with knowledge and skills to include CWD in education. Many of the teachers felt that these children should be taught only by a special teacher or in a special school;
- RT visits to regular schools is very rare and since these children are severely disabled, they require one to one support which is not available;
- The parents are overprotective and try to shield their child from physical injuries and mental traumas. They feel there is no sensitivity towards these children and other children may tease or bully them;
• Only when the resource room is near the house and is easily available, it can be used by the child. In Dharavi, the resource room was just 150 meters away and accessible. Even then carrying the child was difficult;
• Even if the child is very intelligent but unable to move, there are no facilities like adapted wheelchair, caretakers, transport to enable this child to attend school. As a consequence, the child becomes helpless and dependent and suffers the mental pain of watching his/her siblings going to school just because they are able to move normally;
• The school is not flexible to the needs of these children. Even if the school is located next doors the child has no access even to the mid day meal;
• Inadequate attention to the child, unsafe environment, no provision of required services and expecting all students to have normal behavior are some of the reasons some parents may prefer HBE over regular schools.

The Attitudes

The attitude of society towards CWD is the major challenge faced by them. The reasons for negative attitudes may be lack of knowledge regarding the disability, stereotypes and prejudices. The findings from the case studies are:

• There is a poor understanding of the disability condition and generally the diagnosis has been done late. This serves as a barrier to successful rehabilitation. These children grow up without early interventions and this affects their condition further and leads to strengthening of prejudicial beliefs;
• Disability is still considered to be punishment for sin. Most of the neighbours and teachers interviewed, although sympathetic on face, were of this opinion and considered the suffering of the family as a result of their karma;
• The severity of the condition and the unhygienic appearance including dirty clothes are significant factors in the formation of negative attitudes and negative socialisation;
• The mother of the child becomes the scapegoat and is blamed for bringing such a child in the world by her partner and in-laws. It was seen that the relationship between the parents were strained and generally the entire responsibility of this child and other siblings rests on the shoulders of the mother;
• In a way, it was noticed that there is dehumanization of these children in their family. They lie in one place and are at the mercy of family members for eating, drinking or going to toilet;

5 Neighbours attitude and involvement has also been considered under this.
• The self esteem/image of the children is poor as the family members exchange all negative conversations in front of the child without understanding that the child is not brain dead;
• As compared to urban blocks, tribal lack awareness and adequate knowledge of various provisions and needs of their children. They live in small habitations and are small communities. They have a distinct bend of mind for enjoying life and living day to day life. For them having a CWD is a responsibility they have to undertake and therefore they do their best in their circumstances;
• Attitudes towards girls with disabilities is more negative as two of the families interviewed conveyed that in spite of knowing that the child had disability we preferred not to abort since it was a boy;
• The appearance of the CWD governs the behavior of others towards him/her. Since most of these children are neglected in terms of cleanliness and hygiene, the others in the community try to avoid being near them;
• Teachers have a negative attitude towards inclusion of CWD. They feel that these children are not their responsibility. Teachers’ attitudes towards students with disabilities has a significant impact on their educational experience.

Resource Support

• There are no human resources in the form of physiotherapists, RTs or even volunteers to train the parents and visit the child. The child has to access the resource room, wherever it is situated with the help of parents;
• The transport allowance given to the parents is subject to 75 per cent attendance in the class which many a times is not achieved. So there is no provision for transport for these children;
• The state functionaries organize camps where assessment takes place. The children are also given equipment required. However, it was found that the wheelchairs given are not suitable for the child and require adaptations. Other than that no other devices and educational aids are given;
• Since most of these children have multiple disabilities and have great difficulties in sitting, walking speaking, eating and even going to toilet they required intense one to one early interventions and later support. However, there are very few RTs available and the teacher pupil ratio is very high. In some places one teacher was responsible for more than 100 children that also in different areas. The only best provision for these children is the BRC which is very far from their houses.

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**Conclusion**

The case studies of children under the HBE Programme in remote tribal areas and in slums has valuable implications for practice and intervention deriving from the analysis of interactions held with various stakeholders. This research has provided insights from 5 homes with CWD. However, the common findings from these case studies, together with the findings from the limited number of studies on HBE tend to suggest that educational practices for children under HBE need to be addressed better by the Government and NGOs for improving quality.
Chapter 1
Introduction

We all believe that Policy and Legislative frameworks can radically transform the lives of many, especially of those who are marginalized and vulnerable like persons with disabilities. There are a number of policy, educational initiatives and reforms aiming to provide equal rights and equal opportunities to this group. A significant change in society’s views on special education, from segregation to integration and finally to inclusion in education and society, throughout the world, has led to a global shift in methods used to address diverse learning needs, from a “deficit/medical model toward a philosophy of inclusion” which is based on the social model of disability which implies that disability is socially constructed by social attitudes, policies and practices. Despite all the initiatives taken by the Government and Non Governmental Organizations (NGOs) towards the facilitation of inclusive education, the progress has been slow. It needs to be mentioned here that although creation of inclusive schools was recommended in the NCERT’s National Curriculum Frameworks for school education (2000, 2005) and in NCERT’s position paper (2006), Rights of Persons with Disabilities Act, 2016 (RPWD Act, 2016) there are alternative modes of education, like Home Based Education (HBE) that have been recommended for children with disabilities (CWD) in the Policy and legislative initiatives. According to the National Policy on Education, 1986 (NPE)\(^1\)

..Wherever possible education of children with locomotor handicap and other mild handicaps will be common with that of others. The children with severe handicaps are proposed to be enrolled in special schools with hostels at district headquarters. Appropriate arrangements for pre-school preparation for the handicapped children and vocational preparation in common with others as well as in special vocational centres have also been envisaged.

In 2009, the Government of India passed the Right of Children to Free and Compulsory Education (RTE) Act, 2009. This is the Act that translates the vision of the fundamental right to education into reality. However one of the major loopholes of the Act from the perspective of special needs of the CWD is that the Act did not make any alternative or special provision for the education of children with high support needs. The definition of disability as recognized by the RTE Act (2009) was restricted to Persons with Disabilities Act (1995), and did not include the provisions for the persons regarded under the National Trust Act (1999). The amendment to the act was proposed and RTE Amendment Bill (2010) and was introduced in the legislature. The Bill was passed and it was given the stature of Act in 2012 and it came to be known as “The Right of Children to Free and Compulsory Education (Amendment) Act, 2012”. The amended Act provided for HBE of the multiple and severely disabled child. The amendment in section 3 of the Principal Act stated:

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\text{“ provided that a child with “multiple disabilities” referred to in clause (h) and a child with
“severe disability” referred to in clause (o) of Section 2 of the National Trust for Welfare of}\n\]

\(^1\) Retrieved from: [http://www.ncert.nic.in/oth_anoun/npe86.pdf](http://www.ncert.nic.in/oth_anoun/npe86.pdf).
Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 may also have the right to opt for home-based education”.

The Sarva Shiksha Abhiyan (SSA)\(^2\), launched in 2001 aimed to provide eight years of uninterrupted, good quality education to the children between ages 6-14 years and to have all children in school, learning and completing primary and upper primary education. The key thrust was on providing inclusive education to all children with special needs (CWSN) in general schools. SSA ensured that every child with special needs, irrespective of the kind, category and degree of disability, is provided quality inclusive education. It supported a wide range of approaches, options and strategies for education of CWSN. This includes special training, in the form of school readiness programmes for CWSN, education through special schools, home schooling, community based rehabilitation (CBR). The ultimate aim was to mainstream all CWSN in neighbourhood schools.

Since SSA was the main vehicle for implementation of RTE Act, under the section 3.12.3, there is an important component of Educational placement that states:

“Every child with special needs should be placed in the neighbourhood schools, with needed support services. CWSN need to be facilitated to acquire certain skills that will enable them to access elementary education as envisaged in the Act. For instance, they may need mobility training, training in Braille, sign language, postural training, etc. Thus, school preparedness of CWSN must be ensured by providing ‘special training’ as envisaged in the RTE Act. This training may be residential, non residential or even home based, as per their specific requirements. The existing non formal and alternate schooling (including HBE) options for children with disabilities can be recast as ‘special training’. This means that (a) all CWSN who are not enrolled in schools or have dropped out, will first be enrolled in a neighbourhood school (b) they will be entitled to ‘special training’ through regular teachers or teachers specifically appointed for the purpose (c) and then mainstremed in general schools along with their peers in the age-appropriate class\(^3\).”


The vision of RTE for CWSN to be implemented through SSA is given below:\(^4\):

After the RTE, HBE has been conceptualized as a means for special training of children with high support needs at home through regular teachers or teachers specifically appointed for the purpose and then mainstreamed in general schools along with their peers in the age-appropriate class.

The 12th 5-year plan\(^5\) considers exclusion as the single most important challenge in universalising elementary education. According to the 12th Plan document, the percentage of disabled out-of-school children (OoSC) was 34.19 in 2005 and remained unchanged at 34.12 per cent in 2009. The maximum numbers of OoSC are those with mental disabilities (48 per cent), followed by children with speech disabilities (37 per cent). The following were the interventions suggested:

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The Interventions in the 12th plan:

| Support for inclusive education will be continue to be provided at the rate of Rs 3000 per CWSN per annum, of which Rs 1000 will be available for engaging Resource Teachers. |
| Key thrust of SSA will be on inclusive education to children with special needs in general schools |
| **SSA will also support Special Training for school readiness of CWSN, education through open learning systems, and home schooling, wherever necessary, community based Rehabilitation (CBR) and vocational education. The involvement of Resource Institutions will be encouraged.** |
| The following activities will form components of the programme: |
| a. Identification of CWSN. |
| b. Educational placement in general school, school readiness programmes/ home based education |
| c. Provision of aids and appliances, as needed |
| d. Resource Teacher/ General Teacher Training |
| e. Individualized educational plan |
| f. Community mobilization, parental training, and peer sensitization. |
| g. Other interventions, such as development and production of Braille books, large print material or construction of ramps, disabled friendly toilets, etc. will be sourced from the regular budgets under the relevant components. |
| h. Engagement of resource teachers |
| i. Engagement of volunteers/care-givers for severe-profound CWSN |
| j. Involvement of NGO in CWSN related activities |

The recent Act called the Rights of Persons with Disabilities Act, 2016\(^6\) that gave effect to the UN Convention on the Rights of Persons with Disabilities\(^7\) stated that “the appropriate Government and local authorities shall ensure that every child with benchmark disability has access to free education in an appropriate environment till he attains the age of eighteen years.”

According to the Act, “high support” means an intensive support, physical, psychological and otherwise, which may be required by a person with benchmark disability for daily activities, to take independent and informed decision to access facilities and participating in all areas of life including education, employment, family and community life and treatment and therapy.

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The recent scheme of the Government called the Samagra Shiksha (SS) that integrates all the other schemes related to education of children also makes provision for HBE stating “While the RTE Act mandates inclusion of children with special needs (CwSN), some children with special needs are unable to attend school despite specific interventions designed for their education. The amendment of RTE Act (in August 2012) has included CwSN in the definition of disadvantaged groups. It includes children with severe - multiple disabilities with the right to HBE, thus creating an enabling environment for the children”.

**Home Based Education (HBE)**

HBE as mentioned above was considered as an important programme under the SSA as a bridge to inclusive schooling. SSA adopted a zero rejection policy for all children and for achieving this; it followed a multi- option model for CWD\(^9\). According to SSA (2006)\(^{10}\), no child having special needs should be deprived of the right to education and taught in an environment, which is best, suited to her/his learning needs. These include special schools, Education Guarantee Scheme (E.G.S.), Alternative and Innovative Education (A.I.E) or even HBE. SSA (2006) defined HBE in the following way:

“Generally home-based education is defined as the education of children with severe intellectual/physical disabilities, who can be educated in the combination of home-based and alternate educational settings to enable them to achieve independent living skills. Home-based education aims at school preparedness and preparation for life. Alternate educational settings provide opportunities for learning of social skills, vocational skills and implementation of life skills”.

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HBE, as an alternative mode of education was conceptualized to be supported by the following Institutions/organizations/people:

The broad objectives as envisaged by the SSA (2006) are:

- Parents become effective teachers;
- CWSN show progress in their overall development, including cognitive and language domain;
- Progress of CWSN can be evaluated through a carefully designed individualized programme;
- CWSN improve degree of eye-contact, expressive language and comprehension of instructions and communication skills;
- Disruptive behaviours on the part of CWSN are reduced;
- Parent - “expert” partnership builds mutual trust and sharing.
It was considered that children under the HBE programme would not be able to perform two or more of the following functions independently as compared to other children:

- Toileting
- Feeding
- Communication
- Motor Skills
- Basic social skills
- Self grooming

The following are the additional merits of HBE as proposed by SSA

<table>
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<tr>
<th>Common Merits of a Home-based Programme for CWSN</th>
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<tr>
<td>Families are full participants in all aspects of the planning, delivery, and evaluation of services;</td>
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<td>Increased emphasis on early identification and intervention services;</td>
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<tr>
<td>Children and families have access to a comprehensive and well-coordinated array of services that address the child and families' physical, emotional, social, and special needs</td>
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<tr>
<td>Once a child develops the basic Activities of Daily Living- ADL, services could be extended to the regular schools</td>
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<tr>
<td>Services should be integrated with all other child-serving programmes, agencies, and systems</td>
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<tr>
<td>Services are provided keeping in mind the linguistic needs, socio-cultural norms and values of each child and family.</td>
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Children under HBE

State-wise data on children enrolled in HBE is available in a report of SSA titled “Overview of Inclusive Education in SSA”. According to the report, in the year 2009-10, a total of 138,133 children were enrolled in HBE in India. West Bengal had the highest number of enrolment at 27,450 children in HBE. State standing next to the hierarchy is Assam with a record of 22,857 enrolment and Tamil Nadu with 22,843 children enrolled under HBE. Maharashtra had recorded a total enrolment of 11,412 during the same period. The state with the lowest enrolment with

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only 4 children enrolled is Goa. There were some States showing zero enrolment in HBE like Andhra Pradesh, Haryana, Jammu and Kashmir, Sikkim, Uttar Pradesh, Andaman and Nicobar Island, Dadar and Nagar Haveli and Delhi.

In another report it is mentioned that the enrolment of CWSN has gone up from 1.17 million in 2003-04 to 2.35 million (86.45 per cent of CWSN identified) in 2013-14. In addition, 33,900 CWSN are enrolled in school readiness programmes and 206,000 children were provided home-based education. The total coverage of CWSN is 2.6 million, which is 95.3 per cent of the total number of CWSN identified.\(^{13}\)

In the year 2015-16, household surveys and special surveys have been conducted by all states to identify CWSN. 27.79 lakh CWSN have been identified. 25.03 lakh CWSN (89.53% of those identified) are enrolled in schools in 2015-16. Further 69,881 children with special needs are being covered through School Readiness Programme and \textbf{1.16 lakh CWSN are being provided HBE}. In all 96.18% of the identified CWSN have been covered through various strategies\(^{14}\). Around 4 percent of the identified CWSN in all States are under the HBE Programme. The data given above shows a decrease under the HBE education from the year 2014 to the year 2015-16.

**HBE Status in Maharashtra**

Since this study was conducted in Maharashtra, the progress in 2016-17 in Maharashtra is as follows\(^ {15}\):

In the year 2016-17, the State had identified 298448 CWSN and the total budget provided the State was \text{Rs. 7642.17 lakh}. 286323 CWSN Enrolled in schools and \textbf{30125 CWSN covered through HBE}. In addition, the following activities were conducted in the area of inclusive education that included HBE:

- 408 Assessment Camps Conducted and 16544 CWSN given assistive devices
- 407 Resource Room are functional
- 816 BRPs and 1948 RTs are placed for academic supports for CWSN and Schools.
- 176 CWSN Girls are enrolled in KGBV
- All teachers have been given one day orientations workshops in I.E
- 40 State Key Resource Persons Trained on Curriculum adaptation
- 504 District Key Resource Persons Trained on Curriculum adaptation
- 1224 Block Resource Persons Trained on Curriculum adaptation
- 16256 Teachers Trained on Curriculum adaptation.
- Parental Awareness Programme given to 34697 Parents.
- 17773 SMC trained
- 30710 SMC member trained


\(^{15}\) The data was obtained through the SSA IED Coordinator under SSA.
• 51.60 % CWSN have IEPs
• 53% schools have CWSN enrolled in them
• 100% CWSN given Braille through NAB Mumbai and Large Print Book through Text book bureau Balbharati.
• 16256 Teachers trained on ICT tools and uses.
• 1117 CWSN corrective surgery done
• 18125 CWSN given Therapy support.
• 11191 CWSN given Transport support
• 21454 CWSN given Escort Support
• The State has Enrolled 700 CWSN under section 12 C of RTE2009
• Conversations with RMSA in assessment camp and celebrated Equal Opportunity Day.
• State has Celebrated World Disability Day as Equal Opportunity Day.
• CWSN participated in state level Sport Competition.
• Music Dance and Drama Training given to 100 BRPs.

However, the PAB (Project Advisory Board, SSA) approved the outlay of inclusive education for 254739 CWSN identified at a unit cost of Rs. 3000/- per child for the year 2016-17 for indicative activities as given below

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Activity</th>
<th>Unit Cost</th>
<th>Phy.</th>
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<td>1.</td>
<td>Assessment Camp</td>
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<td>2.</td>
<td>Surgery</td>
<td>0.10</td>
<td>3643</td>
<td>364.30</td>
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<td>3.</td>
<td>Aid and Appliances/ Equipment etc.</td>
<td>0.04</td>
<td>16509</td>
<td>671.09</td>
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<tr>
<td>4.</td>
<td>Repair &amp; Maintenance of aids &amp; appliances</td>
<td>0.50</td>
<td>57</td>
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<td>5.</td>
<td>Additional Cost of Braille Books</td>
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<td>3114</td>
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<td>6.</td>
<td>Additional Cost of Large Print Book</td>
<td>0.015</td>
<td>6618</td>
<td>99.27</td>
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<td>7.</td>
<td>Escort Allowance</td>
<td>0.025</td>
<td>22839</td>
<td>570.98</td>
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<td>8.</td>
<td>Transport Allowance</td>
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<td>11699</td>
<td>292.48</td>
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<td>9.</td>
<td>NCERT Module Residential Training for CWSN RPs at BRC and selected RTs for 5 days</td>
<td>0.010</td>
<td>1459</td>
<td>14.59</td>
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<td>10.</td>
<td>Residential Training for Primary Level Teacher on Curricular adaptations for 5 days</td>
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<tr>
<td>11.</td>
<td>Residential Training for Upper Primary Teacher on Curricular adaptations for 5 days</td>
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<td>12.</td>
<td>3 days BRC CWSN RP Training on ICT</td>
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<td>2 days Teacher Training on ICT</td>
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<td>19534</td>
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<td>14.</td>
<td>1-Day Parents training</td>
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<td>68803</td>
<td>68.80</td>
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<td>Salary of Resource Teacher (Existing)</td>
<td>0.205</td>
<td>1948</td>
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<td>16.</td>
<td>Hiring Therapy Services</td>
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<td>296</td>
<td>118.40</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>7642.17</strong></td>
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16 Minutes of the 236th meeting of the Project Approval Board held on 7th April, 2016 to consider the Annual Work Plan & Budget (AWP&B) 2016-17 of Sarva Shiksha Abhiyan (SSA) for the State of Maharashtra. Retrieved From: http://ssashagun.nic.in/docs/PAB/Maharashtra21661.pdf
The budget outlay above shows that there were no special provisions made in the budget for HBE. We all realize that it is a most challenging task to include children with high support needs in regular classroom settings along with other children. In spite of this, very few researches have been done in this area that highlight the issues related to children studying under HBE.

Parents have reported concerns with individualised attention and support available for their children in mainstream classrooms in the western countries (Lynch & Irvine, 2009; Starr, Foy, & Cramer, 2001). Murphy (2012) lamented that not much has actually been written on the question of home school mechanics among homeschoolers at large: ‘While attention has been lavished on the motivations for homeschooling and the demographics of these families, he remarked, considerably less work has been directed to “seeing” inside the home school’ (p. 106). This paucity of information is even more acute when it comes to CWD under the HBE programme in India. There are no studies available in India and even after the RTE Act, 2009, when HBE was included as a fundamental right of the child, the situation has not changed.

**Review of Literature**

Whilst the literature on home education has grown steadily there exists relatively little, and somewhat dated, research examining the home education of CWSN (Duffey, 2002; Duvall et al., 1997; Ensign, 2000; Reilly et al., 2002). Most of the literature that is available is from western countries where home schooling is an option available for non disabled children too. Initially, concern existed over parents lacking expertise and experience in teaching students with special education needs. These concerns however were soon overridden when home educated students with special needs were found to experience greater academic success than their peers with similar disabilities, who attend public schools (Blok, 2004; Duvall et al., 1997). One of the studies on home children with disabilities has been conducted by Reilly et al. (2002). In this study West Australian parents outlined the reasons behind their decisions to home educate their children with disabilities.

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educate. These included both child related (e.g., negative socialisation and difficulty to progress academically), and school related concerns (e.g., time and resource issues for assisting the child with psychological and academic needs). However, consistent among all parents using the home based educative method, and in confirmation of other contemporary studies incorporating CWSN and disabilities, (Duffey, 2002; Parsons & Lewis, 2010), was the benefit of flexibility and the ability to attend to individual learning needs which lead to enhanced social and academic progress for the child.

Julka, A. (2015) interviewed, 62 parents of children enrolled under the HBE interventions in the States of Rajasthan, Uttarakhand, Goa and Karnataka on issues like parents’ satisfaction with the programme, the problems faced by them in rearing up and educating their CWD at home, the benefits they derived and the suggestions they can make regarding the improvement of the programme for better development of their child. Analysis revealed that although parents welcomed the interventions being provided and were also coping with the problems after consulting the resource teacher/volunteer/caretakers, they felt that the training given to them or also to the resource provider was not adequate, the financial and other provisions were not sufficient, the frequency of visits of the resource provider needed to be increased and the child should get the opportunity of going to a school after building up the basic skills. The parents also had very low expectations from their child and showed a lot of pessimism in spite of the interventions.

Ali, S.L (2016) conducted an investigation in to the Implementation of HBE for CWSN provided by Inclusive Education Resource Persons (IERPs) of SSA in Mahabubnager District. The study was conducted on a sample of 21 IERPs (Inclusive Education Resource Persons), 89 CWSN children, 81 parents and 10 officials. The results indicate that the present implementation of HBE is not sufficient for the multiple disorder children. The SSA efforts have created a system but the multiple disorder children need more training for progress of their skills which meet their daily life routine. The same thing was expressed by the sectoral officers, MEOs, Parents and IERPs. Hence, the frequency of HBE visits should be increased and it is better to conduct HBE daily. For this purpose trained volunteers should be recruited and they should be assigned to HBE regularly. In order to monitor the HBE, the government should fix monitoring mechanism with trained personnel in IE activities.

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Kidd, T. and Kaczmarek, E. (2010) conducted a qualitative study to explore mothers’ perspectives of home educating a child with Autism Spectrum Disorder (ASD). Ten mothers were interviewed using a qualitative research design within a phenomenological framework. A thematic content analysis identified three main themes; ‘school experience’, ‘coming home’ and ‘mother’s experience as educator’. Mothers commented that educating their child at home lead to improvements in their child’s behavioural and psychological wellbeing. The experience of home educating was influenced by the children’s school experiences, parents’ perceived choice to home educate and level of educative and social support available. On the other hand, majority of the mothers in this study highlighted the juggling of roles required of them reflecting on the complexity of being an educator mother and one who oversees the day to day running of the household. In addition the study also found that whilst some mothers said that they did not need educational support to help them with home education, others had tried to attain it, often to no avail. Finally, it was seen that consistent with McDowell’s (2000) finding, two of ten mothers who felt ‘forced’ into home education viewed the experience in a more negative way.

Parsons, S. and Lewis, A. (2010) created an online survey for homeschooling families with special needs kids and got 27 British parents to fill it out. They found that majority of these families pulled their child out of school because of a felt sense that the child’s unique needs were not being adequately addressed. Two-thirds of them were not ideologically committed to homeschooling (and many had other children still in school), but turned to it out of frustration with institutional schooling, what the authors call the “push factor.” As one mother put it, “We are not choosing home education as an alternative lifestyle choice, but have been left with no other acceptable option.” (p. 77) what is pushing these parents away? The most frequently cited reason was child unhappiness, stress, or depression at school, followed closely by bullying.

Similarly, it was found by other researchers that the main motivation for many parents to choose home school was that their children’s special education needs simply were not being met (Arora, 2006; Duffey, 2002; Hurlbutt, 2011; Olsen, 2008; Parks, 2009; Parsons & Lewis, 2010; Reilly et al., 2002). Hurlbutt, (2011) stated that a chief concern of parents of children

The experiences of mothers home educating their children with autism spectrum disorder. Retrieved from: https://pdfs.semanticscholar.org/1e8d/7e3a3c68e9e5aebb12b89a7cc3b8096e1198.pdf


with ASD was that schools were either unwilling or unable to provide therapies or treatments that parents considered effective. In addition, parents also attributed negative experiences with public schools as a deciding factor in choosing to home school (Duffey, 2002; Parsons & Lewis 2010). Other reasons for homeschooling included avoiding the stigma of a labeled disability (Ensign, 2000; Olsen, 2008).

Obeng (2010) found that parents did not receive enough professional and social support, and as a result, they were feeling overwhelmed with sadness and frustration. Obeng concluded that while many other factors may influence the intensity of homeschooling challenges, certainly the severity of the child’s needs and the amount of support available to the family are two major components that will affect the success of the home school program.

Olsen (2008) in a interview of educators in Canadian schools indicated mostly negative opinions about students that had been removed from their schools for homeschooling. Administrators reported being aware that parents probably did not share their real reasons for choosing to home school, but also expressed frustration with parents for not working with the school to resolve problems. On the other hand, Olsen (2008) found that parents reported not feeling genuinely welcomed to ask for support from schools, even though some administrators offered part time classes and the opportunity to reenroll students. Overall, most of the educators reported negative views on homeschooling.

Sofia (2010) narrated a personal account of her experiences of homeschooling her son with ASD, and described her frustrations with her son’s fourth grade teachers. Sofia felt that the teachers expected all students to have normal behavior and placed inordinately high value on student compliance as a measure of success. Rather than providing differentiated instruction, teachers blamed her son’s inappropriate behavior for his lack of progress.

Cook, K.B., Bennett, K.E. Lane, J D. and Matarasa T. K. stated that the common conclusion among studies was that a collaborative relationship between home schools and school systems would be beneficial for students with disabilities (Arora, 2006; Duffey, 2002; Olson, 2008; Parks, 2009).
Loten (2011) and other researchers concluded that public schools might prevent some loss of students to home schools by increasing individualized instruction. Of special concern are families whose children have severe disabilities. Obeng (2010) concluded that parents who home school children with extensive medical needs would also benefit from psychotherapy and other supports to maintain their own health.

Researches on home schooling reviewed by Cook, K.B., Bennett, K.E. Lane, J D. and Matarasa T. K. found that some of the many benefits of homeschooling are greater parent involvement, a strengthening of the family unit, opportunities for more natural learning experiences, increased self esteem in students with disabilities, increased individualization and student paced learning, and increased flexibility with family schedules (Peterson, 2009; Romanowski, 2001). However, the review also shows that the challenges include making curriculum decisions, managing finances, accessing special education services, facilitating socialization opportunities, and finding connections with other parents for support.

Pavlides (2014) found that for families of CWD, the decision to home school may not come as a first choice in education, but as a result of feeling that other avenues of schooling are closed to them. He found that “home educators of CWSN are often confused about their own role in the educational system. From a legislative point of view, parents who choose to utilize home education for their CWD seem to do so with either no state guidance or support or with paralyzing state control”. In India, parents of the CWD may decide on HBE when they feel lack of support services that would meet the special needs of the child at the regular school. A lack of an inclusive environment in the formal schools also attracts the Indian parents towards the option of home schooling. They expect the child will be protected from ridicule and they may not have to spend time accompanying him/her to school every day. In the developed countries, the motivation of parents is the opportunity of getting a truly individualized attention necessary for the child’s growth both academically, and socially and as a result, improving performance.

A very similar finding of Duffey (2002), was that the dissatisfaction of parents with conventional schooling and feeling that their home to be a more suitable environment. A

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negative experience in school, poor reputation of the public schools, noncompliance of schools to provide required services, inadequate attention to child, failure to meet child’s needs, and an unsafe environment are some of the other prominent reasons that the study found that led to the choice of homeschooling. The most frequently ticked motivation (for just under half of the group) was ‘child was unhappy/stressed/depressed at school’ with others citing bullying; child wanting to be educated at home or being able to develop or work at their own pace (Parsons et. al., 2009).

Jolley et.al., (2012)\textsuperscript{36} found that the parents before opting home schooling to formal school education has made numerous attempts to work in collaboration with the public schools to make the schooling experience of their children a success. Following a failure in their attempts the parents decided for home schooling. Dissatisfaction with the school curriculum is another profound reason behind parents opting for home school. The study found three most important contemporary reasons for increasing number of CWSN children homeschooling- religious reasons, poor learning environment in school and dissatisfaction with the curriculum.

Though there is no literature available about who takes the decision to home school the child. The literature is, however, available to indicate that in most of the families it is the mother who is responsible for the education of these children at home. Jolly E.T. al., (2012) found that the mothers bore the primary burden of responsibility for homeschooling in these families. They were responsible for the overall coordination, planning and execution of homeschooling. They also assumed the responsibility of arranging the extracurricular activities, finding the social peer for their child. Working mothers had to make arrangements in their work if they decided to home school their child. It was also found that the mothers, due to overburden with the responsibility of home schooling the child and the household work, were left with no time for themselves and often felt frustrated with their life. Duffey (2002) also had a similar finding. However the educational level of the fathers in the general population was slightly higher (15.6 to 14.8 years) as was the mother’s level (14.7 to 14.3 years).

Khairul Azhar Jamaludin, Norlidah Alias and Dorothy DeWitt (2015)\textsuperscript{37} mapped the trends of the current studies in the area of homeschooling development and practices, through the analysis of the research settings, sample selection, methods and instruments, focus and issues covered as well as the similarities and differences in the selected studies. Although the studies were all conducted in the United States, they indicated that homeschooling has offered a flexible learning for children who might face difficulties in traditional schooling. Issues such as racism, special needs in learning, and incompetency of traditional learning were able to be resolved through homeschooling implementation. However, there are still areas that can be improved


such as in maximizing the support material and other educational supports from the government. Also, informational and communication technology has a brighter potential to further develop a strong learning community and access to relevant materials to homeschooling learning.

Korkmaz and Duman (2014) highlighted that the parents who wish to home school their children still require support from the government in term of materials, financial and chances to attend some classes in public school. In addition, Blok and Karsten (2011) claims that homeschooling inspections are needed to accommodate and monitor children’s learning. The monitoring and mentoring by the government is relevant in maximizing the ‘quality’ of homeschooling learning and to avoid them to be left behind from public schooling.

In India, unlike the west, HBE is the only option available for children with high support needs. As stated by Aarth-Astha, an organisation working on the issues of disability writes:

“Such an option is likely to foster great social isolation, exclusion from community and peers and devalue the child. It is likely to exclude the child from many other entitlements and also expose the child to a lack of protection that social isolation brings. The quality of life of any child will be seriously compromised if we isolate them at home”.

Conclusion
In light of the HBE being included under the RTE, 2009, it is expected that increased support in the form of special education services from schools would serve to improve the HBE experiences of many students with disabilities. In addition, it is expected that improved relationships between neighbourhood schools and families of children with disabilities would result in parents choosing HBE for the right reasons—not as an only option available for their children. The studies given above show that home schooling is widely practiced in the west where parents withdraw their children from schools for more individualized attention. However, in India, this is the only option available for some children who have severe multiple disabilities and high support needs. The findings of the studies given above reveal the following reasons for choosing home schooling: Bullying by other students; not being welcome in school and depression associated with it; academic needs not being met in schools; high value on students’ compliance as a measure of success, negative experiences and inadequate attention to child in school and unsafe environment. All these reasons lead to pushing the child out of the school. Some of the benefits stated are: flexibility and opportunity to attend to individual


needs of the child, greater parental involvement; opportunity for more natural learning experiences and increased self esteem. Finally the disadvantages include: parents and support staff not adequately trained; mothers bearing the entire responsibility leading to increased burden on them of looking after the house, responsibility of other siblings and looking after this child at home; difficulties faced in making curriculum decisions, managing finances and mobilizing support; lack of socializing opportunities and finding connections with other parents.

To conclude, it becomes clear from the review given above that some of the factors that can impact the choice and implementation of HBE includes: the amount of support available, collaborative relationships between school and home, mental health of parents, and use of ICT for HBE.
Chapter 2
Methodology

In the past few years there has been a significant change in the society’s views on education of CWD. Globally, the strategies used to address the diverse learning needs have been changing from segregation to integration and to inclusion. These changes are linked with paradigm shifts in attitudes from a pathological/medical view of ‘persons with disabilities’ as dependents on society to social models wherein disability is considered to be a consequence of environmental, societal and attitudinal barriers that restricts full and free participation of persons with disabilities in society.

CWSN form a very important group under the SSA and now SS programme that emphasizes providing inclusive education to all CWSN in general schools. SSA ensures that every child with special needs, irrespective of the kind, category and degree of disability, is provided quality inclusive education. However it also supports a wide range of approaches, options and strategies for education of CWSN. This includes special training, in the form of school readiness programmes for CWSN, education through special schools, home schooling, community based rehabilitation (CBR). The ultimate aim of all these provisions is to mainstream all CWSN in neighbourhood schools.

In the revised framework of SSA, the existing non-formal and alternate schooling (HBE) options for children with disabilities can be recast as ‘special training’. This means that (a) all CWSN who are not enrolled or have dropped out will be enrolled in a neighbourhood school (b) they will be entitled to ‘special training’ through regular teachers or teachers specifically appointed for the purpose (c) and then mainstreamed in general schools along with their peers in the age-appropriate class.

The present study is an attempt to understand the effectiveness of HBE programme as it exists today by talking to the parents, teachers, administrators and other stakeholders and through observations of the households. There is very little research in this area especially after the RTE amendment in 2012. Since HBE was included under the RTE after a lot of advocacy by certain group of experts from the voluntary sector, it would be helpful to know how the lives of CWD have changed under the HBE Programme. The present study would explore various angles and perspectives in describing and justifying the relevancy of HBE as an alternative education system for CWD.

41 Framework of SSA
Methodology

Objectives
The study would explore how the presence of CWD under home education practices affect the parents, teachers/resource teachers, schools and community members in remote tribal, dominated areas and urban slum areas and the resources are being provided for meeting their needs.

Specifically the objectives of the present study are:

1. To assess how the tribal and poor backgrounds effects the provisions and other factors related to the family, teachers and community members of a CWD under the HBE programme.
2. To analyze views and perspectives of resource teachers, parents and community members regarding the implementation of home based practices over the years and about the provisions especially after its inclusion under the RTE Act.

Sample
The sample for this exploratory study was 5 students living in the remote Scheduled tribe dominated areas and from slums of Maharashtra. Various houses where children were under the HBE in remote areas in the State were visited and the final sample for case studies was selected on the basis of number of factors like: identifying children staying in tribal areas and enrolled under HBE, willingness of the Parents to participate in the study, accessibility of the home through public transport and provisions for staying overnight by the programme coordinator in the village for observation and intense interactions with the stakeholders.

Interactions were held with parents of 20 households before 5 students were selected for preparing case studies. The places visited for selecting the children were: Chandrapur and Gadchiroli Districts in Nagpur, Pune, Shahpur town in Thane District, Igatpuri in Nashik District, Jawhar and Palghar district, Alibag, a municipal council in Raigad District and Dharavi and Ghatkopar slums in Mumbai.

Methodological Strategy

- A focused literature review was conducted to provide a policy and legislative context for the supports available for CWD under HBE in Maharashtra;
- Various ST concentrated Districts and urban slum areas were visited and out of 20 children visited, 5 were selected for deeper case studies;
- Case Study semi structured interview schedules based on the various components under the SSA and literature review were formulated utilising questions designed to elicit a rich description of the participants’ experience for parents, teachers and community members (See Annexure 1). Data was also collected through the combination on different levels of techniques, methods, strategies, like focus group discussions and observations and from secondary sources. An observation checklist was also prepared;
- The case studies were written based on a thematic analysis of all the interview content was performed;
- Information gathered under the case studies was also validated from secondary sources.
- A road map for further action/interventions was prepared and discussed with States for implementation.
**Procedure**

Participants in the case study were selected after taking consent of the parents. Semi-structured interviews were conducted and also video graphed. The interviews with the participants who were parents, teachers in the school and community members lasted for nearly 45 minutes. Following each interview, the reflections and impressions were documented to assist in analysis.

**Analysis of Data**

The interview transcripts were read a number of times and thematic content analysis techniques were employed to analyze the data. The videos developed were watched a number of times to assist in analysis. The information gained through the interviews was also validated through secondary sources like officially prepared case history of the child, other records in the office and discussions with the administrators coordinating the HBE Programme at the District block and village levels.
Chapter 3
Results and Analysis

The aim of the project was to highlight the experiences of HBE through case studies and to explore the meaning of HBE for the participants and for the system at large. In the present context, this involved the child under HBE, parents, family members, teacher, administrators and community members. The name of the child in the case study has been changed; information that may be particularly sensitive and personal has been deleted. Some photographs have been given to explain the situation. The method used to develop case study is triangulation, and a combination on different levels of techniques, methods, strategies, or themes has been used.

Case Study 1

The Context

A village called Junijwahar located in Jawahar Taluka in the backward area of Palghar District of Maharashtra is the residence of Varali tribe. According to Census 2011, the location code or village code of Juni Jawhar village is 551931. The village is situated 3 kms away from sub-district headquarter Jawhar and 107 km away from district headquarter Thane. As per 2009 stats, Juni Jawhar village is also a gram panchayat.
The total geographical area of village is 696 hectares. Juni Jawhar has a total population of 382 peoples. There are about 80 houses in Juni Jawhar village. Jawhar is nearest town to Juni Jawhar which is approximately 5 kms. away. Juni Jawhar village has lower literacy rate and in 2011, the literacy rate of Juni Jawhar village was 65.41 % compared to 82.34 % of Maharashtra. The male literacy stands at 75.64 % while the female literacy rate was 55.56 %. Schedule Tribe (ST) constitutes 96.07 % of total population in Juni Jawhar village. The Warlis or Varlis are an indigenous tribe, living in mountainous as well as coastal areas of Maharashtra-Gujarat border and surrounding areas. They have their own animistic beliefs, life, customs and traditions. As a result of acculturation they have adopted many Hindu beliefs and follow Hindu religion and festivals. The Warlis earlier used to speak an unwritten Varli language but now they are communicating in Marathi language with local dialects.

The Child

Sushil (name changed), born in the year 2007, is a child residing in Junijawahar village in Jawahar Block. Both the parents of Sushil are illiterate. His father Ram (name changed) is a farmer and also works as daily wage labourer. Sushil’s mother is a housewife. His grandparents and two siblings, one elder to him in class 8th and one younger to him in class 3rd also stay with Sushil.

The medical certificate of Sushil diagnosed him as having intellectual disability and CP. The term used to describe him in various papers is multiply disabled. His medical certificate was issued by V.S.Hospital which is a civil hospital in Thane in the year 2015, 8 years after his birth. Although this was denied by the state office who claimed that he was identified at birth. According to them the child is under HBE since last 5 years. He was diagnosed as having an IQ of 50 and 60 per cent disability. It was not clear how the conclusion of having an IQ of 50 was reached although some observations were made in the certificate but not proof of any testing was there. He was also assessed through the Directorate of Primary Education for getting benefits under the SSA.

Sushil is detected with multiple disability- intellectual disability and macrocephaly (a condition in which the head is abnormally large - circumference 2.5 standard deviations above the normal). Macrocephaly can be caused by congenital anatomic abnormalities, genetic conditions, or even by environmental events. Other associated problems that Sushil has are that he is unable to sit without the modified CP chair. He cannot walk or stand. After the intervention of the resource teacher, who comes twice every week, Sushil is able to walk a few steps when someone holds his hand. The resource teacher visiting the child teaches him to sit and use the modified chair. He does not speak much but can listen and respond to people when called by name. When called he tries to find out the direction and source of the sound by turning his head slowly.

Observation of Sushil at his home revealed that he is physically small in size for his age and is carried by his mother from one place to another. Although he cannot speak, he responds to his name and also connects with family members through gestures. He has a very poor grip even then he tries to hold things that are given in his hand. He is a quiet and shy child but over years is able to speak a few words like ta ta, bye bye. As per the State functionaries, Sushil had poor eye hand coordination, could not walk or talk and that is why he was referred to the Civil Hospital for certification.

Sushil is unable to perform any activity completely on his own like going to toilet and eating and has to be supported by his family member to perform various daily living activities. He is enrolled in class 5th of the regular school in the neighbourhood. Though he appeared to be clean but he was not dressed in proper clothes. His clothes appeared to be oversized for him and seemed to belong to his brothers.
The House

THE INSIDE OF THE HOUSE
Sushil’s house is a mud house with thatched roof. The house has two large rooms and a small room used for cooking. Having a large house in the particular area is not very uncommon. All the surrounding houses are also equally big but bigger house does not indicate a good economic condition of the family. The house though big is almost empty and has only one bed (no mattress), a television and a table, Sushil’s modified wheel chair and some utensils in the kitchen room.

The house is located near other houses and the community members are good to Sushil in general. Everyone gathered around Sushil’s house when the visit was made and were listening to the conversations.

**The Family**

The family of Sushil comprises of parents, grandmother, and two siblings. The responsibility of looking after the child is mainly on the mother who stays at home and looks after Sushil and her other two children. The grandmother is also supportive and appears to be the main decision maker in the house. The parents are not aware about the kind of disability Sushil has. When asked about it, the father said that their son is not like other children and has some problem. The father presently works as an agricultural labourer.

Sushil’s mother Pushpa (name changed); when interviewed, said she became aware of the fact that the child had some problem when she was just 5 months pregnant. She didn’t want to
abort the child and decided to give birth to him and look after him. She is still hopeful that he may become something in life and protects him from being teased and bullied. She is very concerned about him and is keen to learn about the techniques that would bring improvement in Sushil and makes every effort to look after his needs. During the visit, Pushpa was the only one in the family who was curious to know about the disability of Sushil. Although he goes to school with his brother or mother sometimes, his classmates or children in the neighbourhood and even sometimes his brother bully him by snatching stuff from his hand or by teasing him. Sushil also responds to this bullying by either bursting into crying or by beating them. He gets angry on being pushed around by his brothers. They do not teach him anything at home and as a result there is no education for him.

Sushil’s grandmother is the most vocal person in the house and during the interview with the mother; she was the one answering most of the questions. She also expressed her concern regarding the help from the Government. She felt that the child can improve if he is operated upon. However, she said “हम लोग बहुत गरीब है और अपने आप कुछ नहीं कर सकते। सरकार को हमारी पैसे से मदद करनी चाहिये” (we are very poor and cannot do this on our own. Government should provide financial help for this). She felt after surgery, Sushil will be able to carry out many activities on his own. Even when the resource teacher visits, she interacts with the grandmother as father goes for work and mother doesn’t speak much.

In spite of the disability, Sushil appeared to be protected by his family and the parents were interested to learn the techniques that would be beneficial for him and lead to his improvement. One thing that was surprising was that Sushil goes for call of nature only twice or maximum thrice a week. According to the parents this was because he does not eat much and therefore doesn’t need to go to the toilet on daily basis.

**The School**

Sushil is enrolled in Jila Parishad Prathmic Vidalaya which is about 200 meters from his home but he does not go there on regular basis. He goes there mostly for meals, plays around and comes back. He is taken on a wheel chair by his brother. The parents’ of majority of students in the school are from the neighbourhood and involved in agriculture labourer.
Three teachers teaching in the school were interviewed and they said Sushil was the only child with disability who came to school. According to them, Sushil does not learn anything in the
school nor they themselves know how and what to teach him. He enjoys coming to school and is playful with other children. He understands if anyone taunts him and starts crying or gets angry. He just comes and sits on the floor as he is unable to sit on the chair (there is no adapted furniture available for him). Sometimes he just lies down on the floor. The special educators assigned to the village comes once in a while (once in a month) and gives him toys and makes him do some exercises.

His brother looks after him in school and sometimes his mother also comes. The teachers felt it was very difficult for them to give specific attention to Sushil as they didn’t have the time. They felt that special educators should take the responsibility of such children or they should study in a special class or a special school. However, they pointed out that the other children were friendly to him and he learns a number of things watching them for example how to eat and drink etc. They take him to toilet and look after him. The teachers were also of the opinion that they require training if they have to include such children in their class. One of the teachers expressed:

“हमारी कोई ट्रेहनिंग नहीं है तो हम उसे पढ़ा नहीं सकते। वो कभी भी आता और जाता है। हमारे पास कक्षा में बहुत बच्चे हैं और उसकी जरूरत को नहीं पूरा कर सकते। वो दूसरे बच्चों के साथ खुश रहता है। वो सब उसको देखते हैं और अचूक व्यवहार करते हैं।”

(It is difficult for us to educate Sushil as we have no training of special education. He comes on his own and goes back on his own timings. We have too many children in the class and cannot look after his needs. He enjoys being with other children. They all protect him and are good to him.)

The Neighbours
In Sushil’s village, the houses are located near to each other and every person knows the person next door. Although the children from the neighbourhood do not play with Sushil, they do smile at him whenever they see him and he also responds to them by saying bye bye, ta ta. The neighbours interviewed were sympathetic towards the family and felt sorry for them. They also expressed that this is a result of their karma/destiny and nobody could do anything about it. They also do not interfere in any actions of the family. In fact, they extend support if they are asked to do so by the family.

The Attitude
Interactions with the family revealed that the parents of Sushil and the grandmother had a positive attitude towards education of their children. The grandmother said:

“पहले ज्ञानन्द में हमारे घर के पास स्कूल नहीं थे और बच्चे हमें खेती और जानवर देखने में मदद करते थे। स्कूल दूर-दूर थे और हमें पढाई की अहमियत का पता नहीं था। इसलिए मेरी बहु और दामाद अनपढ़ है।”
(In earlier times we had no schools nearby and our children used to help us with farming, looking after our animals. Schools were located very far and we were not so aware about the importance of education. That is the reason my son and daughter in law are illiterate.)

While talking to the grandmother it was also revealed that although Sushil’s disability was known even during pregnancy, but the fact that the child was a boy made them take the decision to keep him. According to the grandmother, “लड़का था तो हमने उसे रखने का सोचा.” (Because he was a boy we thought of keeping him). This showed that even in a remote tribal place like Jawahar, boys are valued more as compared to girls even if they are disabled.

The parents also revealed that they do not take the child to any gatherings or functions of the village. The mother only takes him to her parents’ house whenever she visits them. The neighbours also show a lot of sympathy to the family and counsel them by saying that it is your destiny. The family takes no help from the neighbours in the upbringing of the child.

**Resource Support**
Sushil has been given a wheel/ CP chair by AIMCO in collaboration with the SSA two years back. Sushil sits on the chair, which is too big for him, for not more than 1-2 hours every day. There is no transport given to the child for going to school. A very small amount of money in the name of transport allowance is given to the parents but it is difficult for parents to arrange a transport to take the child to school and bring him back every day. Other than that, there is no teaching learning material (TLM) given, any assistive devices etc. Even in the regular school nothing is provided for the child. The resource teacher, who has 15 more children to visit, comes very infrequently to visit and may bring some toys and games with him/her. S/he generally comes in the presence of mother or grandmother. When interviewed the resource teacher (RT) said that he has made Sushil do a number of exercises and trained him to sit on the adjusted wheel chair. He has also taught him to walk though if he tries to walk, he does that in a very clumsy manner and only by holding hands for support. According to the RT, earlier, Sushil had a very poor grip and was unable to hold anything. But after a few months of intervention he is now able to hold certain things and also plays with colourful balls. The mother also helps him with a number of exercises.

**Issues**
After interacting with the administrators, RT, school teacher, parents and community members and after analyzing the records etc. it was found that although Sushil has multiple disability he is not brain dead. There are some issues that need to be addressed which are given below:

- The child was identified late for placing under HBE Programme. Although born in 2007, he was identified to be a part of HBE IN 2015 when he was already 8 years old. This has deprived him of early intervention which would have helped him to develop his milestones better.
- Although he is enrolled in regular school, he visits the school infrequently and whenever he is there he is not taught anything. He just has his meal and sits with other children for one or two hours.
- The wheelchair (modified) provided to him is too big for him. He needs to be tied to it and then also there is a danger of his tilting on sides.
- Actual transport is very difficult to arrange and that hampers his movement to and fro school.
- Parents have no training or inputs on how to help in developing their child’s daily living and other skills.
- Society is indifferent to the needs of the parents. Most of the time if they interact with the family they express sympathy.
- There is no meaningful support being provided through the RT. She has 15 children to visit and as a result there are long gaps between her visits.
- As the child grows older, he becomes heavier and difficult to carry. His nutrition is minimized to lessen the burden of taking him to the toilet again and again. He goes for his natural call only twice or thrice a week.
Case Study 2

The Context

Ghutewadi is a hamlet (Pala) located in Shahpur, Distt. Thane in Maharashtra. It is a small hamlet hosting 15-20 houses having only people of the same tribe living there. It has a primary school which caters to the population of this hamlet. The tribe located here is the Katkari tribe that generally likes to settle near the river for catching fish.

Shahpur is one of the seven talukas in Thane District. The Shahapur Town has population of 11,623 of which 5,930 are males while 5,693 are females as per report released by Census India 2011. Shahpur Taluka has around 571 schools which are private schools, Zila Parishad schools and Shalas for tribal children. The population consists of OBCs, SCs, STs and Muslims and Thakurs. The most backward tribe in India, Katkari is settled in Raigad and Thane districts of Maharashtra. This primitive forest tribe is also known as 'encroachers.'

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43 Retrieved From: https://www.census2011.co.in/data/town/552914-shahapur-maharashtra.html
<table>
<thead>
<tr>
<th>Sr.No</th>
<th>Name of the district</th>
<th>Percentage population</th>
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<td>Others</td>
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<td>7.</td>
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</table>

*Source Patnaik (2004)*

The tribal people are laborers and firewood sellers and experts in hunting and gathering. Stone crushing, tree felling and charcoal making are the other occupations. Today, most of the people are engaged in brick making. Much of the time is spend on alcohol and entertainment. Early marriage is their custom. The huts are made of mud with a peaked roof covered with palm leaves.

All sorts of flesh, except the cow and the brown faced monkey, are eaten. The tribe is a carefree tribe and get married very early sometimes at the age of 15-16 years. Many of the tribal people stay out of villages for 4 to 5 months for work. These migratory tribes also carry their children along when they leave village. Ghutewadi is a hamlet of few houses and the habitants are tribal. They speak Katkari, or Kathodi- Maharashtrian dialect. Most Katkari people are landless workers with only periodic and tenuous connections to their original nomadic, forest-based livelihoods. The food habits of the Katkari are a reason for their social exclusion.

There are around 1100 CWSN in this taluka, and for these 1100 children there are only 8 RTs. Out of these there are around 12 children under HBE and the rest of the CWSN go to regular schools.

**The Child**
Dinesh (name changed) is a 15 year old child born in Ghutewadi habitat. His delivery took place at home through a local nurse and his mother being illiterate and poor could not organize good medical facilities. The umbilical cord got severed but Dinesh kept bleeding for a long time. The mother feels that because of lack of medical facilities, Dinesh got a seizure after 5 days of birth. Although he was taken to the doctor, his seizures continued for a long time and though reduced now are still continuing.

As a result of his seizures, he had slow milestones and was unable to walk or talk for two and a half years. He was diagnosed at the age of 10 years in the Civil Hospital, Distt. Thane as intellectually disabled. The associated problems include the problem of constant drooling, not being able to speak anything and having very little understanding of things. However, he can eat solid things like roti which does not spill on his own without assistance but if he has to eat rice or similar things, someone else has to feed him. Dinesh appeared to be of shy nature and never initiates any conversation. His only mode of conversation is through signs or by nodding his head. When a person speaks to him he understands that the person is talking to him and responds with a smile. The child has been given some medicine which he has to eat twice daily for his fits. Since the medicine is expensive, his mother only gives him once a day instead of twice. The mother expressed that she didn’t expect him to live for long given his condition but he was destined to live and is living.

Dinesh was admitted to the school when he was 9 years old. His name is written in the school register but he hardly goes there. Mostly, he just goes there for a meal and comes back. He never sits there with other children. He lost his father when he was 11 years old and the whole responsibility of looking after the house and Dinesh came on the mother. She does a number of things for earning money. She cooks the mid day meal in the school, works as a labourer and also sells liquor. Whatever she does, she takes Dinesh along as there is no one to look after him although Dinesh has an elder brother.

Dinesh has a lot of health issues and gets sick after every 15 days. He is admitted in hospital during his sickness. As a result of no detention policy Dinesh completed class 1V in the neighbourhood school and at present, is enrolled in class VIII in upper primary school which is around 5 kms away but he never goes there. He just keeps roaming about here and there. He has been under the HBE Programme since last 5 years.

Dinesh is unable to understand when to stop eating. He can eat anytime and anywhere. He is aggressive sometimes and hits other children who seem to be afraid of him. He has no control over his actions and is not toilet trained. He urinates in front of anyone with his clothes on. As a result, he remains dirty and other children do not want to play with him. Dinesh only sits in one place when he has to eat otherwise he just roams about the whole day. He keeps calling his brother’s name.
The House
In a small hamlet of tribals where there are just 15-20 houses, Dinesh’s house is made of mud and a thatched roof.

Dinesh with his brother and sister-in-law
Dinesh going around on his own

Dinesh’s House
A SMALL HAMLET WITH 15-20 HOUSES
THE BARE INSIDE OF THE HOUSE
There is no furniture except a plastic chair. Most of the time, the family eats and sleeps on the floor. There is only one big room and a small verandah. The floor is made of mud there is no separate kitchen and toilet. They go in the open for call of nature. Even the hamlet is primitive, cramped and filthy. The house was not clean involving a number of health hazards and there was utter lack of privacy. While talking to the parents, one could see anyone entering the house and listening to the conversation. The house lacks the basic amenities. Also, not many medical facilities are available in the neighbourhood and are expensive if available.

The Family
The family of Dinesh comprises of his mother, a sister and a brother. The sister studies in the school and the brother lives separately in another house in the same hamlet with his wife and child. There is no sustainable livelihood and the family depends completely on the mother who earns through wage labour (cooking mid day meal) and by selling liquor. The elder son, Dinesh’s brother, attended school till class seventh and then dropped out. He married early at the age of 17 years. He also has no means of income and is dependent on his mother for money to run his household. He stays separately with his wife and a young child. Compared to his mother’s house he stays in a pucca house.
Dinesh’s mother was very friendly and willing to talk about her son. She is the busiest person in the family. Her husband committed suicide when Dinesh was 11 years old. After that she had the entire responsibility of looking after her three children. Her elder son who is a smart boy and well versed with the latest fashions and gadgets does not work and takes money from his mother. He is also abusive to his mother when she expresses her inability to support his family. The mother blames the mid wife who came to deliver her baby as the main reason for her problems. She expressed:
“र्ये हमारी क्रिस्म्यत या हमारा कर्म है। मैं दाई को जिम्मेदार समझती हूँ। उसे कुछ आता नहीं था और इसलिए मेरा बेटा ऐसा है।"

(It is not our luck or our karma. I blame the Dayi who came to the house to for my delivery. She had no knowledge of how to go about it and it is because of her, my child became like this).

She also admits that:

“मैं और मेरा पति कई जगह बच्चे को लेकर गये। बाद में पैसे नहीं होने के कारण हम उसकी ट्रीटमेंट नहीं कर सके। अब मैं सिर्फ उन गोलियों पर निर्भर हूँ जो वो दौरों के लिए खाता है। पाँच गोलियों की कीमत 100 रुपये है। डॉक्टर ने हर दिन 2 गोलियाँ खाने को कहा है पर हम सिर्फ उसे दिन में एक गोली ही दे पाते हैं। इससे उसके फिट कुछ हद तक संभले रहते हैं।"

(Both me and my husband went to many places for our child. Afterwards, because of having no money we could not get him treated properly. Now we are only dependent upon the tablets he takes for his convulsions. These cost us around Rs. 100 for 5 tablets. The doctor has given 2 tablets /day but we can only afford to give him one/day. That controls his fits to some extent).

She said that both she and her husband tried to keep their child alive in spite of problems they faced. She now sells liquor which is an illegal profession but she has to do it because of her child’s condition. She takes him along wherever he goes and she cannot risk leaving him behind with anybody. Everyone in the neighbourhood drinks alcohol and fights with each other. She feels it is not safe to leave him behind.

The School

There is a school till class IVth in the Ghutewadi Hamlet. The Ghutewadi - Shendrun Khurd School is managed by the local body and is a primary co-educational school. It is located in Lenad Budrek Cluster of Shahpur Block, Distt. Thane. All the local children go to this school which is only till class IV.

The teacher was interviewed and she felt that Dinesh was not fit to study in the school because of the following reasons:
• He can’t sit in one place
• He hits other children and they are scared of him
• He can only come with his mother and with no one else
• He wanders in and out of school on his own
• He doesn’t remain clean and does not have hygienic habits
• Is not toilet trained and also not trained in daily living skills
• Has a lot of saliva drooling

She felt that he cannot study in a regular school and would require one to one support. He should have been put in a special school. Initially the mother used to bring him to school but because he doesn’t sit in one place she stopped bringing him. The teacher clearly expressed her helplessness in teaching children like Dinesh since she has no training regarding how to teach children with disabilities along with other children in the class. Nor she gets the help of a RT who comes only once in 2 months. Although after the RTE, the children under HBE are also enrolled in the school and the regular teacher is responsible for their education, she has never actually visited Dinesh at home.

The Neighbours
The people in the neighbourhood feel sorry for Dinesh but keep their own children away from him. They don’t want them to mix with him or play with him. Still, once in a while, some younger children in the neighbourhood play with him. They also make fun of him and he hits them with stones. The community is also critical and jealous of the income which Dinesh’s mother earns through illegal means i.e. through selling liquor and feel that she earns enough for looking after her child.

In the interviews held, the neighbours conveyed that they feel there is no future for this child. They believe he is a result of bad karma and the parents have been punished by God for their sins. When asked whether he is looked after well, one of the neighbours said that “he is only being kept alive”, nothing more than that.

One of the neighbours also stated that he helped the family by accompanying the mother to the civil hospital when Dinesh was sick. The people in the community are indifferent to each other, drink alcohol and are aggressive. Most of them are travelling outside the hamlet for work. Dinesh’s mother doesn’t go out because of Dinesh. Other than that there is not much concern about each other.

The Attitude
The tribal community in which Dinesh is born is a carefree community. It is considered to be a very backward tribe and is ignored by most of the people who are in a position to make a change. The tribal in this hamlet drink a lot and are not concerned with what will happen the next day. They get married at the age of 14-15 years even if they are not earning. They migrate for work to other places nearly for 4-5 months in a year. They are not land owners and hunt animals and fish.
Dinesh’s mother is the only caretaker of Dinesh and has no expectations from him but looks after him whenever he falls sick. She spends money on his illness but is not able to do much as her elder son also takes money from her. She has accepted Dinesh’s disability and considers it
to be her duty to keep him alive. She doesn’t trust anyone else with her child. Even her eldest son doesn’t help her. She expresses it by saying:

“मेरे पति के गुजर जाने के बाद मेरे बेटे ने भी मेरा साथ छोड़ दिया”

(After my husband died my son also left me)

She feels that her neighbours are sympathetic towards her but want her to keep her child away from their children. She also feels ashamed of his disability and hesitates to introduce him as her son on many occasions because of his disability. She has no hope that he will improve but wants the child to at least live in the present condition.

As far as the teaches are concerned, they are sympathetic towards Dinesh but do not want to take any extra burden. They feel they are untrained for looking after these kind of children and they should be taught in special schools. It appears that because of RTE, these children are compulsory admitted to schools but the responsibility of their attending the school lies with the parents as they have to bring them to school, sit with them to look after their daily needs and take them back. Since most of the parents are poor and need to work, to carry out this additional responsibility becomes impossible for them.

Overall, the attitude of society towards Dinesh is neither positive nor negative but indifferent. He is living and actively roaming about the hamlet but no one wants him near their children. He is ridiculed by some but not cared by any except his mother.

Resource Support

The Shahpur Taluka hosts a number of villages and hamlets. Every village has a Zila Parishad school and the population residing in this taluka is of diverse nature. There are SCs, STs, Muslims, OBCs and Hindus. As per the District records there are around 1100 CWSN and SSA has provided these children around 2BRPs (Block Resource Persons) and 6 RTs (RTs). The RT pupil ratio is very high approximately 137 children for 1 RT and as a result the teacher is unable to visit the child regularly if at all s/he visits. The regular teacher in the school is untrained and considers herself not equipped for teaching these children along with other children in the class nor does s/he visits the home. As a result, the resource support for Dinesh does not exist and he has not developed any daily living skills like eating, toileting, changing clothes etc. The mother is also not trained for developing her child’s skills. She is only feeding him and keeping him live. She has no time to take Dinesh to the BRC since it is far from the village. However, she knows there are teachers to develop Dinesh’s skills but they only come once in a while to take stock of his medical condition. The transport allowance is dependent on 75 per cent attendance and since the school after class IV where Dinesh is enrolled is far from house, he is not able to attend it regularly. So the family is also deprived of that allowance also.

Issues

The following are the specific issues that emerged from this case study:

- In backward hamlets inhabited by tribals who are poor, illiterate, drink country liquor and pick up fights, CWSN are most neglected and ignored not only by community but also government functionaries as they are hesitant of visiting places like this;
- There is no opportunity for early intervention as the child is diagnosed very late;

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46 As given by the Block Coordinator
• Because of parents having no time and no training the CWSN have developed no daily living skills. They cannot eat on their own, change clothes or go to toilet when required. Nobody wants to touch a child or stand next to him because of his unhygienic condition;
• There is a Zila Parishad (ZP) school till 4th class and the school that is 5th class onwards is situated at a distance of 5 kms. Because of no detention policy, Dinesh had been promoted to class 5 but because he is unable to go there on his own he is deprived of mid day meal and the company of other children in the village;
• The parents generally have no money to provide medical facilities to their child. Even Dinesh’s medicine is costly (Rs700/month for a full dose). Because of this he is only given half the dose;
• The parents are not aware about the disability of their child and how it was caused. They blame the illiterate and untrained midwife who delivered the baby at home;
• It is the mother who takes up the entire responsibility of the child not only for physical support but also for economic support;
• There are no medical facilities available near the hamlet for proper health interventions.
Case Study 3

The Context

Slum is defined as a very poor and crowded area of a city\(^{47}\). Dharavi, is one such slum in Mumbai and is considered to be Asia’s largest slum and houses nearly more than million people with its narrow dirty lanes, open sewers, small rooms, and also having electricity and cooking gas. People there have opened their shops and are also residing in these shop cum residence kind of accommodation. There are schools, small scale industries that produce embroidered garments, export quality leather goods, pottery and plastic in spite the constraints of the place. It is called a slum because it lacks the basic facilities such as roads, housing with individual toilets, and public amenities. Dharavi is a unique self-contained township having everything that is required by the residents including government and private schools and a resource centre. Dharavi is currently a highly multi-religious, multi-ethnic, and diverse settlement.

The Child

Shikha (name changed) was born in the year 2009 in Mumbai. The 9 year old girl who looks younger than her age keeps smiling and looking around at people visiting her mother’s small shop in the Dharvi Slums. She is unable to sit or stand on her own and either stays in the arms of her mother or grandmother or lies down on the floor and keeps looking around. She speaks very few words like Aayi (mother), drools saliva, is unable to understand any instructions, is unable to eat on her own, has poor grip, is not able to convey if she is hungry, has no control on her toilet, cannot balance her neck and gets fits nearly twice a month. She can only take liquid diet. She always needs a caretaker with her. She reacts to anyone who calls her name by moving her body.

\(^{47}\) Retrieved from: https://dictionary.cambridge.org/dictionary/english/slum
Shikha was diagnosed as having CP with mild intellectual disability although there is no medical certificate available. She and her twin Diya were born underweight and kept in an incubator for nearly 16 days. While the child was in incubator the mother was in coma because of weakness and lack of blood. When she recovered and brought children home, Shikha remained underweight. After 4 months of Shikha’s birth, her mother took her to her village with a hope that Shikha’s health will improve. In the village Shikha suffered from fever and seizures and also got a rat bite. Since there was no improvement the mother brought her back to Mumbai. She took her to the nearest resource centre in Dharavi transit camp BMC School, Dharavi kela bakhar road when she was 11 months old for diagnosis. By birth Shikha was born with underweight and had continuous bleeding from her umbilical cord. The mother believes that this was the cause of seizure in the beginning and also of disability. Her IQ was tested by a RT of SSA and she was considered to be mildly intellectual disabled. She was assessed to be placed under HBE Programme 4 years back through an Assessment camp
The House

Shikha’s house is not like a house at all. It is a small room which is divided into two floors: a lower floor which is a shop and an upper floor which is used for sleeping and cooking. Shikha’s mother runs a small grocery shop (kirana store) in the lower floor and Shikha keeps lying there the whole day.
Shikha does not live in a house. She lives in a shop and there is no attached toilet, so no matter what there are long queues every morning in which her siblings, mother and grandmother have to stand. What’s worse, women find it unsafe to use these public bathrooms in the middle of the night. Shikha does not use the toilet at all. Since she has no control, she will do it anywhere anytime. As a result she may have to be changed and even the house remains dirty because of this. While the house is not ventilated, there is a good flow of fresh air on the street as there are no high-rise buildings blocking its path.

Outside the shop you could hear so many people talking on the street. There are so many languages being spoken like Hindi, Marathi, Tamil and Telgue etc. There is always something going on and people are so busy. There is a food shop where food is being fried, there are recycling units, there are tailors, there are trucks bringing stuff and there are pots being made. Even if Shikha stays in the shop she can see so many colourful things and hear an orchestra of sounds that makes her feel at home at Dharvi.

**The Family**

Shikha’s stays in Mumbai with her mother two siblings and her maternal grandmother who owns the shop managed by Shikha’s mother. Other than that, Shikha has paternal grandparents, uncle and aunt and father who stay in Bhiwandi in Maharashtra. Shikha’s father used to drive a rickshaw and now is an agricultural labourer. He went back to his village and now stays there with his parents. Meena, (name changed) Shikha’s mother visits him once in a while but the entire responsibility of the children is on the mother. Meena feels that there is no one else who can look after her children. She is the one who takes the child to the resource centre, medical camp and hospital whenever she gets time. She lives with her mother and earns from the shop. She just wants Shikha to improve. Shikha has a brother and a twin sister. Both of
them try to help Meena with Shikha. They play with Shikha and try to make her eat. Meena is a strong woman and is determined to look after her children to the best of her resources.

**The School**

Shikha is enrolled in the neighbourhood BMC (Brihanmumbai Municipal Corporation) school but she only goes to the resource room situated in that school. In the resource room (RR) she is looked after by a physiotherapist, occupational therapist who make efforts to make her stand, improve her grip, toilet training, daily living skills training and also tell Meena how to make interventions at home. She has shown slight improvement because of the interventions. She started going to the resource room regularly around 4 years back but only with her mother. The RR room is just 150 meters away from the house but the mother takes her only 2-4 times in a week. The other children in the regular school are nice to Shikha and try to interact with her sometimes by giving her some things and toys that make noise and trying to make her walk and sit. On the other hand, according to Shikha’s mother none of the regular teachers support Shikha and always advice her to send Shikha to special school. They say:

“शिक्षा इस स्कूल में कैसे पढ़ सकती है। हमारे पास उसके लिये न समय है न ट्रेनिंग। कृपया उसे विशेष स्कूल में भेजे जहाँ उसे अधिक अच्छा देखा जायेगा।”

(She cannot study here as we do not have time and training to handle her. Please send her to a special school and she will be better looked after).

Another problem faced by the mother is of taking the child to the school. She has to carry Shikha to school as the narrow lanes of Dharvi are always crowded and difficult to steer a wheelchair. Even when she enters the school she faces a lot of crowd of children playing in the open ground. She has to then be careful as she may be pushed or a ball may hit Shikha. She also needs someone with her throughout to take her to the toilet, for drinking water and eating food. Nobody helps her in school even her own siblings.

Although Shikha’s mother is grateful for what she is getting in the RR she feels much more can be done like providing adapted chair, special teachers, caretakers for better and more interventions.

Each teacher in the RR works with 5 children in each cluster and alone looks after 13 clusters. The teacher pupil ratio is high i.e. 1:65. They also prepare Individualized plan for each child and work accordingly. However, they are not able to visit the child more than once or twice in a month which is not adequate.
The Neighbours
Dharavi as mentioned above is characterized by narrow and crowded lanes, small houses and since there is very little space in the houses, everyone remains most of the town outdoors. The neighbours meet each other while filling water and for other interactions daily and know everything about each other. However, as conveyed by Meena, none of them have any time to help her. In fact, they are scared that Shikha has a disease which their children can catch. So they do not allow their children to play with her.

They sympathize with Shikha’s mother as she has to look after her all the time. She gets no time for herself. They feel it is very unfortunate and is a result of some bad karma. While interacting with the neighbours it was seen they all collect together whenever an outsider comes to the slums. This is because Dharvi shot to fame as a result of being depicted in movies. The residents feel everyone who visits Dharvi comes for some film shooting and this is an opportunity to make money. Other than that they consider Shikha as a curse especially so because being a girl and a disabled one is the saddest experience of anyone’s life.

The Attitude
Shikha’s mother realizes that Shikha can never be totally alright but she wants her to improve as much as possible. She makes tremendous efforts to take her to School and hospital for therapy and training. She, however, has limited time but never regrets anything. Her husband left her and went and stayed with his parents and other family members. He has no responsibility towards this child. She doesn’t blame anyone or any happening in her life for Shikha’s condition. She said:

मैं अपनी किस्मत, भाग्य, सुविधा की कमी, अस्पताल की गलती या किसी और घटना को शिक्खा की हालत के लिए जिम्मेदार नहीं मानती। इसके कारण मेरा पति मुझे छोड़ गया और उसका परिवार मुझे इससे लिए जिम्मेदार
मानता है | मैं अपनी समस्या अपने पति को नहीं बताती क्योंकि शिखा मेरी जिम्मेदारी है चाहे मेरा परिवार मेरी मदद करे या नहीं।

(I don’t blame my luck, destiny, and lack of resources, hospital neglect, or any other circumstances for Shikha’s condition. Because of her my husband left me and all his family members blame me for giving birth to such a girl. I don’t tell my husband my problems since he doesn’t help. I am the mother and it is my responsibility to look after Shika even if I get no support of the family).

She doesn’t take her out anywhere as nobody cares and even the relatives don’t behave with her well. The community members/neighbourhood people pity Shikha’s mother and feel it would have been better if she hadn’t lived. According to them:

“अच्छा होता अगर इस तरह जीने की जगह वो मर जाती। बेचारी माँ को सब कुछ करना पड़ता है। अगर वो लड़का होती तो बेहतर होता। एक लड़की होना और वो भी विकलांग बहुत दुख की बात है।”

(It is better if she would have died then living like this. Poor mother has to do so much for her. It would have been better if it was a boy but having a girl like this is very sad.)

Resource Support

Shikha goes to a RR sometimes where she is looked after by a resource person and physiotherapist. She is taught some daily living skills and interventions are made for improving her posture. She has also been given a wheel chair which is not adapted according to her needs. She was diagnosed in an assessment camp and other than that she gets no educational interventions, no TLM, nothing to work at home.

Her mother has been trained for making interventions at home but she hardly gets anytime for that. The special educator is unable to provide resource support continuously and comes only once in a month and that does not help at all. More interventions from the special educator are required for equipping Shikha with the skills. The family gets no transport allowance as per norms as that is linked with 75 per cent attendance which is never the case for Shikha.)
Issues
Some of the issues that emerged while interacting with the parents, teachers and neighbours are:

- Shikha being a girl faces a double disadvantage based on gender and disability and is rejected by her father and his family members;
- There is no provision for a caretaker or an Ayah in school for looking after the needs of children like Disha who cannot eat, drink, sit or even go to the toilet on their own. As a result her mother has to take her sit with her and bring her back, look after the shop and her other children and also take her to the hospital etc.;
- The mother bears all the responsibility and has no one to share her problems. Her own physical and mental health is at a great risk;
- The living conditions in the slum area are not at all hygienic and there is no attached toilet and water connection. It is not possible to carry Shikha to a community toilet and also Shikha is not able to communicate her needs. This results in her being constantly in a dirty and unclean environment with ants crawling around her;
- The neighbourhood looks at the family with pity without mixing much with the family. This further segregates them from the community. There is sympathy but no support from the neighbours;
- The resource support being provided is negligible as there are no regular visits of the special educator. As a result there is hardly any improvement seen in Shikha;
- The regular teachers are not interested in educating Shikha and want her to study in special school.
Case Study 4

The Context
Nagpur is the third largest city of Maharashtra after Mumbai and Pune. Located in the Vidarbha region, it is considered to be the second capital of Maharashtra. Also called orange city, it the main trade centre of oranges in the country. Nagpur got its name from Nag River which flows through the centre of the city. The total numbers of slums are 179,952 and about 859,487 individuals live in them. This is around 35.73% of the total population of Nagpur. Schedule Caste (SC) constitutes 18.6% while Schedule Tribe (ST) were 9.4% of total population in Nagpur district of Maharashtra.

Source: https://www.censusindia.co.in/district/nagpur-district-maharashtra-505

Nagpur city is the district headquarters and is part of Nagpur Division. Nagpur district is bounded by Bhandara district on the east, Chandrapur district on the southeast, Wardha district on the southwest, Amravati district on the northwest and Chhindwara district of Madhya Pradesh state on the north. The district is divided into fourteen talukas and five sub-divisions.

The Child

Sunita (name changed) was born in the year 2003 and is now 15 years old. She stays in a small house in a small basti in Nagpur city. She has been diagnosed as having intellectual disability and CP and was issued a certificate in the year 2014, at the age of 10 years although the parents came to know of her condition when she was 7-8 months old as her milestones were very slow. She was a born prematurely in the 7th month of pregnancy and at home. Since there was no provision of any incubator etc. that may have a major factor contributing to her present condition. According to the parents she had jaundice at birth and she was born prematurely and they could not go to the hospital for proper delivery. She is unable to sit or stand on her own without support. She can swallow, bite, suck and chew her food. She is very weak but is able to speak and make eye contact. As per her individualized education plan, long term goal for development is independent standing and short term goal is independent sitting. The interventions suggested are helping her to stretch, position, learn daily activities and trunk exercises with the help of a physiotherapist. She was enrolled in a resource centre when she was 5 years old.

Sunita lies on the bed the whole day and when she has to go to the toilet, she is picked up and taken by her mother or sometimes by her grandmother. As she is growing older this has become a difficult task. Since she is on bed the whole day, she is unable to sleep at night. She suffers from pain in her joints but still keeps smiling and talking to people around her. She was admitted to a school nearby (at a distance of 2kms) at the age of 5 years where she was enrolled in class 1. She used to sit in the RR the whole day with her mother. She was very attentive and learned fast. However, she went to school till she reached class 4th but when her brother was born, her mother could not accompany her to school and Sunita had to drop out.
Sunita loves her parents and feels obliged by the effort they make for her. She is intelligent and can recite even the poems she learned 2 years back. She feels that she would have gone to school like others if she could move. She said that she would have been in class IXth if she could walk. She also helps her younger brother with his studies.

**The House**

Sunita’s house is located in a crowded basti of Nagpur and has 4 rooms, including 2 bedrooms, a living room and a small kitchen. It has one set of toilet. The living room where Sunita lies down is airy and well lit. Rest of the house is dark and dingy and not very clean. In fact, since there are two families living and cooking separately, there is a small kitchen in one of the bedrooms.
The house has electricity and there is a TV, sewing machine, radio and also a parrot to cheer all of them. The TV is in the living room and everyone sits together to watch it.
The house is situated in a colony with narrow lanes. These are very crowded and uneven. You can walk around and take shortcuts to reach from one place to other. These lanes are not clean and also inappropriate for a wheel chair. However, Rickshaws and small cars are seen on these narrow lanes which make the colony further crowded.

The Family
Sunita’s family has other than her parents, a younger brother, grandmother and uncle and aunt (chacha and chachi). The family stays together in the house although they have separate kitchens; they all eat together in the common living room where Sunita keeps lying on the bed. When asked why their kitchens were separate they said it was easier to stay together like this. There were no fights of any kind. While talking to Sunita’s mother it became clear that her own sister in law doesn’t help her in any way. The entire responsibility of Sunita and her younger brother is on the mother alone. The father helps before going to office and after coming back. He works as a peon in some private company.
Sunita’s mother’s routine starts with early getting up, cooking the food, taking the younger child to school. After that she looks after Sunita’s needs. Then again she has to pick up the child from school, feed him and in the afternoon she stitches blouses and earns a bit of money. Again in the evening she has to cook dinner and feed everyone. In her busy schedule she cannot find time for taking Sunita to school. She is unable to pick her up, is not able to organize a rickshaw to take her nor she has found about the neighbouring school. So although Sunita desires strongly to go to school she is denied of that opportunity because she is unable to walk.

The mother, Geeta (name changed) has no expectations from her daughter and is just doing her duty. However, she clearly expresses that she cannot take Sunita to school firstly because it is an effort but more importantly, she has to take her son to school too. She said that if a caretaker could take her and bring her back it will help. She also said in the earlier arrangement this was possible but today there is no caretaker.

When asked why Sunita looks so weak and undernourished, she said that she doesn’t eat much and when this was further probed it became evident that Sunita doesn’t eat properly because she doesn’t want to burden her parents by going to toilet again and again. She feels that if she eats less she wouldn’t have to go frequently.
According to Geeta, Sunita was taken to a number of places before they could accept that she will never be able to walk. These included medical places, religious places and finally a missionary when Sunita was one year old and was kept there for 6 months. When the parents saw no improvement they brought her home as they felt they can look after her better.

Geeta also expressed that her husband didn’t want to have another child as he was scared that their second child may have disability too. After persuasion from relatives they had another child. She also said that there was a school which was keen to take Sunita. Run by an NGO, they had organized a car to pick her and drop her. However, Sunita refused to go there after a few days. When asked the mother conveyed that the particular school in question was for children with intellectual disabilities and Sunita felt that she didn’t fit in the school. Sunita also had physiotherapy for 6 years but now since last 2 years she has had no therapy at home.

Sunita’s grandmother and aunt are all nice to Sunita but do not take any responsibility. In fact, it was strange that the aunt’s child goes to a neighbouring school but no one has yet been able to find out whether Sunita would get admission there. Sunita’s aunt also stitches clothes for an earning and remains busy in that. The grandmother is cooperative and understanding but she also is old and unable to help Sunita’s mother in the household chores. According to Sunita’s grandmother Sunita’s parents fight a lot and she felt it was because Geeta gets tired and irritable after a long day’s work.

The school
Sunita was going to a government school which was situated a few kms away. Earlier the family used to stay in Chandanpur and Sunita used to go to the RR everyday with the help of a caretaker. After two years Sunita’s parents changed their house and she went to another
school’s RR for approximately 2 years. All the time the mother used to sit with her in the RR. She was then smaller in size so the mother could easily carry her.

However, when the younger child was born, Sunita’s mother became too busy in looking after the child. Also, she was unable to find appropriate transport to take Sunita to school. According to the mother:

“कोई रिक्शा वाला उसे स्कूल ले जाने को राजी नहीं था। उन्हें अधिक बच्चे चाहिये ताकि वो अधिक पैसे कमा सकें। स्कूल की तरफ से कोई केयरटेकर नहीं है। सुनीता को स्कूल ले जाने, वापिस लाने और दिन भर वहाँ बैठना मेरी जिम्मेदारी थी। अब मैं यह कैसे कर सकती हूँ क्योंकि दोनों बच्चों का समय एक ही है, अब मैं उसे उठा भी नहीं सकती क्योंकि वो बड़ी हो गयी है।”

(No rickshaw person is ready to take only one child to school. They want more children so that they can earn more money. Also, there was no caretaker given from the school’s side. It was entirely my responsibility to take Sunita to school, bring her back and sit with her throughout the time she was there. How is possible for me as the timings of her school now clash with my son’s school timings. I can’t even carry her now as she has become big and it is difficult for me.)

Sunita, on the other hand wants to go to school. She says:

“मेरा स्कूल जाने का बहुत मन करता है। मैं चल नहीं सकती नहीं तो मैं नवीं कक्षा में होती। मुझे जो स्कूल में पढ़ाया था अभी भी याद है।”
(I would love to go to school. I can’t walk otherwise I would have been in Class IX. I still remember what I was taught in school)

Since Sunita’s younger brother is also going to school in the neighbourhood it was suggested that Sunita can take admission in the same school as this will save the effort of the mother of dropping her to a separate school. The parents have never thought of that option as Sunita has to be taken on a modified wheelchair or in a rickshaw. Both these options are not available for them.

**The Neighbours**
The colony in which Sunita lives with her parents has a close community. In fact, Sunita’s neighbours go in and out of the house frequently and Sunita recognizes them. They help by sitting with Sunita if the parents have to go out. In fact children from the neighbourhood also come and play with Sunita once in a while. One of the neighbour’s daughters also used to come to teach Sunita till she got married.

When interviewed one of the neighbor expressed that we all feel sorry for Sunita and her family. According to her it is a result of their destiny and they have to live with it. She also said that parents have frequent fights and there is an issue of money also. The person who is most stressed in the family is her mother.

**The Attitude**
Outwardly, Sunita looks a happy child and talks and smiles when people interact with her. However, during interactions it was revealed that she remains sad and blames herself for the stress she causes her family. She feels that the parents have to carry her to the toilet so she eats less. She likes to study but is unable to insist on going to school because of the problems faced by her parents.

It appeared all the fights, and family interactions that happen in front of Sunita convey to her that she is a huge burden on the family. When asked what her strongest desire was, she said:

“काश मैं मर जाती, इस तरह मेरे माता-पिता का बोझ हल्का हो जाता”
(I wish I was dead. This would have lessened the pressure on my parents.)

In spite of having a sharp brain, ability to speak, Sunita is unable to develop to the best of her potential because of inability to move. Parents look after her and keep her alive. Although they do not convey anything directly to Sunita but their interactions amongst themselves and with neighbours affect Sunita in a very negative way. She feels helpless and wishes she was dead.

**Resource Support**
Sunita presently gets no support at home. Earlier when she was going to a regular school RR, she had a special teacher there and was taught some basic daily living skills. After she left school a few years back she has no support. In fact, earlier she was taken to a physiotherapist who made her do some exercises. That helped her joints to soften but presently all her movements are painful as she does no exercise.
In State there are no special provisions for children who are at home and cannot come up to the RR. She was given splint calipers and wheel chair at home which are of no use. These were given to her nearly 3 years back. Modified wheel chair is only available at school. There is no maintenance of these devices. There was some training given to the parents by a physiotherapist and special teacher in some basic exercises like stretching, sitting etc. but the parents still are not able to do that. Although there was an IEP developed for the child, it was never followed up. Another shocking fact is that in the IEP Sunita has been diagnosed as intellectually disabled.
इसी भी जिद
दुःख में भी वो कहते हैं भगवान तू प्यारा है।
साही की कहानी - लड़की के हीसले को हिम्मत से साथ देने वाली माता

नागपूर तारिख 18 मार्च, 2009 - केवल 5 साल की आयु, शरीर से दुःख-पतली, बिना सहारे के बैठना भी संभव नहीं है, खड़ी भी नहीं हो सकती, रात-रात भर सोती नहीं, पीड़ा के साथ वो जीवन जी रही है। आकाश का समान दुःख है फिर भी कहती है, कि भगवान आप भर्ती ही प्यारे हो, आप की मेरा प्राणम, मम्मी-पापा ने भी आपका धन्वाद किया है। ऐसा गीत साही गाती है और तालियाँ बनाए हैं। जीवन में दुःख आने नहीं चाहिए ऐसा नहीं, फिर भी उस दुःख की एक निर्वाचन सीमा होनी चाहिए। दिनभर और निना के जीवन में भी दुःख का पहाड़ खड़ा हुआ। अकेली लड़की वो भी महत्त्व है। वो अच्छी हो जाने इसलिए उनका संस्रंधी हो। चिकित्सा एवं उपचार हेतु उन्होंने नई तालाब झोपड़ी छोड़ दी। चंदनगर में किसान का पर लिया है। पर में बुरू हो गयी, जो काम नियत वो करके परिवार का पेट भरते हैं और उनमें से जो पैसे बचते हैं उससे वो साही का उपचार करते हैं। साही महत्व होते हुए भी उसमें सीखने की चाहत बहता है। वह गान में चैठी उड़ान भरने की चाहत रखती है, लेकिन पूरी में जान नहीं है। साही के हीसले को जिद के साथ बनाये रखती है उसकी माँ - मिता। उसकी माँ स्कूल में पूरा दिन साही को कक्ष में लेकर बैठती है। साही कविता, साल के बारह महीनों के नाम, पहाड़े बोल कर सुनाती है और यह सूनकर दिल से लगा लेती है और साही को साहस प्रदान करती है। स्कूल में छुट्टी करता साही को बिल्कुल भी पसंद नहीं है। मागा स्कूल में हमसफर नाग में साही पढ़ती है। समावेशित शिक्षण (अपंग) उपक्रम में पहली कक्ष में साही पढ़ती है। शिक्षक की बहुत ही लाड़ती है। चिकित्सा ने असर परंपरा काटते होते वो साही ने संसार की दिन लिया होता। ऐसा कहाना है शिक्षक दिना कालकर का। तब दिल भर आता है और साही के मुख के करुण भाव देखकर दिल तड़प के साथ रो उठता है।
Issues
The major issues that emerged from this case study are:

- Lack of resource support and low expectations from a girl with disability is a major concern as it serves as a major barrier in development;
- The condition of children under HBE has worsened after the inclusion in RTE as there is no resource support being provided at home;
- The assistive devices are not matched with the needs of the child and as a result they are of no use;
- Regular schools still deny admission to children with disabilities in spite of their equal right to education;
- Gender is a major issue because the parents give more attention to boys as compared to girls. In case of CWD a disabled boy gets more attention than a disabled girl and finally a girl without disability is more useful for parents as compared to girl with disability;
- Transport allowance given to the parents is not utilized. They either don’t want to spend it on the child’s transport or are unable to organize a transport on their own. In both the cases the child is deprived of education;
- Lack of finances is another major barrier as it leads to shifting of priorities for the parents. They would rather go for work than take this CWD to school;
- A child having physical disability is generally considered to be intellectually disabled too. This is what happened with Sunita;
- Parents have higher expectations from their able bodied children and spend more time on them rather than on a CWD.
Case Study 5

The Context

Kamthi is a medium size village located in Ramtek Taluka of Nagpur district, in Vidarbha (Eastern) region of Maharashtra with total 70 families residing in the village. The Kamthi village has a population of 316 of which 149 are males while 167 are females as per Population Census 2011 and out of this population of 230 belong to scheduled tribes. This village therefore has a high concentration of tribal. As per Constitution of India and Panchyati Raj Act, Kamthi village is administrated by Sarpanch (Head of Village) who is elected representative of village. There is a primary school in the village called the Swami Vivekananda Vidalaya. Most of the villagers are agricultural labourers.

Within the village there is a primary school till class IV and all the young children are enrolled in that neighbourhood school. The upper primary school is nearly 4 kms. away from the village.
Raghav (name changed) is a 13 year old tribal boy born to parents residing in this village. He belongs to the Gond Tribe and his mother tongue is Gondi. However, the family also speaks Marathi. Gonds believe in evil spirits and that the gods' displeasure causes most diseases and misfortunes. They ask soothsayers and diviners to find out the cause of problems and to suggest remedies. This is what the parents also felt when Raghav was born like this in their
house. The Gonds can marry more than once and divorce their partners with the approval of the Tribal Council/wise men and this is what Raghav’s father did.

Raghav is having multiple disabilities and has been specifically diagnosed with CP and intellectual disabilities through a SSA camp. He was identified to be placed under the HBE programme. He was born at home with physical disability and never could move. He has problems with his spinal cord and therefore cannot sit without support. He responds with his eyes and a smile to any stimulation and understands when he is talked to. He cannot eat on his own and requires help of family members for his daily needs. He appears to be severely malnourished and passes stool once in two days.

Raghav is lying on the cot the whole day mostly and his needs are looked after by his step mother whom everybody calls ‘Badi Ma. He eats with the help of his step mother. He generally wears no clothes and lies on a thin sheet on the bed on which he not only eats and drinks but also urinates since mostly there is nobody to take him to the toilet, and keeps lying there since he is unable to move. Sometimes there are flies on his body which he can’t even remove on his own.

Although he has been enrolled in school and as a result of RTE and some money has been provisioned for him, the money is not used to provide services to him. No volunteer, RT, special educator, physiotherapist comes to the house to teach him anything. Over the years, being alone in the room has made him withdrawn and quiet. He loves having his family or other people around him.

The House
Raghav’s house is like all other houses in the neighbourhood. It is built of mud and thatch. It has a big room like a living room where Raghav is lying on the bed and a small room, a small kitchen and a big verandah at the back. The verandah of Raghav’s house cuts into the primary school of
the village. It is a quiet village where most of the persons are away to the fields and return only in the evening.
The family

Raghav’s parents are agricultural labourers. Raginibai (name changed) is the second wife of Subhash (name changed) and also mother of Raghav. Subhash got married at the age of 21 but his first wife now called badi ma, could not bear him children and that is why he remarried after 10 years to the younger sister of his first wife. He had 3 children from his second wife including Raghav. His elder son is working but has a health issue and has to take medical treatment for it. In fact he had to undergo a surgery to overcome the congenital physical defect in the renal system. The daughter appears to be the smartest of the three children and at present studying in upper primary school. Both Subhash and Raginibai work as in the agricultural fields and leave the house early in the morning and come back in the night.

Raghav’s parents are too busy to take care of him. Mostly, his step mother looks after him, bathes him, feeds him and takes care of all his needs.

In her words:
“राघव बहुत प्यारा है और मुझे अच्छी तरह से पहचानता है। अगर मैं उसे खाना न दूं तो कोई भी उसे खाना नहीं देगा। आसपास हमारे रिश्तेदार भी हैं पर वो राघव को नहीं देखते। मेरा अपना कोई बच्चा नहीं है, इसलिए ही शायद भगवान ने नहीं दिया।”

(Raghav is very nice and recognizes me well. If I don’t give him food then nobody will give him. We have relatives nearby but none of them look after Raghav. I don’t have a child of my own maybe God wanted it like this.)

Badi Ma also works as a mid day meal maker and takes out time in between to come home to look after Raghav. She is unable to take him out even to the school where he was enrolled as she feels the other children will stare at him like a specimen and even talk negatively.

Raghav’s father often blames the mother for delivering a CWD. He said that according to the doctor, Raghav was born like this because his mother used to eat Supari (tobacco). When asked why this didn’t affect the other two elder siblings he said that while she was carrying Raghav she increased the intake.

The mother confessed that her husband gets angry easily and scolds her and the children including Raghav. He feels that I am lazy and therefore unable to do the any work properly. He also blames me for the illnesses of my two boys and keeps saying what is the point of having children like this?

Raghav never goes out of the house, has no interaction with any other children, and is cleaned once in two days. Parents feel that till he is alive they will look after him but want money from the government for feeding him properly.
RAGHAV’S PARENTS
Raghav is enrolled presently in Class 7 which is an age appropriate class for him. He was earlier enrolled in the primary school which was located just behind the house. Even then, he never went to school as he was unable to sit. Since he appeared to be malnourished, it was difficult to understand why he was not given the mid day meal at home. Badi ma who cooks the mid day meal in the primary school said that the Headmaster does not give permission for bringing the mid day meal home for Raghav and hence he was not availing this provision. Although the school teacher was responsible for this child’s education as he was enrolled in regular school, the teacher had never visited the child. The upper primary school is around 4 kms. away from the house and his enrollment in the school has no meaning. He is not utilizing any provisions from the school nor there is anyone visiting him at home.

The block resource centre (BRC) according to the school teacher is around 40 kms away and parents have no means to take their child there. The CRC (Cluster Resource Centre) is 4 kms away looking after 12 villages but there are no resources available for these children at the CRC. The school teacher also felt that the parents are willing to cooperate but being illiterate and having no knowledge regarding the interventions required, they are not able to do much. They are just keeping him alive the way he is without having any expectations or hope for
improvement. The teacher felt that if the parents are given some training with the help of resource person, they will be able to teach him some daily living skills. Even the teacher felt that he is not able to help much except offering them help with transport etc. as he also has no knowledge regarding *these children*.

**The Neighbours**

The houses in the village are located in a dense manner. As a result the next door neighbour is a few meters away. Most of the neighbours interviewed feel sorry for the family but are indifferent to the issues the family faces. They feel since two members of the family earn well they are managing well. Regarding Raghav the neighbours felt that this is their destiny and they have to look after him. The community members are busy in their daily chores and also travel outside the village for finding work. They have no time to help anyone.

**The Attitudes**

Raghav is a part of the Gond community residing in this village. His parents look after his basic needs but nothing more than that. The parents kept saying that till he is alive we have to look after him. He is not cleaned regularly and he keeps lying on the soiled cot for days. He is fed and cleaned by his Badi Ma who has a soft corner for him.
Nobody from the neighbourhood visits him. Even the teachers of the school where he is enrolled have no idea of his condition. Although the primary school is just behind his house, children from the school have never interacted with him. This is most unfortunate as Raghav is happy to interact with people and welcomes them with a broad smile. At present Raghav is just alive but unable to react to any hardships he is facing. He appears to be severely malnourished and the parents feel the need for money to feed him. When asked how they feed their other children they had no answer. He can’t even drive away the flies on his body. Raghav is forgotten by the community including the school, the District administrators and even the family.

**Resource Support**

No resource support is provided to Raghav in terms of RTs/volunteers/physiotherapist and no toys/learning material is made available for him at home. The nearest BRC is 40 kms away and Raghav has never gone there. Since it is a remote area with narrow roads commuting with him is difficult. Even for going for medical care, someone has to sit at the back of the motorcycle to hold Raghav.

**Issues**

The following are the issues that emerged from this case study:

- The regular school teachers do not think that education of CWD is their responsibility in spite of these children being enrolled in regular schools after the RTE;
- There are no human resources in the form of physiotherapists, RTs or even volunteers to train the parents and the child. The child remains alone most of the time and in a miserable condition. The idea of equal rights and justice are farfetched when the child is not even treated as a human being;
- The mother of the child is blamed for everything wrong in the house supporting the notion that whenever there is a CWD at home the mother becomes the scapegoat;
- The remoteness of the village and the distance to be traveled for availing resource services in BRC becomes an impossible goal for these poor and illiterate parents;
- There is no flexibility in routine for children like Raghav. Since he could not go to school he was deprived of the mid day meal being served even when the house was just behind the school;
- The school administration relaxes no routine, shows no flexibility to meet the high support needs of CWD.
Chapter 4
Overview and Road Map

The present study explored in-depth the lives of CWD living in poverty and remote conditions under the HBE Programme of SSA in the State of Maharashtra. The major objectives were to assess how the tribal and poor backgrounds effect the provisions and other factors related to the family, teachers and community members of a CWD under the HBE programme and secondly to analyze the views and perspectives of RTs, parents and community members regarding the implementation of home based practices over the years and about the provisions especially after its inclusion under the RTE Act.

After reviewing the literature and carrying out preparatory work like collecting lists of children under HBE programme in various Scheduled Tribe (ST) a concentrated talukas/districts and urban slums in Maharashtra, five children based in Shahpur taluka in Thane district, Jawahar taluka in Palgarh district, Nagpur district (rural and urban) and Mumbai city were visited. Interactions with Stakeholders like RTs, regular teachers, headmasters, community members, parents and District coordinators were held for in-depth case studies. The accessibility of the houses and the willingness and availability of the parents to participate in the case studies were also taken into consideration for deciding the households to be visited for case studies. Also, based on the visits and the interactions with the stakeholders, 3 tools, one for the parents, one for teachers in the neighbourhood who are required to provide support to children under HBE and for community members were prepared (Annexure 1).

The case studies were based on in-depth analysis of the experiences of parents, teachers and community members. As mentioned above, there were 5 CWD under the HBE programme whose case studies have been developed. Out of these 2 are girls and 3 are boys. Two of these case studies are focused on CWD in slums urban areas while 3 are from very remote, backward and tribal areas. The children visited were enrolled under the HBE programme for a minimum of 2-3 years.
The following diagram illustrates the Services that are accessible to a CWD under the HBE under the provisions in the State.

However, after the RTE Act, the children under HBE have been enrolled in the regular schools and no special provisions are available for them at home. Three of the children whose case studies were prepared were from remote tribal areas. We all know that life in a remote tribal society is simple and not compartmentalized into economic, religious, educational categories etc. whatever social interactions happen they happen in a form of a primary group. The tribal society is small and homogeneous and people are religious and marry young. Most of them are agricultural labourers or daily wage labourers and few of them are involved in forestry, food gathering, household industry etc. In the 3 houses visited, women took care of the home-front, gathered and prepared food and were responsible for taking care of their children. There are no medical facilities available and all these children were born at home. The poverty, illiteracy and the culture of believing that these are karmas has led to neglect of these children. The parents in the tribal areas had no expectations from these children and were just keeping them alive.

They go everyday out of their village to earn money and generally leave these children at home without anyone to look after them. Since, they are living in remote hamlets, very little resource support is available for them. The nearest BRC is around 30-40 kms. away and they do not have the transport to carry the child there for therapy. Even the upper primary school is situated nearly 4-5 kms away and this child cannot be taken there. The remoteness of villages, the poverty, the illiteracy of parents are some of the factors that have a profound effect on the self image and development of these children.

The families that were visited for in-depth case studies were very poor, parents were illiterate and barely had money to make two ends meet. The findings that emerged from the analysis of 5 case studies including the tribal children are:
The Children

- Four of the children were delivered at home by a non medical person due to either lack of medical facilities, ignorance or lack of finances. All the children suffered severe infections after birth and the parents’ attribute their disability condition to the birth trauma suffered by these children;
- All the children were diagnosed late, around 5-10 years after birth. As a result, they were deprived of early intervention services like daily living skills, speech development, physiotherapy for bodily movements etc.;
- All five children appeared to be in poor health, malnourished, badly dressed or not dressed at all and dirty. They are living in serious unhygienic conditions and prone to multiple infections;
- All these children are enrolled in regular schools post RTE Act. Even if they do not attend the school they are promoted to higher classes because of no detention policy;
- All the children are dependent on a family member for their daily living especially the mother. Since the mother remains busy with house work and in looking after the other siblings, this child is generally neglected. As observed, these children are just kept alive and the parents have no time for doing anything more than this.
- All these children in addition the physical disability were also considered to be intellectually disabled without any proper diagnosis.

The House

- The houses of tribal children are located in small hamlets with physical environments which support them and determine their economic activity. Nearly all of the houses are similar in the hamlet with thatched roofs and mud walls. The houses visited had limited furniture like a chair or a bed. Most of the tribal like to stay outdoors most of the time;
- The children in urban slum areas are staying in small houses with limited space. There is no provision for attached kitchen or bathroom especially in the slum area of Dharavi where there is no water connection and toilet;
- The houses are dark and dingy with a number of family members inhabiting the house. The child in these houses is placed at one point and since she is unable to get up lies at the same place throughout the day.

The family

- In all the case studies it was observed that the mother was the person solely responsible for the child. This is true for both tribal and urban areas. She was also explicitly blamed for the child’s condition in two houses (Dharavi and Kamathi village and appeared to be very unhappy;
- The parents of the children under the study were illiterate and employed (or self employed) in low wages. The families were hard pressed for money and wanted the Government to help them with finances;
In 4 out of 5 case studies it was observed that there is a marital discord between the parents. The reason for this constant fights is attributed to irritability due to excessive work or burden of responsibility;

There was explicit gender discrimination even amongst children with disability. Being a boy with disability had more advantages and acceptance than being a girl with disability;

The parents had no training for looking after the special needs of their child. They were ignorant about the kind of techniques they need to use with their child to even develop the daily living skills;

All the parents complained about lack of resources for looking after the needs of their child. They had no money even for medical interventions and as a result the child had deteriorated over the years. They felt the need for a physiotherapist speech therapist etc. to be made available at home.

Most of resources are available at the BRC level which was around 20-40 kms away from the houses except in Dharavi slums where it was almost next door. Carrying a severely disabled child on a motor bicycle or cycle was a herculean task and therefore the children had no access to resource support. Even if the parents did attempt to take them to BRCs, these visits were not frequent and the continuous support needed was not available;

All the parents interviewed had tried a number of religious and spiritual ways to treat their children like taking to a particular shrine, leaving them in missionaries. Especially, the tribal children were exposed to a lot of attempts of miracle cure.

The School
The primary school is located in the village while the upper primary schools are a few kilometers away. In the existing scenario, after the RTE Act, all children under the HBE programme are enrolled in the schools. As a result, regular schools are responsible for their education. However, when the teachers were interviewed and the school was visited, the following findings emerged:

- The regular schools, especially in the rural areas are not equipped with any facilities for CWD. Even in the city, there are a few government schools having the resource centre;
- The CWD occasionally come to school carried by their mothers for mid day meal. Even that becomes difficult as the children grow and are heavier and the wheelchair given is not suitable;
- There is no transport available for bringing these children to school. Even if parents manage that, there is no caretaker appointed to take the child to school. It then becomes the responsibility of the parent to accompany the child to school, sit there throughout the school timings and bring the child back home. The scenario is worse in upper primary schools as these are far from the house;
- The parents need to be highly motivated to take their child to school in the absence of facilities. With low expectations from the child, parents are happy to let him/her stay at home and keep him/her alive;
• Parents of other children sometimes complaint regarding the CWD studying with their children. They feel that this can affect their children both physically and mentally;
• There is no training both at in-service and pre-service levels that equips these teachers with knowledge and skills to include CWD in education. Many of the teachers felt that these children should be taught only by a special teacher or in a special school;
• RT visits to regular schools is very rare and since these children are severely disabled, they require one to one support which is not available;
• The parents are overprotective and try to shield their child from physical injuries and mental traumas. They feel there is no sensitivity towards these children and other children may tease or bully them;
• Only when the resource room is near the house and is easily available, it can be used by the child. In Dharavi, the resource room was just 150 meters away and accessible. Even then carrying the child was difficult;
• Even if the child is very intelligent but unable to move, there are no facilities like adapted wheelchair, caretakers, transport to enable this child to attend school. As a consequence, the child becomes helpless and dependent and suffers the mental pain of watching his/her siblings going to school just because they are able to move normally;
• The school is not flexible to the needs of these children. Even if the school is located next doors the child has no access even to the mid day meal;
• Inadequate attention to the child, unsafe environment, no provision of required services and expecting all students to have normal behavior are some of the reasons some parents may prefer HBE over regular schools.

The Attitudes
The attitude of society towards CWD is the major challenge faced by them. The reasons for negative attitudes may be lack of knowledge regarding the disability, stereotypes and prejudices. The findings from the case studies are:
• There is a poor understanding of the disability condition and generally the diagnosis has been done late. This serves as a barrier to successful rehabilitation. These children grow up without early interventions and this affects their condition further and leads to strengthening of prejudicial beliefs;
• Disability is still considered to be punishment for sin. Most of the neighbours and teachers interviewed, although sympathetic on face, were of this opinion and considered the suffering of the family as a result of their karma;
• The severity of the condition and the unhygienic appearance including dirty clothes are significant factors in the formation of negative attitudes and negative socialisation;
• The mother of the child becomes the scapegoat and is blamed for bringing such a child in the world by her partner and in-laws. It was seen that the relationship between the

50 Neighbours attitude and involvement has also been considered under this.
parents were strained and generally the entire responsibility of this child and other siblings rests on the shoulders of the mother;

- In a way, it was noticed that there is dehumanization of these children in their family. They lie in one place and are at the mercy of family members for eating, drinking or going to toilet;
- The self esteem/image of the children is poor as the family members exchange all negative conversations in front of the child without understanding that the child is not brain dead;
- As compared to urban blocks, tribal lack awareness and adequate knowledge of various provisions and needs of their children. They live in small habitations and are small communities. They have a distinct bend of mind for enjoying life and living day to day life. For them having a CWD is a responsibility they have to undertake and therefore they do their best in their circumstances;
- Attitudes towards girls with disabilities is more negative as two of the families interviewed conveyed that in spite of knowing that the child had disability we preferred not to abort since it was a boy;
- The appearance of the CWD governs the behavior of others towards him/her. Since most of these children are neglected in terms of cleanliness and hygiene, the others in the community try to avoid being near them;
- Teachers have a negative attitude towards inclusion of CWD. They feel that these children are not their responsibility. Teachers’ attitudes towards students with disabilities has a significant impact on their educational experience.

Resource Support

- There are no human resources in the form of physiotherapists, RTs or even volunteers to train the parents and visit the child. The child has to access the resource room, wherever it is situated with the help of parents;
- The transport allowance given to the parents is subject to 75 per cent attendance in the class which many a times is not achieved. So there is no provision for transport for these children;
- The state functionaries organize camps where assessment takes place. The children are also given equipment required. However, it was found that the wheelchairs given are not suitable for the child and require adaptations. Other than that no other devices and educational aids are given;
- Since most of these children have multiple disabilities and have great difficulties in sitting, walking speaking, eating and even going to toilet they required intense one to one early interventions and later support. However, there are very few RTs available and the teacher pupil ratio is very high. In some places one teacher was responsible for more than 100 children that also in different areas. The only best provision for these children is the BRC which is very far from their houses.

In summary, the following are the major issues that have emerged from the study:
Based on the findings of the Study a Road Map outlining the Outcomes/Goals to be achieved, Strategies/Activities to achieve these and Stakeholders involved has been developed which is given below:
## A ROAD MAP FOR FACILITATING HBE

<table>
<thead>
<tr>
<th>DESIRED OUTCOME</th>
<th>STRATEGIES</th>
<th>INSTITUTIONS &amp; RESOURCES</th>
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</table>
| IMPROVING HEALTH    | - Extend full range of immunizations to children with disabilities (CWD). If deprived, they are at risk of developmental delays, avoidable secondary conditions & preventable death;  
                     - Raise awareness regarding health and hygiene through posters and other promotional materials;  
                     - Make early detection and treatment of impairments as an integral aspect of public health. Train all Medical/health workers to execute it into practice through BRPs;  
                     - Move towards focusing the National health care policies on reducing the disparities in health care as CWD may experience health inequalities Providing mobile adapted toilets for CWD at home;  
                     - Organize developmental screening for detecting disability in children and referring them to further assessment and as well as providing vital information to family members;  
                     - Medical, social workers and RTs can collaborate to provide basic information about how their bodies develop and change, to reduce the risk of abuse;  
                     - Conduct regular parental counseling for dealing with their own mental stress and for improving the mental health of CWD;  
                     - Foster policies and programmes to alleviate financial hardships for families by providing financial assistance to purchase sufficient and necessary nutritious diet and medicines for the child;  
                     - Educate Health workers and other paraprofessionals working in the community about child development and disability and also train them to deliver integrated service effectively;  
                     - Plan Community based rehabilitation centers in each cluster for improving access to health services particularly in rural and remote areas;  
                     - Take Feedback of CWD from their family member so that facilities and services can meet their needs better;  
                     - Appoint women paraprofessionals and social workers to help address specific health needs of girls with disabilities and provide guidance to family members;  
                     - Extend collaboration between different Ministries like health, social justice and empowerment and human resource development ministry, NGOs, hospitals to ensure widely available services to CWD;  
                     - Engage volunteers from various NGOs and social workers for developing daily living and other skills in primary health centers, free health help lines, hospitals, medical camps, training of medical staff, workers and volunteers. | Health Ministry and Department:  
- Primary Health Centers  
- Free Health help lines  
- Hospitals  
- Medical Camps  
- Training of medical staff, workers and volunteers  
SCERTS, DIETs, SOCIAL WELFARE & SAMAGRA SHIKSHA (SS)  
- Organizing Camps  
- Assistive aids distribution  
- Transportation facilities  
- Distribution of material related to policy and legislation in language and format accessible for all  
  > Collaboration with:  
  1. Hospitals  
  2. NGOs  
  3. Social work departments  
  4. Health Ministry  
  5. National Institutes  
  6. Integrated Child Development Services Scheme (ICDS)  
  7. National Commission for Protection of Child Rights (NCPCR)  
  8. Commissioner Disability |
| CWD at home; | • Promote increased understanding, knowledge and positive perceptions of people with disability through awareness raising targeted communication and social media campaigns, developed in conjunction with NGOs. |
| Disseminate knowledge to the families of CWDs in rural areas regarding primary health care centres and other provisions under various schemes of the government existing in their district; | • Showcase abilities and success stories that will help in changing attitudes; |
| Provide frequent and free transportation to the health care centers because most of the families of CWD in the rural areas cannot afford the high cost of transportation since the centers are located far off; | • Organize community meetings, camps etc. where families, neighbors etc share their positive experiences to shift the community’s mindset from disabilities to abilities, break many misconceptions, myths and prejudices and build positive expectations; |
| Make provisions for home visits of staff, paraprofessionals like speech therapist, physiotherapist and others frequently. A lot of the families work on daily wages to survive and cannot skip a day of work; | • Organize various interactive events like street plays (nukkad natak), dance performances, games and activities involving CWD; |
| Encourage local administration and authorities to set up health camps and demonstration sites with the help of families, community members and the state government to raise awareness and mobilize support for healthcare; | • Encourage parents, neighbours not to dehumanize the child by discussing all their problems in front of the him/her as if he/she is brain dead; |
| Provide access to clean water, toilets and sanitation to ensure good health of CWD; | • Prepare regular and RTs to have a positive approach while addressing the specific needs of CWD. |
| Provide guidance to the families in order to ensure successful impact of services as they are ignorant of the provisions available. | • Encouraging non-disabled children in the community by family members, neighbors, health workers and social workers to interact and play with children with disabilities. |
| BUILDING POSITIVE ATTITUDES | • Make provision in the nearby resource centers and schools, to include CWD, even part time by making SCERTS, DIETs, SOCIAL WELFARE & SS |
| • Promote increased understanding, knowledge and positive perceptions of people with disability through awareness raising targeted communication and social media campaigns, developed in conjunction with NGOs. | • Resource Support to schools for implementing inclusive education and awareness campaigns to be organized by |
| • Showcase abilities and success stories that will help in changing attitudes; | 1. Social Workers |
| • Organize community meetings, camps etc. where families, neighbors etc share their positive experiences to shift the community’s mindset from disabilities to abilities, break many misconceptions, myths and prejudices and build positive expectations; | 2. NGOs |
| • Organize various interactive events like street plays (nukkad natak), dance performances, games and activities involving CWD; | 3. Volunteers |
| • Encourage parents, neighbours not to dehumanize the child by discussing all their problems in front of the him/her as if he/she is brain dead; | 4. Community Members |
| • Prepare regular and RTs to have a positive approach while addressing the specific needs of CWD. | 5. Media (for positive portrayal) |
| • Encouraging non-disabled children in the community by family members, neighbors, health workers and social workers to interact and play with children with disabilities. | 6. RTs ( ) |
| • Make provision in the nearby resource centers and schools, to include CWD, even part time by making SCERTS, DIETs, SOCIAL WELFARE & SS |
| SCERTS, DIETs, SOCIAL WELFARE & SS | 7. District administrators |
| • Resource Support to schools for implementing inclusive education and awareness campaigns to be organized by | • Providing education and training about disability to |
| 1. Social Workers | 1. Teachers and Resource Center Staff: Training on benefits of inclusion, assessment of academic progress, adapting the curriculum and using |
| IMPROVING MENTAL HEALTH OF PARENTS | • Provide transport facilities to the parents to visit the counselors and therapists in the resource centers. Also, therapists and counselors should also make home visits to meet, discuss and counsel the parents on regular basis;  
• Conduct counseling sessions and orientations for parents to support development of life skills in their CWD and also to help them cope up with difficult situations;  
• Hold individual and collective discussions at the resource centers or in local community for parents to share their experiences with other parents and learn from each other.  
• Allocate specific sessions of counseling to mothers where they share their experiences and learn life skills to deal with their situation better since mothers are primarily responsible for looking after the child;  
• In cases of marital discord, support through counseling and employment opportunities;  
• High cost of medicines, assistive devices and transportation etc increases the mental and financial stress of parents. Making financial resources and support available will help reduce their mental stress and devote more attention to the needs of their child;  
• Train teachers at the BRCs and schools to involve parents in decision making process and for bridging the gaps  
• Involve various para-professionals like speech therapists, physiotherapists for supporting the CWD;  
• Local Administrators like members of Panchayats along with district officers can arrange mental health camps and awareness programs for families of CWD and other community members. |
| --- | --- |
| HEALTH DEPARTMENTS, SS & SOCIAL WELFARE DEPARTMENTS, NATIONAL INSTITUTES | • RTs  
• Counselors, Therapists at Block Resource Center (BRC)  
• Home visits by Counselors and Therapists  
• Class Teacher in Schools  
• Cooperation from district authorities and  
• Panchayati Raj members  
• Funds for camps and campaigns and counseling sessions  
• School Management Committees(SMCs) |
| CAPACITY BUILDING/ TRAINING OF TEACHERS | • Sensitize teachers to the needs of CWD to encourage their participation even part time in classrooms  
• Include preparation for supporting CWD under the HBE under In service training programmes for assistive technologies  
2. Parents  
HEALTH DEPARTMENTS
1. Employing people with disabilities |

| HEALTH DEPARTMENTS, SS & SOCIAL WELFARE DEPARTMENTS, NATIONAL INSTITUTES | • RTs  
• Counselors, Therapists at Block Resource Center (BRC)  
• Home visits by Counselors and Therapists  
• Class Teacher in Schools  
• Cooperation from district authorities and  
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• Funds for camps and campaigns and counseling sessions  
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• Train teachers at the BRCs and schools to involve parents in decision making process and for bridging the gaps  
• Involve various para-professionals like speech therapists, physiotherapists for supporting the CWD;  
• Local Administrators like members of Panchayats along with district officers can arrange mental health camps and awareness programs for families of CWD and other community members. |
| --- | --- |
| HEALTH DEPARTMENTS, SS & SOCIAL WELFARE DEPARTMENTS, NATIONAL INSTITUTES | • RTs  
• Counselors, Therapists at Block Resource Center (BRC)  
• Home visits by Counselors and Therapists  
• Class Teacher in Schools  
• Cooperation from district authorities and  
• Panchayati Raj members  
• Funds for camps and campaigns and counseling sessions  
• School Management Committees(SMCs) |
- Organize workshops at Block level to plan and implement support for children under HBE programme. These workshops should also focus on attitudinal change;
- Provide opportunities for collaboration between regular teachers and special educators for effective delivery of services;
- Organize resources such as part time or full time paraprofessionals, integrating speech therapy or physiotherapy for students with disabilities into the general classroom and for HBE;
- Encourage teachers to make regular home visits for those CWD who are unable to reach the resource center or school. Individualized instruction and choices should be given depending on child’s needs;
- Provide detailed feedback to parents about the learning of their child. Parents should also be given training by teachers on how to replicate teaching and learning methods at home;
- Organize teams of teachers to discuss and problem-solve learning and behavioral concerns for individual students;
- Expand neighborhood amenities like flat and even surfaces in playgrounds, non-bumpy roads and mobile toilets etc. so that children with disabilities play, read, and socialize easily.

**IMPROVING INFRASTRUCTURE**

- Plan infrastructure requirements for mobility and access of CWD especially with movement problems in the wider context;
- Make classrooms equipped with adaptable furniture and materials for meeting the access and learning needs of different students;
- Classroom setup should be flexible and chairs/benches should be easily moved or modified to include individual needs of all children in the classroom;
- Make provisions for enough space to accommodate an adapted wheel chair;
- Establish a resource centre in schools for children who cannot sit in class for long;
- Remove barriers for children on in moving around e.g., too many pathways in between narrow spaces, bumps on the floors, narrow edges, etc.;
- Involve community members in maintaining school infrastructure (i.e., improvement of buildings and other infrastructure, procurement of textbooks and scholastic materials);
- Make BRCs and schools and even homes accessible through ramps, facilities of accessible/adaptable ;
- Create awareness of accessibility needs through

**Capacity Building of**

- General Educators and Special Educators
- Parents
- School Authorities
- Block Resource Persons

- Restructuring of Pre-Service and In-Service Training
- Development of Toolkit and Resource Material
- Availability of Braille materials & Training in Sign Language

**MINISTRY OF HOUSING & URBAN AFFAIRS, NGOs, CORPORATES (CSR Funding), DISTRICT ADMINISTRATORS, PANCHAYATI RAJ INSTITUTIONS & COMMUNITY**

- Transport Facilities
- Ramps
- Tactile paths
- School buildings
- Resource Centers
- Mobile Adapted Toilets
- Signage
- Well lit & Noise less classrooms
- Funding for refurbishing old buildings and institutions
- ICT in classrooms
- Assistive devices like
printed exemplars using photos, culturally tempered graphics, icons or symbols, etc.;
• Support the development of low-cost private/public special transport solutions to cater for CWD who have no access or who cannot utilize the existing provisions. In addition, escort facilities are to be provided for bringing these children to and fro schools.

| BUILDING INCLUSIVE CURRICULUM | • Modify the curriculum as per the needs of the child under HBE who may be able to participate in some but not all classes; • Make accessible ICT, assistive technologies including low vision devices, hearing aids, augmentative and alternative communication, walking frames, modified wheelchairs, and prostheses such as artificial legs to enable their functioning and participation; • Include dance, drama, music, painting, sculpture, carving, puppetry, etc. in the school curriculum to help all children including children under HBE in developing self-confidence and self-worth; • Empower teachers to modify or to exercise reasonable autonomy in curriculum delivery as per the need of the child. | SS, NATIONAL INSTITUTES, NCERT, UNIVERSITIES, NGOs, HEALTH DEPARTMENT |
| | • Experts in Curriculum Development • Teachers • Parents • Community Members • Headmasters/Principals Educational Technology Experts |

**Recommendations**

Some of the major recommendations that emerged from the study are:

• Since the delivery of services to the children have not improved after the RTE, it becomes important for the Government at Central and State Levels to mentor and monitor the programme for maximizing the quality of HBE to avoid their segregation from society;

• The Schools where these children are enrolled should be flexible enough and make appropriate curriculum decisions for these children. They should be strengthened to provide the required services to meet the child’s needs, opportunities for socialization, training to teachers and a safe environment for all;

• Parents of children under HBE Programme are at a great risk of developing mental problems. Mothers, due to overburden with the responsibility of CWD, household work are left with no time for themselves and feel frustrated. Parental counseling is very relevant in improving their mental health;

• Resource Support near the child’s residence, adequate aids and appliances, provision of an escort to take these children to school and bringing them back, transportation and financial help for medical interventions are some of the issues that need to be addressed;
• Special focus on girls with disabilities in all provisions would help them to survive better and achieve success;
• Early detection and early intervention of children having high support needs would help in controlling further damage and would improve the lives of these children.

**Conclusion**

The case studies of children under the HBE Programme in remote tribal areas and in slums have valuable implications for practice and intervention deriving from the analysis of interactions held with various stake holders. This research has provided insights from 5 homes with CWD. However, the common findings from these case studies, together with the findings from the limited number of studies on HBE tend to suggest that educational practices for children under HBE need to be addressed better by the Government and NGOs for improving quality.

At this point in time there appears to be a view held by parents included in this study that teachers and educational professionals have limited awareness of the needs of their children and require knowledge and skills so that they can effectively provide optimum learning environments for these children if they attend schools as recommended under the RTE.

A further implication of this research is that parents of children under HBE are not able to cope up with their daily chores and finances and tend to neglect these children having no expectations from him/her. As a result the child is just living and not developing in any way. The study reveals challenges faced by the parents include managing finances, managing households, accessing special education services, giving attention and time to the child, providing opportunities to socialize and sharing concerns with other parents for support.
विशेष आवश्यकता समूह शिक्षा विभाग  
राष्ट्रीय शैक्षिक अनुसंधान और प्रशिक्षण परिषद  

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परिवार में दादा-दादी, चाचा, चाची और अन्य।  
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| माता | पुष्पा | – (माता) |  |  |  |  |
| दादा | दुरवेश्सिंतोष्पागी | – (भाई) |  |  |  |  |
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**बच्चे की अक्षमता**

| सातवें महीने में घर पर ही माता का जन्म हुआ था और किसी साधन का इंतजाम नहीं था। बाद में अस्त्यलाल में दाखिल कराया गया। वह चल फिर नहीं सकती है। उन्होंने बेटी का, चलन संभव नहीं है मंदवृद्धि। |
| 1. बच्चे का विकास व संबंधित अक्षमता किस प्रकार की है? | बच्ची होने के बाद में ज्ञान दाखने से आकड़ी आई थी। |
| 2. अक्षमता को क्ष कहा गया था? | 3-4 महीने की उम्र से ही बच्ची का वजन बढ़ नहीं पाता था। दो-दिन दिन में बच्ची का वजन बढ़ता था। 16 दिन तक कैप्टन की पेट में रखा गया था। तो वह सात-आठ महीने की थी। जब से बच्चे की अक्षमता की पहचान हो गयी थी। | जब वह दो माह बाद पहचाना गया था।
### संदर्भ

3. क्या किसी परीक्षकीय बोर्ड/संस्था से अभ्यास के निदान के लिए, किसी प्रकार का प्रमाण-पत्र/सर्टिफिकेट प्राप्त हुआ है और यदि हां तो यह सर्टिफिकेट प्राप्त करने की कार्यवाही के बारे में बताएः

- कोई भी प्रमाण पत्र नहीं है।
- एस.एस.ए. से IQ टेस्टिंग किया था।
- सर्व शिक्षा अभिव्यक्ति समावेशन शिक्षण के द्वारा बच्चे का प्रमाण पत्र, जनरल अस्पताल टागों, टेम्बो नाका से प्राप्त किया गया है।
- हां केम्प के डाक्टरों ने बताया कि उसे सी.पी. है।
- साइकोलैब्रिकल असेसमेंट हो चुका है (सर्व शिक्षा अभिव्यक्ति के प्रभार) केम्प में किया गया था।

4. क्या संसाधन प्याक्ष/परीक्षकीय विषय/इनियर/डॉक्टर/आदि के द्वारा कोई क्रियाकलाप संबंधित आकलन/विशेष आयुर्विज्ञान संबंधित आकलन किया गया था?

- हां विशेष पत्र और विशेष शिक्षक के द्वारा परीक्षित की थी।
- इस बच्चे को सर्व शिक्षा अभिव्यक्ति समावेशन शिक्षण की सहायता से modifychair/बीडी चेयर/बिल्ली चेयर की सहायता दी गई है, जिसका प्रयोग वैयक्तिक कीश्लय विकसित करने के लिए विशेष शिक्षक नियुक्त की गयी है।
- नहीं बच्चे का द्वारा स्कूल के रिसर्स केंद्र में जाती थी। नहीं उसे आवेदकता नुसार प्रशिक्षण दिया जाता था।

5. बच्चे की अभ्यास का दूर करने के लिए किसने प्रकार के प्रयास किये थे?

- डीसी, कीव, अद्वैत, अन्य (परीक्षकीय, आयुर्विज्ञान और अन्य कार्यनीतियाँ)
- वरिष्ठ के के सदस्य सिविल अस्पताल, टागों के पर एक या दो महीने में एक बार विशेष शिक्षक आता है।
- कोई दवाई नहीं गई।
- केम्प के के पर एक या दो महीने में एक बार विशेष शिक्षक आता है।
- कोई विशेष शिक्षक नहीं दी कंप्यूटर वह पर नहीं थे।
- कोई दवाई नहीं गई।
- हां बच्चे के अभ्यास का दूर करने के लिए, Occupational Therapist/Psycho Therapist ने प्रयास किया था।
- नहीं बच्चे को प्रयास करने के लिए, व Miscellaneous द्वारा वरिष्ठ के के सदस्य सिविल अस्पताल और अद्वैत वरिष्ठ को परीक्षण के सदस्य ने प्रशिक्षित किया था।
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<tr>
<td>6. क्या इन प्रकारों के परिप्रेक्ष्य कितनी प्रकार का संयुक्त बच्चे में हुआ है?</td>
<td>डोपर, शिक्षक और टैपिनिट की वजह से दीक्षा में बदल-सा सारा आया है। पहले हाथ, पैर और गद्दियाँ नहीं पत्ती थीं पर दूसरे और शिक्षक के मार्गदर्शन के बजाय से हाथ, पैर और गद्दियाँ पत्ती है। हाथ से पकड़ने का प्रयास करती है। आवाज देती है। शरीर की हसत-सोट करती है और प्रतिक्रिया देने का प्रयास करती है। लेकिन न तो वह बोल सकती है, न अपने आप खाना खा सकती है और न ही बाध्य करने के लिए, बता सकती है।</td>
</tr>
<tr>
<td>बच्चे का शैक्षिक विकास</td>
<td>दो साल पहले गांव के स्कूल में जाता था। नहीं जिस मदद के जिन्दगी बचाया करता था। इस वजह से बार-बार स्कूल में 5-10 मिनट के लिए आया था। आकड़ी की दाखिलों के कारण से जो रोग आकड़ी आती थी वह अब 15 दिन में आती है।</td>
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### 1. बच्चा गृह आधारित शिक्षा (एच.बी.ई.) के लिए कैसे पहचाना गया और प्रेम और एच.बी.ई. से संबंधित निबंध किसने लिया था?

| आई-डी. शिक्षकों के संबंध के आधार पर और आधारित वैद्यकिय कैन्य के दौरान बी.एच.सी. के डोटर ने कहा कि सी-पी. बच्ची है और शिक्षकों ने निर्देशक का एच.बी.ई. की विशेषता है। यह भी कहा कि इसका फॉर में नाम दर्ज कराये। |
| एस.एस.ए. की टीम से पता चला और गांव के स्कूल के टीम से पता चला की टीपक रेगलस स्कूल में पहुँच नहीं कर सकता। |
| बच्चा पैदा होते ही उसकी पत्नी ने गये थे। तभी उसकी अवहितकल से लगे। इसके अलावा उसके अंतर्गत खाना की समस्या थी। लेकिन फिर दूर दूर की समस्या थी। तभी बच्चे की जनसंख्या बढ़ने लगा। जो बच्चे के बच्चे के दौरान फिर नाम दर्ज कराये। |

### 2. बच्चा कितने साल में गृह आधारित शिक्षा के अंतर्गत नामांकित है?

| यह बच्ची कम से कम 4 साल से संसाधन क्षेत्र में नामांकित है। टीपक को 5 साल पहले से ही गृह आधारित शिक्षा के अंतर्गत नामांकित किया गया था। |
| बच्चे की आयु के 5 साल से ही गृह आधारित शिक्षा के अंतर्गत नामांकित है। |
| 10 साल में पर्यतन ढेंगा साल पहले उसने इससे सेंटर की छोटी थी। |
| 2-3 साल में |

### 3. क्या आपको लगता है कि इस बच्चे को गृह आधारित शिक्षा के पालन को लगता है कि स्कूल में लेना चाहिए? विशेष शिक्षक (H.I, M.I, V.I) यह प्रश्न के टैपिनिट होने चाहिए |

| टीपक को एच.बी.ई. के अंतर्गत रखना चाहिए। उसे एक साल तक विशेष शिक्षक के नजर में रखना चाहिए। विशेष शिक्षक के द्वारा, टैपिनिट, सायकोतोडमिट और कई व्यक्तियों के द्वारा बच्चे की विशेष शिक्षक करके और साथी को स्कूल भेज सके तो अंतर्गत रखना चाहिए। |
| 10 उपलब्धता और तत्कालीन विभिन्न वस्त्र के द्वारा रखने के रूप में एक जगह पर गृह आधारित शिक्षा के अंतर्गत रखना चाहिए। |

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<td>4. क्या आपका बच्चा सामान्य विद्यालय में भी नामांकित है और यदि है तो किस कक्षा में?</td>
<td>नहीं है। बच्चे के परिवार के और से बच्चे की कोषिश के अनुसार बच्चे का एच.बी.ई. में ही रहना बेहतर होगा।</td>
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<td>5. पर से विद्यालय कितनी दूर है?</td>
<td>पर से विद्यालय का दूरी 100/120 किलोमीटर तक है।</td>
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<td>6. क्या बच्चा यह विद्यालय प्रतिदिन सामान्य और स्थिति के बाद जब बच्चे नहीं बच्चे के स्कूल कोई कोटा नहीं है।</td>
<td>जाता ही नहीं। बच्चे का समाह के अंतर चार दिन स्कूल होता है।</td>
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<tr>
<td>7. क्या बच्चे की विद्यालय में किसी प्रकार की सहभागिता है?</td>
<td>सामान्य विद्यालय के बच्चे कोई बनाए देने की कोशिश करते हैं। खाना खिलाते समय मदर करते हैं। विचरण बनाए रखने की आवाज सुनते हैं। हाथ, पैर हिलाने की कोशिश करते हैं।</td>
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<td>8. क्या सामान्य विद्यालय विद्या के बच्चे को किसी प्रकार की गहरी सहयोग प्रदान करता है?</td>
<td>सामान्य विद्यालय विद्या के बच्चे कोई सहयोग नहीं करते। विशेष विद्यालय के परिवार देते हैं और वहाँ जाने के लिए चुनाव होते हैं।</td>
</tr>
<tr>
<td>9. बच्चे को विद्यालय में, इसमें से किन समस्याओं का समाप्त करना पड़ता है: (क) विद्यालय पहुँचने में</td>
<td>रोड में ज्वाला ट्रॉफिक और लोगों की भीड़ का वजह से वीहल चेहरे में नहीं ले जा पाती। बच्ची को उठाना कर समाह के में ले जाती है।</td>
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$$g)$$ विद्यालय के अंदर खाना-पीना

| विद्यालय के अंदर जाने के लिए सामान्य बच्चों की ज्यादा भीड़ होती है और मेडिटेशन में सामान्य बच्चे खेलते हैं। धक्का या कोई बीज जैसे बीत लगने की समस्या आती है। |
| सामान्य बच्चों की तरह कक्षा में बच्चे को एक,एम.ए. (IED) द्वारा ती कालीन modify chair पर बैठने की व्यवस्था की गई है। पर वह कुछ उसके लिए बहुत बड़ी है। |

$$h)$$ कक्षा में बैठने की व्यवस्था में

| दीवार को संसाधन कक्ष में बैठने के लिए सफर्ट चेयर की व्यवस्था की गई है। नैसर्गिक खाना खाने वाले खाना और सूत्र नहीं बना पाती है, और बच्चे हवालय के अक्षमता के कारण महसूस करते हैं। |
| हवालय में शौचालय और पानी की सुविधाओं तक पहुँचने में दीवार को पानी और पानी की सुविधाओं तक पहुँचने का लिए, एक व्यक्ति हमेशा रहना चाहिए। जब बच्चे को पानी पीना होता है तो बच्चे पानी की ओर झार करता है, और पानी पीता है। |

$$d)$$ विद्यालय में खाना, पीना इत्यादि में

| विद्यालय में खाना खाते समय वह बच्चों का अनुकूलण नहीं करती जैसे बच्चे। वह बच्चे हवालय के अक्षमता के कारण बच्चे किले पर बैठने करते हैं। उसे खाना मिलता पड़ता है। |
| खाना ठीक से खाना। खाना खाने का मन हो तो बच्चा खाने की ओर इशारा करता है और जगह पर खाना परोस देने से बच्चा खुद अपने हाथ से खाना भी खाता है। |

$$c)$$ क्या आप यह मालूम करते हैं कि आपके बच्चे की अक्षमता के कारण विद्यालय-पढ़ाई के व्यक्तिबंधन बच्चे उसे दराटे-धरकरे-परेशान करते हैं?

| बच्चे की अक्षमता कारण पर चेयर परेशान करते हैं। जैसे भाई-बहन और पढ़ाई वाले, बच्चे के हालात देखकर नजरी कह नहीं आते। |
| हां, अनुकूल सताती जी, विकल्प सताते ही, बलिक बच्चे की मदद कर देते हैं। जब बच्चे की टीका होती है। |

$$b)$$ आप बच्चे की सिद्धांत के में क्या सोचते हैं? क्या आपने करना है कि आपके बच्चे को और वेदान्त सुविधाओं मिलती?

| दीवार की शिक्षा बेहतर होनी चाहिए। दीवार के तियंग शिक्षा, शिवाण, टेकर, एवं नजरी के विद्यालय में शेयरिट पहनने बाहर होने या हां, एक सी.पी. चेयर की भी झड़त है। दीवार को संसाधन कक्ष में शिक्षा मिल रही है। |
| इस बच्चे को 3 चौथे स्कूल शिक्षा बाहर होने जाते और पर में ए,बी,ए. के तरह शिक्षण शिक्षक के माध्यम से पढ़ाना चाहिए। बच्चे की टीका होती है। जब बच्चे की शिक्षा में सुधार हो जाते, बच्चे को अपने जीवन में किसी के इतिहास की ज्यादा न हो, विकल्प सहायता मिलती चाहिए। नियमित शेयरिट बाहर होने तथा सभी शिक्षक समय पर हो। शिक्षण शिक्षक की शिक्षा तथा आर बच्चे की सिद्धांत जीवन में आर बच्चे की सुविधा मिलती है। |
चाहिए, जैसे कि समाज विद्यालय या आप उनको घर में मिल रही शिक्षा से खुश/संतुष्ट है?

उससे मैं खुश हूँ पर उसका विकास इतना नहीं हो रहा क्योंकि विशेष शिक्षक बहुत कम आते हैं।

पर मे मिल रही शिक्षा से हम लोग संतुष्ट नहीं है।

ज) क्या आप बच्चे के नामकित विद्यालय की किसी समिति के सदस्य है?

नहीं है।

अभिभावकों की प्रतिक्रियाएँ/समझाएँ

(क) जब आपको आपके बच्चे की अस्थायी के बारे में पता चला तो आपने क्या प्रतिक्रिया दी?

जब बच्ची की अस्थायी पता चला तब बच्ची 3 महीने की हो गयी थी। मैंने निर्णय किया था मैं यह बच्छी को पालन/सहयोग की तरह देखेंगे। पर क्योंकि डॉक्टर ने बताया था कि यह बच्छी ठीक हो जायेगी और कौई विकल्प मे पास नहीं था। इसलिए बच्छी की शिक्षा की ओर ले जा रही हूँ।

जब के बाद पौंच ने दिन से ही उनको आकरी अपना शुरू हो गई। शरीर से खरू की कमी भी। जब ये ज्यादा दिन जिदा नहीं रहेगा ऐसा लगता था। लेकिन डॉक्टर की कोशिश की बजते से बो जाता रहा। यहाँ हम भाग्य समझते है।

जब बच्छी की अस्थायी के बारे में पता चला, तब हमारे पारिवार के सब सदस्य दुखी हो गये थे। परिवार वालों को पता चलने पर पारिवार के सब सदस्य बच्छे के भविष्य के बारे में चिंतित थे।

मुझे बहुत दुख खुश और बहुत रोई। भी थी। हम सोचते थे कि इसका जीवन पूरी रोग और इसे मर जाना आया। परन्तु जब वह हमारे यहाँ पैदा हुई है तो हम इसे देखना चाहते थे। हम इसे भाग्य की तौर मानक बच्छे पता करने के लिए परिवार के सब सदस्य तक पहुँचे। फिर इसे हमें 6 महीनों के लिए भिनरी में दिखाकर किया जब वह एक साल की थी। लेकिन उसकी हालत में कोई सुधार न आने के कारण हमें इसे वापस लेकर आना पड़ा।

हमे दुख हुआ परंतु फिर सोचा कि जब तक वह जिन्दा है हमें देखना पड़ेगा। कई गुंडे के पास भी गये पर कुछ फायदा नहीं हुआ।

(ख) क्या आप, अपने भाग्य/कर्म, या आपकी अन्य परिस्थितियों जैसे स्वास्थ्य, अनानात्मा, सुविधाओं की कमी, गर्भवती और दोषी समस्या, गर्भवती और विभिन्न चरणों के बारे में भाग्य, कम स्वास्थ्य, अनानात्मा, गर्भवती या समस्या या सुविधाओं की कमी या अभाविता इसमें से किसी को भी मैं दोस्तों नहीं मानती। क्योंकि इसके जम हो गए के 3 महीने के बाद मुझे पता नहीं चला। चाचा डॉक्टर ने कहा खुश की कमी होने के कारण और एक जुड़ा बच्छी हूँ। भाग्य और कम को नहीं मानते। उसका जन्म पर में ही हो आ था, जब के समय जो परिवार का उसे गर्भवती का जन्म नहीं था। उसी के गलती से बच्छे को बाचा पेटा हुई।

जी नहीं, हम सब लोग ने अपना भव्य अभाविता आश से अपने नसीब में होने से स्वीकार किया है, गर्भवती और विभिन्न चरणों के बारे में हमने अभी तक से खुलासा रखा है।

सिर्फी ठीक हार तक से इलाज न मिलने से उसका यह हार हुआ। उसका मारे सातवें महीने में पर पहुँचा था। उससे पहले हमने कोई सोशलवारी नहीं करायी थी। उसे ऐसे भी और उसे बुखा चढ़ने के आवश्यकता पड़ी थी। इसके बावजूद विभिन्न समस्याओं के कारण उसका यह हार नही। मैं तम्बाकू सुपारी लेती थी। डॉक्टर ने कहा उस कारण समझना हुआ। पर ही पहुँचा हुआ था।
<p>| (ग) आपके पति-पत्नी का इस तरह के बच्चे की पर में उपस्थिति पर व्‍या प्रतिक्रिया/व्यवहार या इस परिस्थिति से निपटने के लिए आपके उसमें क्षम सहयोग मिला था? | हमारे पहले बारे में हम पति-पत्नी ही हों। मिल के बच्चे को जिंदा रखने के लिए प्रयास किया। | कुछ भी समस्या नहीं आयी, परिवार के सब सदस्य बच्चे के प्रति प्यार जताते हैं। पहले सब लोग तुम्ही हैं। विशेष प्रतिक्रिया नहीं की थी। |
| डॉक्टर नहीं बोलते। जैसे कि मेरा दादा के बाद दादी की कुछ बच्चे प्रकार चक्की में तकरार नहीं हैं। इससे पता पत्रकार का समान तो करना ही पड़ता है। उसे नहलाना-पुलाना, खिलाना और शीर्षालय ले जाना इत्यादि में बहुत समय लगता है। बाहर भी पुराना नहीं जा पाते क्यों क्यों उसे उठाना अब मुशकिल है और उसे बह चेत चेत मिलता है वह भी बढ़ी है। | हाँ। | मिलजुलकर सभी सदस्य ने परिस्थिति को आपत्ति हुई। एकमेक्षोकर प्रशंसा किया। पति कभी-कभी बच्चे और मैं को दूर उसे और भला-बुरा भी कहते हैं। आपनी वित्त पक्ष को कोसते भी है। |
| (घ) क्या आपको लगता है कि आपके पर में अर्ध बच्चे की उपस्थिति के कारण आपके दैनिक जीवन के कार्यक्रमों में आपके परेराजन का सामना करना पड़ता है? | पर में बच्चे को अकेले छोड़े जाने के जा चक्की मुशकिल नहीं है। उसके साथ किसी को पूरे 24 घंटे रहना पड़ता है या उसे साथ ही रखने जा रहे हैं। उसी समय में दादा बच्चे हैं तकी मेरे बच्चे मेरे साथ एक ही जाने रहे। | जी, पति-पत्नी का सामना होता है, बच्चे की शौच ले लेने, बच्चे की भूख-पीन की वजह से परिवार की किसी एक सदस्य को उसके साथ रहना होता है। हमें पत्रकारी का सामना करना ही पड़ता है। उसे नहलाना-पुलाना, खिलाना और शीर्षालय ले जाना इत्यादि में बहुत समय लगता है। बाहर भी पुराना नहीं जा पाते क्यों क्यों उसे उठाना अब मुशकिल है और उसे बह चेत चेत मिलता है वह भी बढ़ी है। | हाँ। | हाँ। काम पर जाना कठिन होता है। बड़े माँ ही देखती है पर आके कई बार छोड़ गई पड़ता है। |
| (च) इस बच्चे की देखभाल करने समय अपनी परि वार के अन्य सदस्यों के साथ किन परिवार में कोई सदस्य भी साथ नहीं देखते हैं। पति के अंत के बाद मेरे बड़े बच्चे ने शादी करके एक अन्य संसार स्वागत किया और वे अलग रहने लगे। उसे, वह जेबा और एक 15 साल की तकी हम हमारे परिवार के किसी भी सदस्य को बच्चे को लेकर कोई परेराजन नहीं है। बालक सभी सदस्य बच्चे को प्यार नहीं है। किसी के भी कठिनाइयाँ का नहीं सब अपने-अपने काम में व्यस्त रहते हैं। कोई मदद नहीं मिलती है। | परिवार के सदस्य सभी कामों में हाथ बदलते हैं। |</p>
<table>
<thead>
<tr>
<th>कठिनाइयों का सामना करना पड़ता है?</th>
<th>चबाती नहीं आया खाना पिरा देती है। बच्चे थूक नहीं खाते हैं। साथ हैं।</th>
<th>सामना नहीं करना पड़ता है।</th>
</tr>
</thead>
</table>

(3) क्या आपको आपके बच्चे की देखभाल के समय अधिक कमी का सामना करना पड़ता है?

बच्ची की देखभाल करते समय बच्चे और कपड़ों में यथायथ खाना हो जाता है। जैसे कि बच्ची सिफ्रि पतला पतलाव लेती है और पेशाव तित्र लेने के बच्चे के बच्चे से हर हँसते या महीने में नया कपड़ा लेना पड़ता है। वह बस की बात नहीं है इसलिए अधिक कमी का सामना करना पड़ता है।

जी हां, परस्थितियों के लिए, हम प्रमाणित बिंदु नहीं दिया है। कभी-कभी पैसे की बजह से दिन में बच्चे बच्चे बच्चे को मदद की जाती है।

हम गुजरा कर रहे हैं।

(4) अपने बच्चे की देखभाल के समय आपको किन सुनिर्दिष्टाओं का सामना करना पड़ता है?

मुझे अकर्षीय कमी की देखभाल करनी पड़ती हैं। महीने अभिव्यक्ति और गोलियां खिलाना, खिलाने का समय और क्रूर जाने की समय रहती है।

बच्ची की उठाकर लेना आदि यह बड़ी मुद्दाओं हैं।

बच्चे का बड़ी भाग की दिशा में रहती है। बच्चे की कारण उसके मुख्य के बारे में विचार होते हैं।

हां, हमारा छोटा बेटा हमसे साझा के बारे में प्रयास पूछता है। उसे ज्ञात है।

(5) क्या आपको लगता है कि इस बच्चे की अक्षमता आपके अन्य बच्चों को किसी प्रकार से प्रभावित कर रही है?

अन्य बच्चों का उचाई कोई प्रभाव नहीं पड़ता, इस बच्चों की लक्षण नहीं है कि वह खाना हो जाते, हमारे साथ खिलते। बच्चों उसके साथ सामने गाना, खाते-खाते उसके मुंह में एक एक निवासी दालना और उसका हां हाक कर खड़ा करने की कभी-कभी कोशिश करते हैं।

हां, मेरे साथ बच्चे ने हमारी साथ छोड़ा है। यह कोई काम भी नहीं करता।

हां, हमारा छोटा बेटा हमसे साझा के बारे में प्रयास पूछता है। उसे ज्ञात है।

(6) क्या आपको प्रति अन्य बच्चे की प्रश्नावली की प्रश्नावली को लगता है जबकि से जबकि अन्यथा हो जाय, उसकी अन्य बच्चों

प्रस्तुती संतुष्टि दिनत है। लेकिन खुद के बच्चे को मेरे

बच्चा असम होने के कारण बच्चे की आदेश का नज़रिया अन्त: होता

किसी ने हमारे साथने कभी कोई सहानुभूति पूछता करते नहीं।
<table>
<thead>
<tr>
<th>क्या प्रश्नक्रियाएँ हैं?</th>
<th>के साथ पढ़ाई-लिखाई हो जाए और समाज के साथ चलना सीख और उसे अन्य सेवा-सुविधा मिल जायें।</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) समुदाय के सदस्यों का आवके बच्चे के प्रति क्या व्यवहार है?</td>
<td>बच्चे से संबंध के रहने की सलाह देने हैं।</td>
</tr>
<tr>
<td>(2) समुदाय के सदस्यों का आवके बच्चे के प्रति क्या बच्चे को मदद करते हैं और सब बच्चे के साथ व्याप होता है परंतु इसे कहीं ले जा नहीं पाते।</td>
<td></td>
</tr>
<tr>
<td>(3) क्या आप अपने अन्य बच्चों को बहारी दुनिया से सुरक्षित रखना चाहते हैं और उसे भारी कहीं भी जाने देना नहीं चाहते?</td>
<td>पढ़ाई बाले सहानुभूति दर्शाते है।</td>
</tr>
<tr>
<td>(4) क्या आप इस बच्चे का दूसरी से परिचय करते हैं साथ हिंदियाचाहत महसूस करते हैं? अगर, हां, तो ऐसा कैसे?</td>
<td>समुदाय के सदस्यों को होमे बच्चे के बारे में उसकी शर्म और शर्म को प्राप्त करते है, क्यबी भी हमे समुदाय के सदस्यों को कोई समय नहीं आते है।</td>
</tr>
<tr>
<td>(5) क्या आप इस बच्चे का साथ रखना चाहते हैं कि बच्चे की अनुभवा ने आपके पढ़ाईयां के साथ के संबंध को किसी भी रूप में प्रभावित किया हैं?</td>
<td>इस बच्चे का दूसरी से परिचय करते समय हिंदियाचाहत महसूस नहीं करती। क्यबी भी बच्चे है। दूसरे बच्चे की तरह से वह भी भी हो बच्चे है। कोई ज्ञान अपनाना हिंदियाचाहतो से तो कोई सामने ही बदनाम करता है।</td>
</tr>
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<td>(6) क्या आपको लगता है कि बच्चे की अनुभवा ने आपके पढ़ाईयां के साथ के संबंध को किसी भी रूप में प्रभावित किया है?</td>
<td>यही चिंता है। जब कभी आव‍्य जाते हैं। अब हम उसे कहीं नहीं लेकर जाते है।</td>
</tr>
<tr>
<td>(7) क्या आप उसे बढ़ाई के प्रति क्या बढ़ाई के प्रति की चिंता है?</td>
<td>पढ़ाई की दीवारों का दूसरा आदमी ज्यादा ध्यान नहीं देगा इसकी विचार है।</td>
</tr>
<tr>
<td>(8) क्या आप अपने अन्य बच्चों को बहारी दुनिया से सुरक्षित रखना चाहते हैं और उसे भारी कहीं भी जाने देना नहीं चाहते?</td>
<td>साथ हास्य को बहार ले कर नहीं जाते हैं। अब हम उसे कहीं नहीं लेकर जाते है।</td>
</tr>
</tbody>
</table>

समाधान: उपन्तहो हो तो बाहरी दुनिया दिखाना चाहते हैं। अभी हम उसे कहीं नहीं लेकर जाते है।
### संसाधन सम्बन्ध

| (त) आपके गांव के बच्चे एक-दूसरे के साथ कैसे मिलते-जुलते हैं और क्या आपका बच्चा इस प्रक्रिया का हिस्सा है? | नहीं क्योंकि यह बच्ची सी.पी. होने के बजर से बच्चों के साथ संबंध नहीं कर पाती। पर दूसरे बच्चे उससे संबंध करने की कोशिश करते हैं। | गांव के बच्चे तो स्कूल के माध्यम से ज्ञात होते-जुलते हैं लेकिन यह बच्चा तो स्कूल जाता ही नहीं। | सभी पढ़ाईयों के बच्चों के साथ होने से, और बढ़-बढ़त मिलने से सभी बच्चों के साथ नहीं जाता है, फिर भी सभी पदयात्राओं का देखकर हस देता है टाटा, बाह्य-बाह्य जैसे इलाज करता है। | एक-दूसरे के घर पर जाकर। साधी तो उसने पर पह हीं मिल पाती है। | नहीं घर पर ही लेटा रहता है। |

| (ब) क्या आपके परिवार को गांव के अन्य परिवारों से किसी प्रकार के भेदभाव या अलगाव का सामना करना पड़ता है? | गांव के परिवार उसको सुई लगाकर मार डालने का सुझाव देते हैं पर हमारा परिवार ध्यान नहीं देता। गांव के लोग अक्सर बच्चे का ममोरिज नहीं करते, उसको जुड़ते नहीं। उससे दूर, दूर रहते हैं। इस यवहार से हमे भेदभाव या अलगाव का सामना करना पड़ता है। | मुझे लगता है मेरे व्यवसाय के बजर से मुझसे जलन रहते हैं। | नहीं, इस प्रकार की समस्या नहीं है। | कभी-कभी यह सुनाते हैं कि हमने कोई गलत कर्म किए होगे। | नहीं |

| (क) क्या आपके सर्व शिक्षा अभियान (एस.एस.ए.) के गृह आयोगों अधिकार शिक्षा वालों के साथ आपका बच्चा प्रावधानों के अन्तर्गत आयो वाले प्राक्कारों के बारे में पता है? | हाँ, सर्व शिक्षा अभियान की बजर से यह बच्ची को व्हॉल चेयर मिलती है। और विशेष शिक्षा का साहाय्य मिलता है। उसकी बजर से जोरी और अस्पताल की सेवा मुक्तता मिलती है। | हाँ, एक बार तालुका में लेकर गए थे और 4-5 बार आए थे। हम इसी बच्चे के ठीच है ऐसा बोलते हैं। | हाँ, सब पता है, विशेष शिक्षक विशेषतर्जन और अन्य कर्मचारियों के साथ चर्चा होती है, और सभी प्रकार की सूचना बच्चे को मिल चुकी है, पालक प्रशिक्षण के द्वारा विशेष शिक्षक तथा विस्तारक के साथ एस.एस.ए. के सभी मुद्रों पर बच्चों होती है। | कुछ पता है पर बहुत कम |

| (ख) क्या आपने, आपके बच्चों के कौशलों को विकसित करने के लिए किसी व्यक्ति द्वारा प्रशिक्षित हुए हैं? | हाँ, शिशुक के ओर बीएसएस ने जैसे बच्चों को बच्चे। उसके बंध वाया के बायो था। हाँ, पहला बच्चे बननी है, प्यार महसूस करना और चर्चा के बारे में बताता था। | मुझे रोज के स्कूल भजन को बोले थे। मैं खुद स्कूल में उसके साथ बाढ़ती थी। लेकिन वो 3 मिनट भी कभी स्कूल में बैठा नहीं। | नहीं |

| (ग) क्या आपने, आपके बच्चों के स्वीकृत सम्बन्धों के लिए एस.एस.ए. द्वारा नियुक्त किया गया है? | नहीं, पर दीक्षा के लिए 3 महीने बीएसएस नियुक्त किया था। | नहीं |

| जो बच्चों को महत्त्वपूर्ण मिलता है, उसी बच्चों को मदद करने के लिए हम दोनों को खुद गया है। | नहीं |
(प) एस.ए.इ. के द्वारा आते हुए भी बच्चे की तरीके और मदद करने वाले साधनों के लिए, क्या सुविधाएं उपलब्ध रहती हैं?

हाँ, एस.ए.इ. के द्वारा व्हील चेयर, मोडलिंग मार्ग, प्रवासभवन, सिंसाधन भाग वह सुविधा मिलती है। विशेष शिक्षकों ने बच्चों का इसका अनुभव कर लिया है।

(च) व्हील चेयर का उपयोग क्या किया गया था?

बच्चों को modify chair, wheel chair, कोच टूल के रूप में इसे बच्चों बीच में आप उन्हें भी बनाता है।

(ण) इसी साधन का उपयोग क्या किया गया?

हाँ, व्हील चेयर, कुछ एनोम गैस। नहीं। संसाधन शिक्षक का निर्देशन से इसमें सुधार कराया। संसाधन केन्द्र के कलाकार की दृष्टि पर और जाना संचालन नहीं है।

(त) क्या बच्चों के लिए व्हील चेयर का उपयोग किया गया?

हाँ, 2012 के बाद भी.इ.इ. और आठ-वी. आय में सामग्री होने के बाद इसकी सम्पत्ति, शिक्षा, ए.डी.आई.., लेख की पकड़, खड़ा करने की प्रवृत्ति करवाई गई। व्यवहार करता है या करवाया गया है। शरीर की ध्यानदाय करना, खुद खड़ा होना भी सीखा है। ऐसे परिवर्तन इसमें आया है।

(ब) क्या व्हील चेयर का उपयोग किया गया?

हाँ, व्हील चेयर का नाम क्लूट्स में लिखा गया है। कोई साधन उपलब्ध नहीं है।

(इ) क्या शिक्षक-संस्थानों के बीच एक बार के लिए शिक्षकों का प्रवेश पाया गया?

हाँ, ऐसे बारों के प्रवेश पाया गया। जब से 2014 से उनका गांव का शिविर पुरा हुआ है, वहाँ से आज तक बहुत से लोग आए। एक बच्चे के लिए दूसरे स्तर में आया है।

(क) क्या शिक्षक-संस्थानों के बीच शिक्षकों का प्रवेश पाया?

हाँ, इसमें कुछ बच्चे का आया है। कभी-कभी उन्होंने इसमें से कोई भी उपयोग में नहीं है।

(द) क्या शिक्षकों का प्रवेश बच्चों के लिए रहता है?

जब जी है, परिवर्तन हुआ है, पहले बच्चा सोता रहा था, सभी साधनों की बदौलत, और खेलों में नहीं है। शरीर की ध्यान बच्चे की जरूरत एंव उपयोग करने के लिए नहीं है।

(ह) एस.ए.इ. समस्त इकट्ठा की दूरी पर साधन तथा उपस्थापना तथा उपाय नहीं है?

हाँ, एस.ए.इ. के 2012 से बारे में कोई परिवर्तन नहीं है। जब से 2012 से उनका गांव का शिविर पुरा हुआ है वहाँ से आज तक बहुत से लोग आए। एक बच्चे के लिए दूसरे स्तर में आया है।

(ज) क्या शिक्षकों के बीच एक साधन का प्रवेश पाया?

हाँ, वहाँ से साधन नहीं। कभी-कभी जल्दी में होता है। आता ही नहीं है।
<table>
<thead>
<tr>
<th>होती है?</th>
<th>व्यतिरिक्त रहते हैं</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3) क्या आप बच्चे की रेखेबाल के समय उपन समस्याओं को शिक्षक के साथ चर्चा करते हैं?</td>
<td>हां, करते हैं लेकिन मैं भी परेशान हूँ।</td>
</tr>
<tr>
<td>(3) क्या शिक्षक बच्चे की गतिविधियों के बारे में आपसे बात (वच्चा) करते हैं और बच्चे में कौशलों का विकास कैसे करें, इस बारे में आपको सुझाव/सलाह देते हैं?</td>
<td>शिक्षक गतिविधियों के बारे में चर्चा करते हैं जैसे ये बताता कि उसे दीवार का सपोट लेना या दीवार के कोनों का सपोट लेकर बैठना सिखाना चाहिए, चूँकि एक तरफ से आया शरीर उठा लेती है तो दूसरी दिशा में सपोट में विकास तो वह खुद सकता जा सकती है। बताते हैं कि उसे हाथ की पकड़ बनाने और सफ सुधरा रखने की गतिविधि करता।</td>
</tr>
<tr>
<td>(2) बच्चे की रेखेबाल में आप किन समस्याओं का समाधान करते हैं, उनके समाधान के लिए आपको शिक्षक से किस प्रकार की मदद शुरू करते हैं?</td>
<td>शिक्षक उसे रिता उठाया, उसे हाथ की पकड़, एक तरफ से दूसरी तरफ गांव, आवाज डेकर विदीया, पति विदीया और चीजों का पता करना ये सब बताते हैं।</td>
</tr>
<tr>
<td>(2) क्या आप शिक्षक द्वारा आपको बच्चे को दिये जा रहे सहयोग से खुशा हैं?</td>
<td>हाँ, खुशा है लेकिन सहयोग के लिए अधिक समय देना चाहिए, जो वह दे नहीं पाते।</td>
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</tr>
</tbody>
</table>

99
| ? | खड़ा रहने की कोशिश कराती है अगर पकड़ मजबूत हो तो। | भी इस्तेमाल करते हैं। बच्चे को बताने वाली एक्स्ट्रीमेटों के बारे में सोचकर पूर्व तैयारी करने आते हैं। behaviour modification में भी बच्चों को लेकर काम करते हैं। |
| (b) क्या शिक्षक बच्चे से बात करने के लिए बच्चे की मतभवन का प्रयोग करते हैं? | हाँ शिक्षक बातचीत करते समय उनकी मतभवन का प्रयोग करते हैं। | जी हाँ, बच्चे की मतभवन का उपयोग करते हैं। |
| (c) क्या आपको लगता है कि आपको बच्चे की देखभाल करने के लिए किसी और प्रकार की महत्त्व की आवश्यकता है? | हाँ, उसे शिक्षक के द्वारा हमें से 3-4 दिन सिखाना चाहिए और भी मुझे भी प्रशिक्षण चाहिए। | सभी बच्चों को किसी एक जगह लेकर बच्चों को सुविधा दी जाए, ताकि शिक्षक को परेशानी का समाप्त करना ना पड़े। |
| (d) अपने बच्चे के भविष्य के बारे में आप क्या सोचते हैं? | बच्चों अपने अप सब कुछ करे और शिक्षा लेकर वो आत्मनिर्भर हो जाये। | हमें चिता है। मैं हाँ, तो उनका पालन पोषण करना वह नहीं करेगा। |
| (e) क्या आपको लगता है कि एच.बी.ई. में बच्चा कुछ सीख पर रहा है और उसमें कुछ सुधार हुआ है? | हाँ सीख पर रहा है। वह आज जीवन की तरफ से मुड़ जाती है, जिसमें फड़क और हाथ के बल उठन।खड़ा होने की कोशिश करता यह। सुधार आया है। | 1. बच्चे को उसके भविष्य में सबसे बेहतरीन सुविधा देने। 2. बच्चों को उसका हक मिलना चाहिए। 3. बच्चों को भविष्य के रोज मिलनी चाहिए। 4. बच्चे को उसकी मिलने वाली सुविधा/साहीत्य समय पर मिले। |
| (f) क्या आपको लगता है कि एच.बी.ई. में बच्चा कुछ सीख पर रहा है और उसमें कुछ सुधार हुआ है? | चाच्चों का समाज में पानी समान होना चाहिए। | जी हाँ, सुधार हुआ है, बच्चा पहले से बेहतरीन हो चुका है। |
| (g) क्या आपको लगता है कि एच.बी.ई. में बच्चा कुछ सीख पर रहा है और उसमें कुछ सुधार हुआ है? | इन बच्चों का समाज में साहीत्य होना चाहिए। | हमारे परम्परा बड़े बेटे को बच्चों की देखभाल करने की जिम्मेदारी लेनी चाहिए। |
| (h) क्या आपको लगता है कि एच.बी.ई. में बच्चा कुछ सीख पर रहा है और उसमें कुछ सुधार हुआ है? | इन बच्चों का समाज में साहीत्य होना चाहिए। | हमारे परम्परा बड़े बेटे को बच्चों की देखभाल करने की जिम्मेदारी लेनी चाहिए। |
| (i) क्या आपको लगता है कि एच.बी.ई. में बच्चा कुछ सीख पर रहा है और उसमें कुछ सुधार हुआ है? | इन बच्चों का समाज में पानी समान होना चाहिए। | हमारे परम्परा बड़े बेटे को बच्चों की देखभाल करने की जिम्मेदारी लेनी चाहिए। |
| (j) क्या आपको लगता है कि एच.बी.ई. में बच्चा कुछ सीख पर रहा है और उसमें कुछ सुधार हुआ है? | इन बच्चों का समाज में पानी समान होना चाहिए। | हमारे परम्परा बड़े बेटे को बच्चों की देखभाल करने की जिम्मेदारी लेनी चाहिए। |
अना चाहिए। समाज में ऐसे बच्चे का प्रचार-प्रसार करना चाहिए और उनके आधिक सेवा-सुविधा अस्पताल में विकासगता का उच्चर मुख होना चाहिए।

तक अनेक इंतजाम करें।
4. विशेष शिक्षक को बच्चों की समस्याओं को देखकर प्रातिंबिक करना चाहिए।
5. बच्चे को सभी सुविधाएं समय पर भेद करना चाहिए।

| शिक्षक/संसाधन शिक्षक/स्वयंसेवक के लिए साक्षात्कार अनुसूची | नाम | अनियम राखकों भड़गी | मधुकर दत्तात्रय चालीबे | सामान्य/विशेष शिक्षक/स्वयंसेवक | विशेष शिक्षक (पूर्णांधिर) | सामान्य शिक्षक | आयु | 37 | 36 | 40 |
|---|---|---|---|---|---|---|---|---|---|
| क्या अनुसूचित जनजाति से है (अपने जनजाति क्षेत्र है) | नहीं | नहीं |
| विषयता | एच.एस.बी., डी.एड. | प्राथमिक विद्यालय शिक्षक |
| जात भाषाएं | मराठी, हिंदी, अंग्रेजी | मराठी, हिंदी |
| अनुभव बच्चों का पढ़ाने का अनुभव (वर्षों में) | मराठी |
| एच.बी.ई. में बच्चों का पढ़ाने का प्रशिक्षण | नहीं |

1. क्या आपको एच.बी.ई. के अंतर्गत नामांकित बच्चे के समाधान के लिए, संसाधन शिक्षक या सीमित प्रकार का सहयोग मिलता है (सामान्य शिक्षक के लिए)? अगर ही, तो विस्तार से बताइए।

होम बेबड़ बच्चे को विशेष शिक्षक हो पढ़ते हैं। सामान्य शृंखला में सामान्य शिक्षक पढ़ाने की कई समस्याओं हो रही थी। संसाधन कार्य का विशेष शिक्षक बच्चों को सिखाने का काम करते हैं। बच्चों की समस्या के बारे में और शिक्षक के बारे में उनका 10 अस्पताल सेवा पूरा करके बच्चों में जो कमीया हैं वो समझकर उसके उपर काम करते हैं।

मिलता है, लेकिन बच्चा स्कूल में आता ही नहीं है और अब यह स्कूल उसकी योग्यता के अनुकूल भी नहीं है। चूंकि स्कूल 4" तक है। और अब उसे 5" कक्षा के लिए दूसरे स्कूल में दाखिल की आवश्यकता है। दाखिला किया भी था लेकिन उपर योग्य ही नहीं।

वींका सामान्य कक्षा में नहीं आती थी सिर्फ रिसोर्स सेंटर में रहती थी।

वींका सामान्य कक्षा में नहीं आती ही नहीं है। बच्चा स्कूल आता ही नहीं है।

नहीं कोई सहयोग नहीं है।

बच्चा स्कूल आता ही नहीं है।

नहीं कोई सहयोग नहीं है।

2. एच.बी.ई. के अंतर्गत अपने गाँव/कलस्तर इलाके में कितने बच्चों को पढ़ाते हैं?

हर शिक्षक 13 कलस्तर में एच.बी. के अंतर्गत 5 बच्चों को सेवा सुविधा देने का काम करते हैं और सभी प्रार्थना के बच्चों के साथ काम करता है।

अभी किसी को भी नहीं।

एक आर.पी. के पास 100 से अधिक बच्चे होते हैं।

कोई नहीं है।
<table>
<thead>
<tr>
<th>पढ़ता है</th>
<th>मैं जब इस बच्ची को पढ़ता था तब रोज पर जाकर पूछताछ करता था।</th>
<th>हम कार्यालय के बायों में इतने स्थ रहते हैं कि घर पर जाना मुश्किल है।</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. आप किसी बार प्रत्येक बच्चे के पर आ पाते हैं?</td>
<td>हम लोग महीने में एक या दो बार यह बच्चों के पर जा पाते हैं।</td>
<td>नहीं</td>
</tr>
<tr>
<td>4. एक्ज.इ. के अंतर्गत नामाकर्षित बच्चों के लिए हमस्त्रों का नियोजन आप कैसे करते हैं?</td>
<td>हम यह बच्चा हमारे स्कूल में था तब उसकी माँ रोज लेकर आती थी। लेकिन वह एक जगह कभी बैठा नहीं, भागता था। उसकी बाकी बच्चों से उस भी बात थी।</td>
<td>बहु मम्मी ही लाती थी। मैं कहता-कहता रहता था।</td>
</tr>
<tr>
<td>5. आप बच्चे से किस भाषा में बातचीत करते हैं? क्या वह उसकी मातृभाषा है?</td>
<td>हम बच्चों की मातृभाषा माराठी होती है तो माराठी, हिंदी है तो हिंदी में। अगर दूसरी भाषा में रहा तो उस भाषा के टीचर को साथ में लेकर उनकी मदद लेकर बच्चों को पढ़ने का काम करते हैं।</td>
<td>माराठी</td>
</tr>
<tr>
<td>6. क्या आपको लगता है कि प्रत्येक बच्चे से मिलने आए कितनी बार प्रयास करते हैं? जानते हैं, वह उन्हें आवश्यक संसाधन समर्पित देने के लिए पहचानता है?</td>
<td>हम मराठी में।</td>
<td>हाँ</td>
</tr>
<tr>
<td>7. क्या आपको बच्चे के पर पहुँचने में किसी समय का समाप्त करना पड़ता है?</td>
<td>मैं तो खाली स्कूल के लिए उनके पर जाता था। उसको पढाने का तरीका तो मुझे मलतुम नहीं था।</td>
<td>नहीं</td>
</tr>
<tr>
<td>8. क्या आप किसी क्रम को लगातार जोड़ते हैं या आपको ऐसा है?</td>
<td>हाँ। पढ़ोंस के लोग दार पीते हैं और उनके आपस में झगड़े रहते हैं तो मैं कभी-कभी नहीं जाता।</td>
<td>हाँ, बच्चों के पर दूर पर है और कई बार गलियों में पैदल चलना पड़ता है।</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>पढ़ता है</th>
<th>हमारे स्कूल में है।</th>
<th>समय नहीं मिलता है।</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. क्या आप बच्चों की प्रश्नों को कैसे लगातार जोड़ते हैं या आपको ऐसा है?</td>
<td>इतना तो नहीं क्योंकि बाकी बच्चे भी हमारे स्कूल में हैं।</td>
<td>समय नहीं मिलता है। पर घर पर नहीं जाते हैं परंतु उनकी सुविधा मिलनी चाहिए।</td>
</tr>
</tbody>
</table>
9. क्या आपके बच्चे में कोई प्रामाण्य दिखाई दी है या आपको लगता है कि उन्हें वर्तमान में मिल रहे हस्तक्षेपों से अलग कुछ विशेष हस्तक्षेपों की आवश्यकता है?

<table>
<thead>
<tr>
<th>बच्चे को जो करने के लिए बोलता था, जो करती है या नहीं को जानना है। शिशु घर/या खेत हो/यात्रा हो इसमें कुछ प्रामाण्य को खोजिए।</th>
</tr>
</thead>
<tbody>
<tr>
<td>है, दिखाई देती है। इस बच्चे के लिए शिक्षा बहुत जरुरी है। सामान्य स्कूल, सभी स्कूल लेकिन पर इसका प्रारंभ-प्रारंभ होना। इन बच्चों को सामान्य विद्यालयों के साथ बैठने की इजाजत दी जाये। कम से कम आधा दिन स्कूल में और आधा दिन घर की एक्टिविटी करके इसमें सुधार आ जायेगा।</td>
</tr>
<tr>
<td>है, उनका भारीतकता अंद बढ़ गया है। उनके विशेष स्कूल में पढ़ाना चाहिए।</td>
</tr>
<tr>
<td>हां आप उर्फ की वैश्विक लोग लिखिए पिक्स्कू डेटल हो तो परवर्त्त होगा।</td>
</tr>
<tr>
<td>हां यह बहुत आवश्यकता है।</td>
</tr>
</tbody>
</table>

10. आपके अभिभावकों के बच्चों के प्रति उल्यकोण से क्या लगता है - क्या वह आश्वासन, प्रोत्साहित करते भाले, सकारात्मक, अधिक सुपरसुधात्मक, अनुरागशील, धिन्द अभावजनक, न स्वीकार करने वाले हैं?

| बच्चों के अभिभावकों के अनुसार बच्चों के पेय बने: होने के कुछ महीनों के बाद जो रिसेवर पहनती, पर के लग, इसके जो होन भावना मिली इसी बजाय से पालक बच्चों को टेस्ट व्याद कंपनी कर सकता है। लेकिन जब विशेष शिक्षक पालक को मादर्शन-समुदाय देखते हैं। तो अभिभावकों को ऐसा लगता है कि उन्होंने बच्चों के साथ पढ़ सकती है। इसी बजाय से अनुसार की आशा बहुत है जो प्रोत्साहित होती है और पालक सकारात्मक/सुपरसुधात्मक महसूस करते हैं। |
| बच्ची-बच्ची माता-पिता अपनी रोज की जिंदगी से काफी परेशान रहते हैं। उनका बच्चे से संबंध उसे जिंदा रखने का है। वह अपने पढ़-लिख नहीं लेकिन बच्चे को रेखना अपनी जिम्मेदारी समझते हैं। |
| न स्वीकार करने वाला। |
| पढ़े-लिखे नहीं है, कुछ समझ नहीं है। करना चाहते हैं पर जानकारी नहीं है। |

11. अपने बच्चों को समर्थन/सहयोग उपलब्ध करते लिए अभिभावकों का योगदान किस प्रकार का होता?

| अभिभावक अपने बच्चों के लिए मिलकर कह कर अपने बच्चों को विशेष शिक्षा के सामने अवयन करने के लिए बड़े हो आनन्द से समर्थन/सहयोग करते हैं। बच्चे या पालक दोनों बच्चे के लिए विशेष शिक्षक को सहकार्य करते हैं। अभिभावक प्रोत्साहित करते हैं काम बहुत अच्छी कह सकता है। पालक विशेष शिक्षक के साथ मिलकर कर अपनी बात कह सकता है। इसलिए, अभिभावकों को सबसे ज्यादा विशेष शिक्षक का योगदान मिलता है। |
| उनके दोपहर का बोलते हैं। कभी-कभी चॉकलेट देता हूँ नहीं तो 2-4 रूपया देता हूँ। |
| स्कूल छोड़ा, वहाँ बैठना, बाहर रहे। रे कर जा, जिम्मेदारी-पिलाना, बाहर लाया सब नहीं करते हैं। इसमें अलावा अपने बच्चे के लिए जाना भी उनकी जिम्मेदारी है, इन्हीं कारों से उन्हें कुशल नहीं मिलती। |
| कुछ जानकारी नहीं है। सब कुछ बहुत दूर-दूर है। कहीं भी ले जाने की सुविधा नहीं है। |
### 12. परिवार के कौन से सदस्य ने बच्चे की दैनिक जीवन की आवश्यकताओं को पूरा करने के लिए जिम्मेदारी ली है?

| परिवार में ज्यादातर आदमी बाहर की नौकरी/छिंदा/मजदूरी के कारण बाहर रहता है। इसलिए अभिभावकों में सबसे ज्यादा माँ की भूमिका रहती है क्योंकि बच्ची नहाना, बिठाना, पेशाब करना आदि के लिए माँ पर निर्भर रहती है। विशेष शिक्षक द्वारा माँ की ज्यादा समस्या बच्चों की स्थिति में ज्यादा समस्या का उस्मानित करते हैं। |
| उनकी माँ ने |
| ज्यादातर माँ ने |
| माँ गोद रखकर खाना खिलाती है। नहलना-भुतना भी करती है। |

### 13. क्या आपको लगता है कि अभिभावक चाहते हैं कि उनका बच्चा सामान्य विद्यालय में जाय या वह एच.बी.ई. से ही खुश है?

| अभिभावकों को भी लगता है कि मेरा बच्चा पढ़ने के लिए सामान्य बच्चों के साथ सामान्य स्कूल में पढ़े जो भी उत्पादित होता है क्योंकि एच.बी.ई. के हिसाब से बच्चा पर में ही प्रदर्शित करता है। बाहर का कोई भी चिक का पता या जान नहीं होता। पर से बुध जाने के रास्ते की जानकारी, टुकान, फल-गाड़ी अलग-अलग लोगों का सहारा आदि का जान नहीं होता। ये बच्चे सामान्य स्कूल में विशेष शिक्षक के साथ और सामान्य बच्चों के साथ अलग-मिल जाने से बहुत प्रात्मवारित और आनंदित होते हैं और इकार सामान्य जान बढ़ जाता है। माँ एच.बी.ई. को लेकर खुश है। |
| सामान्य विद्यालय में भेजना उन्हें सुरक्षित नहीं लगता है। पर में ही पढ़ना चाहते हैं। |
| सामान्य विद्यालय में भेजना चाहते हैं परन्तु आने जाने के साधन न होने के कारण पर पर भी पढ़ने से खुश है। |
| समय नहीं है तो कुछ नहीं करते |

### 14. क्या आपको लगता है कि अब या निकटतम भविष्य में बच्चों की अब या सामान्य विद्यालय में जाने की कोई गंभीरता है?

| नहीं, अगर हर एक सामान्य स्कूल में हर एक उपयोगी उदाहरण DB, HI, MR, CP के बच्चों के लिए विशेष शिक्षक की नियुक्ति कर दी गयी तो अभिभावकों को भी लगता है कि बच्चा सामान्य स्कूल में पढ़ने में कोई गंभीर/शिकार नहीं होगी। अभिभावकों को ईश्वरिक्षण देता है। बड़े उसलाही और आनंद से बच्चे को पढ़ने के लिए सामान्य स्कूल में जायें। |
| अब तक तो नहीं लग रहा है। |
| समस्य है पर कठिन नहीं, पहले विद्यालय बालों से वार करती पड़ते, फिर ट्रांसपोर्ट जुटाना पड़ता और शीघ्रता की आवश्यकता पड़ती। |
| नहीं विशेष शिक्षक के बिना समभव नहीं है। |

### 15. क्या आपने एच.बी.ई. के अंतर्गत बच्चे के कौशलों के विकास के लिए अभिभावकों को किसी प्रकार

| बच्चों के लिए 1.स्नान 2.गुंडांग 3.डेहल्लहनिंग 4.टॉइलेट ट्रेहनिंग ये सब विशेष शिक्षक द्वारा अभिभावकों को प्रशिक्षण दिया |
| अभी तक तो नहीं। |
| थोड़ा बहुत दिया है पर नियमित रूप से नहीं। |
| कुछ नहीं |

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16. अगर आपने अभिभावकों को प्रशिक्षण दिया है तो वह किसी गंभीरता से आपके सुझावों का पालन करते हैं।

अभिभावकों को प्रशिक्षण शिक्षक की तरफ से जो अध्ययन-अध्ययन दिया जाता है, पालक पूरी तरह से प्रशिक्षण की गंभीरता को समझते हैं और प्रशिक्षण का अध्ययन की भावनाओं को भी अच्छी तरह से समझते हैं।

अपनी तरह से खाना- पीना वह इतना नहीं सीखते और कहते हैं हमारे लिए संभव नहीं है।

17. अभिभावकों एच.बी.ई. के अंतर्गत बच्चे के विकास के संबंध में क्या-क्या सुझाव/शिकार देते हैं?

अभिभावकों को सबसे पहले बच्चे को ADI activity करने का सुझाव शिक्षक द्वारा दिया जाता है। अभिभावक बहुत विचार करके प्रशिक्षण शिक्षक से पूछते हैं कि हमसे हो पाएगा सर। प्रशिक्षण शिक्षक के बाहर पर अभिभावक बच्चों से activity कराने से भी हैं लेकिन कुछ पालक ऐसी शिकार करते हैं कि ये सब बच्चे विशेष शिक्षक की बात मानते हैं। ये जरा नहीं सुनते लेकिन प्रशिक्षण का खाना लेने से एटिविटी करने के लिए तैयार हो जाते हैं।

देते हैं कि बच्चे को खस्ते तक बांदी दे के लिए बेठाना चाहिए। बच्चे के साथ मिलाना चाहिए।

हाँ हमेशा पूछते हैं कि एस.एस.ए, और क्या कर सकता है। केवल के बारे में भी पूछते रहते हैं।

कभी-कभी पूछते हैं चिकित्सा के बारे में?

18. बच्चे की अक्षमता का, उसके पारिवारिक बातचीत या इसी प्रकार प्रभाव पड़ा है?

सबसे ज्यादा प्रभाव पड़ा है क्योंकि पर में सब लोग परेशान होते हैं। इस कारण बच्चे की परवरी के लिए संस्थागत नहीं मिलता। पर में सबसे पहले बुझौहर लगते हैं कि पिछले जन्म का पाप है। पढ़ोतरी या जाने-जानने की स्थान देते हैं। इसलिए अभिभावक और उसके बाहर के लोगों का सुनने से ऐसी बात की तरह होती है। इस द्वारा बच्चे की उम्र बढ़ जाती है और उसकी तरफ कोई भी बातचीत नहीं होती। उसके बाहर के लोग भी अच्छी तरह से जानने नहीं सकते। उन्हें लगता है कि जिन्होंने जन्म नहीं दिया उन्हें नहीं जानना है।

माँ अधिक थक जाती है और चिड़चिड़ी हो जाती है। साथी को अनुमान है कि उसके माता-पिता को कठिनाई है इसलिए वह भी तुच्छी रहती है।

उस्ते लगता है कि जिन्होंने जन्म नहीं दिया है और उन्हें नहीं जानना है जो खुद खाते हैं।

19. क्या आपको लगता है कि बच्चे के भाई-बहन, पड़ोसी के बच्चे उससे बात करते हैं या उसके साथ खेलते हैं, ह्में लगता है कि विवादगंग बच्चों के साथ एकता उसके भाई-बहन खेलते हैं दिखते हैं लेकिन कुछ जगह पर ऐसा देखने में आता है कि बच्चे से सब बात करते हैं। पर यह हमें चोटिकर किसी के भी पास नहीं जाता।

उसके साथ बेठक कर बात करते हैं साँप-सीढी खेलते हैं।

नहीं
### 20. क्या अभिभावक उनके पर भर आपकी उपलब्धि से खुश होते हैं या जो नहीं चाहते कि आप उनके पर आए?

हाँ, विशेष शिक्षक पर आए तो पालतू खुश होते हैं क्योंकि उनके ऐसा लगता है कि विशेष शिक्षक द्वारा इस परिवार/संस्थान किसी देरी से में परिवर्तन/प्रगति दिखाई दे रही है। यदि इसके बच्चों में परिवर्तन/प्रगति दिखाई दे तो आप धेराबाद आवे। आप आते हैं तो मेरा बच्चा activity करने लगता है। हमारी बात तो सुनता ही नहीं सर्कारी ही बात सुनता है।

प्रश्न रहते हैं लेकिन उनकी टिकाओं के बारे में ज्ञाता बोलते हैं।

बहुत खुश होते हैं और बार-बार आने को कहते हैं।

उन्हें लगता है कि हमारे आने से बच्चे में सुधार आयेगा।

### 21. क्या अभिभावक आपसे उनके बच्चों से संविदित मुद्दों व पिताओं पर प्रयास पूछते या बात करते हैं?

हाँ, जब हम उनके पहली बार प्रशिक्षण देते हैं तब तो अभिभावक बड़ी ही एकाग्रता से प्रशिक्षण सुनते हैं लेकिन जब दूसरी बार प्रशिक्षण देते समय दौड़कर या दौड़कर इस विशेष शिक्षक को अपनी पिता या सवाल ज्ञाता में पूछते हैं। क्योंकि इससे मेरे बच्चे नया क्या कर सकते हैं। मेरे बच्चे का आम जाकर क्या होगा ये सवाल जब विशेष शिक्षक दौड़कर अक्सर मलाई मलाई देते हैं और अपनी मिशन का पूरा समझन करते हैं।

हाँ, बोलते हैं कि इसका क्या होगा।

हाँ बात करते हैं, उन्हें लगता है कि उनकी बच्ची पहले से अच्छी हो सकती है और इसलिए प्रयास पूछते हैं।

### 22. क्या अभिभावक चाहता है कि उनके बच्चों को अतिरिक्त प्रशिक्षण, शिक्षा या कोई अन्य समर्थन मिलना चाहिए?

हाँ, अभिभावक चाहता है कि कुल में शिक्षा लेते समय (उसके समय) अतिरिक्त प्रशिक्षण मिलना चाहिए। जैसे तिलिपा, मोमबत्ती, कुमari, गिलास, चित्रकला, हस्तकला वा प्रेरणा आदि का प्रयोग करते हुए वह कुछ activity कर सके। प्रशिक्षण की योजना तैयार करना और वो प्रशिक्षण में पास हुआ तो उसको समर्थन के हाँ, बोलते हैं कि मुझे भी योजना सीखना चाहिए और टिकाओं देनी चाहिए।

हाँ चाहते हैं। आर्थिक मदद भी चाहते हैं।

हाँ नहीं तो उन पर बोआ है।
23. पिछले कुछ वर्षों में एच.बी.ई. को लागू करते समय क्या परिवर्तन हुए हैं ? मुख्यतः वर्ष 2012 में आर.टी.ई. में इसके समावेश के बाद।

| पिछले कुछ सालों में एच.बी.ई. में कार्य परिवर्तन नहीं हुआ है क्योंकि इस विकलंग बच्चों का ज्यादा प्रचार-प्रसार नहीं किया गया। विशेष शिक्षकों की कमी थी और जो थे वो भी वह लोग सिर्फ स्कूलों से जुड़े थे। जब RTE act लागू हुआ तो इन बच्चों का समावेश होना चुका हुआ तब विशेष शिक्षक ने daily schedule में एच.बी.ई. बच्चों को टाइम टेबल के हिसाब से daily activity करने का नियोजन किया। 2012 से लेकर आज तक एच.बी.ई. के बच्चे सामान्य बच्चों के साथ पढ़ते हुए daily activity करते हुए दिखाई देते हैं। आर.टी.ई. के तहत विशेष शिक्षक की बहुत जरूरत है।

| कोई भी नहीं।

| भी-भीएच.बी.ई. के लिए जो सहयोग मिलता था वह खाम हो रहा है। बच्चे स्कूल में नामाकरित है और पर पर आना कम हो गया है। वह सामान्य शिक्षक की अधिक जिम्मेदारी है।

| नहीं सिर्फ स्कूल में नामाकरित है।

24. भविष्य में इस कार्यक्रम को उन्नत बनाने या सुधारने के लिए आप क्या सुझाव देना चाहिए ?

| निम्न में चलना चाहिए आर.टी.ई. के हिसाब से सामान्य बच्चों के साथ रहने के नवजात शुक्ल में और बैठने के लिए विकलंग बच्चों को हर सुविधा देनी चाहिए। पूर्वसम के लिए हर सामान्य शूकल में आर.टी.ई. के हिसाब से विशेष शिक्षक की जरूरत है। ज्यादा से ज्यादा विकलंग भरी हो इसलिए हर स्कूल में विशेष शिक्षक होना जरूरी है। आज की तारीख में 100 से ज्यादा विकलंग बच्चों की विशेष शिक्षक से अभ्यास दे रहा है। इसलिए सब बच्चों को अच्छी शिक्षा के लिए टीचर की जरूरत है।

| ऐसे बच्चे को एक जगह लाकर उनको अनलग प्रशिक्षण देनी चाहिए। शिक्षा के अलावा सीखने का तो कोई चाचा ही नहीं है।

| क्यरेटकॉर्ट और आपकी क्यवशथा। अभिभावक का प्रशिक्षण पर पर। शिक्षा के साधन। यात्रा भत्ता की जगह वातावरिक भत्ता

| सुविधा प्रदान करनी चाहिए समझ की कमी के कारण कोई सुधार नहीं है। जो पता है वहीं करते हैं। हमारे पास नहीं है।

| इसलिए इसके सामने भी कोई सुधार नहीं है।
| समूह के सदस्यों के लिए साक्षात्कार अनुशंसा | समूह के सदस्य का नाम | सूज जहाँ | बेगम मोहम्मद फास्फार शेख | शिया लड़कूं, वाणी | नीलू | शी हीराकमण पतित भागुरस्वादकेशि सीता | 0.3 किलोमीटर |
|---|---|---|---|---|---|---|---|---|
| आपके पास व अभाव के पास के पार की दूरी | 50 मीटर | पुड़कुड | री | 0.3 किलोमीटर |
| जाति/जनजाति | जलपिंडिया, जलपिंडिया (भोजपुरी) | हिन्दु काँकरी | गोद (अनुसूचित जाति) |
| जिला | मुंबई-17 | ढाण | नागपुर | नागपुर |
| व्यापक तालुका | विदा (भरतराज) | शहापुर | रमटेक | रामटेक |
| गाँव | पुट्टवाड़ी | कामटी | कामटी |

1. **आपको गुण आपसीतिक शिक्षा (एच.बी.ई.) के बारे में क्या पता है?**

   हम यह शिक्षा के बारे में कुछ भी पता नहीं है।

2. **बच्चों का प्रायोजन उन सभी बच्चों के पर जाते हैं और यदि तो किस उद्देश्य से?**

   हाँ, दीक्षा या उसकी माँ का हालचाल पूछने के लिए अगर कोई समस्या का निवारण करने के लिए, कभी-कभी कोई आवागमन भारत है।

3. **आप इस बच्चे के अभिभावकों की मानसिक स्थिति व उनके अपने बच्चे के साथ संबंध के बारे में क्या सोचते हैं – क्या वह आशावादी, उसाहाजनक, सारास्ती, अधिक सुस्थान, असीमानी, बिन,उसासीन, अपमानजनक या स्वीकृति न देने वाले हैं?**

   दीक्षा अभी से जलदिः अच्छी हो जाये। हम क्षैरी का अपने बच्चे के लिए मेंसें या मां की मात्र टूट हो जाये। हम की सारास्ती में हमें सोचने का बाद उसकी माँ ने उसे पाता-पौषा है।

4. **बच्चे के लिए विद्यालय की चिकित्सीय, आयुष्मान या अन्य कार्यानिवारित का सहारा लिया?**

   एम.ए.ए. से सर आते हैं। अथात्क अभाव के लिए डाक्टर ने आपसीतिक अपलब्त, जे.सी. अपलब्त में इताज चालू है। दीक्षा की माँ के कहने भी आयुष्मान कार्यानिवारित का सहारा नहीं लिया।

5. **विवाह का समय कैसे लिया है कि अभाव के बच्चों के बारे में उपयोगिता पारवर्ती संबंधों में वापस हालाती है?**

   हाँ, बच्ची के बच्चे के बारे में दूसरा काम नहीं कर पाती है। पूरी दिन वह बच्ची के साथ हो रहती है। क्योंकि इस बच्ची को एक व्यक्ति की सहायता होती है।

   हाँ, अब सब अपने परिवार के बारे में सोचते हैं। उसका भाग बड़ा ताबा पीता है और उसके अपर औपन भी देता।

   बच्ची की भी कभी महंसिद्ध होती है।
<table>
<thead>
<tr>
<th>प्रश्न</th>
<th>जवाब</th>
<th>अवधारणाएँ</th>
<th>खरीदारी/पालन</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. क्या आपको इस परिवार की ऐसी किसी समस्या के बारे में पता है?</td>
<td>जब दीवार को उसकी मां उठा के ले जाती है तो उसको लेकर उसमें बच्चा नहीं जाता। माता-पिता झगड़ते हैं। दादी अपनी पैशान से मदद नहीं करती है।</td>
<td>कोई समस्या नहीं।</td>
<td></td>
</tr>
<tr>
<td>7. क्या आप चाहते हैं कि अवसर ब्राह्म बच्चा इस परिवार के साथ बच्चे के साथ ही पढ़े या उनकी शिक्षा के लिए कुछ अलग कैफिरिक व्यवस्था होनी चाहिए?</td>
<td>वह बच्चा सामाजिक विवाह में पढ़े और आगे बढ़े। इस बच्चे के लिए अलग से विशेष शिक्षा होना चाहिए। ताकि उसके बच्चे में परिवर्तन हो जाये यह जरूरी है।</td>
<td>मुझे लगता है वह स्कूल तो नहीं जायेगा। शासन को उसके है.इजाल के लिए पैसे देने चाहिए।</td>
<td>पढ़ना जरूरी है कारण भी। है। क्योंकि उन्हें सब सुनाम करना पड़ता है।</td>
</tr>
<tr>
<td>8. क्या/किसी शिक्षक/स्वयंसेवक/सचेत्तक इस परिवार की होनी चाहिए?</td>
<td>ई.एस.ए. की तरफ से हमें एक या दो बार विशेष शिक्षा या स्वयं सेवक आते हैं।</td>
<td>एक-दो बार में देखा है। ज्यादा तो नहीं।</td>
<td>नहीं देखा है।</td>
</tr>
<tr>
<td>9. क्या अभिभावक उनके बच्चों को उपलब्ध करानी जा रही सुविधाओं/प्रावधानों से सुनिश्चित करते?</td>
<td>हाँ, अभिभावक उनके बच्चों के लिए ईस.एस.ए. की तरफ से व्होल सेवा दिया है। वह संतुष्ट है।</td>
<td>नहीं है। अब स्कूल नहीं जाता तो उनके जो पैसा मिलता या तो भी नहीं मिलता।</td>
<td>नहीं अपने आप ही सब करते थे।</td>
</tr>
<tr>
<td>10. क्या बच्चे के अभिभावक उसकी शिक्षित और आदरनिर्मित बनाने के लिए किसी प्राकृति को कोई प्रयास कर रहे हैं?</td>
<td>हाँ, अभिभावक को तितित करने के लिए विशेष शिक्षा आते हैं और पालक को बच्चे के लिए activity कराने के लिए बोलते हैं। इस प्रयास से बच्चे और पालक आदरनिर्मित हो जातीं।</td>
<td>कुछ भी नहीं। खाली हाट रहने का सोच रहे हैं।</td>
<td>नहीं भूली काम नहीं कर रहे हैं।</td>
</tr>
<tr>
<td>11. क्या आपने बच्चे में, एच.बी.ई., मे साधन के बाद कोई सुधार देखा?</td>
<td>हाँ, बच्चे में श्री और शिक्षा की वजह से बहुत सुधार आया है। जैसे ही, आवाज दो तो दीवा गर्भ में हटाया करती है।</td>
<td>नहीं</td>
<td>संसाधन उपलब्ध नहीं हैं। कुछ सुधार नहीं है।</td>
</tr>
<tr>
<td>12. क्या अभिभावकों के कार्य करने के समय के कारण बच्चे की देखभाल पर कोई प्रभाव पड़ा है?</td>
<td>हाँ जब उनके काम करने कार्य करने बच्चे को खिलाए नहीं दिया है तो देखभाल के लिए एक व्यक्ति की सहायक जरूरत होती है।</td>
<td>माँ तो उनके साथ रहती है। हम सब लौग बाहर जाते हैं। लेकिन उनके बच्छे की कुछ रुकती है और उसके बच्छे का व्यवस्था करते हैं। बच्चा भी उनके साथ फर्जित है।</td>
<td>हाँ बच्छे के साथ कोई समय नहीं बिता पाता। सादी बहुत कम खाती है और उदास भी रहती है।</td>
</tr>
<tr>
<td>13. क्या आपने बच्चे, इस अवसर के बच्चे, इस अवसर के बच्चे बच्चे के साथ बच्छे भी तरह से कोई बातचीत करते हैं?</td>
<td>हाँ वास्तविकता करते हैं जैसे आवाज देने के बाद दीवा की महसूस होता है कि मुझे आवाज दिया।</td>
<td>चोट सबूत नहीं, खाती आऊ, आई और हंसता है। बच्छे उनके साथ खेलना पसंद नहीं करते।</td>
<td>हाँ सादी से बात करते हैं।</td>
</tr>
<tr>
<td>14. क्या आपको लगता है कि अवसर के बच्चे बच्चे के साथ अफसोस जमाते हैं?</td>
<td>जैसे तो किसी को मारता नहीं। काफिला नहीं</td>
<td>नहीं</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>संभालू से बातचीत रखने से आपके बच्चों पर कोई नकारात्मक प्रभाव पड़ता नहीं।</th>
<th>बच्चों में कोई नकारात्मक प्रभाव पड़ता नहीं।</th>
<th>ही रखना पसंद करता है।</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. क्या आपको लगता है कि इस तरह के बच्चे का कोई भविष्य है?</td>
<td>हम नहीं लगता कि इस तरह के बच्चों के भविष्य पर क्या प्रभाव होगा। पह लिख जाये तो कुछ हो सकता है पर ऐसी बच्चे का क्या भविष्य है।</td>
<td>कोई नहीं। कुछ इलाज किया तो होगा। डॉक्टर इलाज</td>
</tr>
<tr>
<td>16. क्या आपको लगता है कि अस्तित्व एक अभिवाद है?</td>
<td>हाँ कभी-कभी ऐसा लगता है कि अस्तित्व एक शाप है जो पिले हुए का पाप है।</td>
<td>हाँ शाप ही है। पाप के कारण है। किसी बच्चे में ऐसा किया जा सकता है।</td>
</tr>
<tr>
<td>17. बच्चे की इस दशा के लिए आप किसको दोषी मानते हैं? क्या आप सोचते हैं कि बच्चे को यह दशा अभिभावकों के कम्य का फल है या इसका कारण कुछ और है?</td>
<td>यह कभी-कभी नहीं मानते। यह कभी-कभी नहीं है। जब तब के बाद हुआ। हालत के बाद हुआ।</td>
<td>नहीं ऐसा है। हाँ कभी कभी नहीं। काम के कारण है। रोगी के जरूरत है।</td>
</tr>
<tr>
<td>18. समुदाय के सदस्यों/पदर्शियों का अस्त्र बच्चे व उसके परिवार के साथ व्यवहार कैसा है? क्या आपको लगता है कि इस परिवार की किसी भी प्रकार के अलगाव या परिवार का सामना करना पड़ता है?</td>
<td>अच्छा रुप में है। यह परिवार की किसी भी प्रकार का अलगाव या भेदभाव का सामना करना पड़ता है।</td>
<td>ना-ना। ऐसा है। हाँ कभी कभी नहीं। सबको सहानुभूति है।</td>
</tr>
<tr>
<td>19. क्या आपने और आपके समुदाय के नेताओं ने अस्त्र बच्चे की शिक्षा/कल्याण के लिए किसी प्रकार का योगदान - पैसे, सामग्री, मालिकादेतियों का रूप में किया है?</td>
<td>आज तक कोई भी नेताओं ने इस विकल्प में किया है। कभी कभी नहीं। पाप का होना है। पाप के कारण है।</td>
<td></td>
</tr>
<tr>
<td>20. क्या आपने अस्त्र बच्चे के परिवार को शारीरिक रूप से किसी प्रकार की सहायता दी है?</td>
<td>इन लोगों की समस्या पर होने चाहिए। और सरकार ने विकल्प जनों को भाग में रखना उनको भी सेवा सुविधा का स्कूल हर विकल्प के लिए देना चाहिए।</td>
<td>हाँ में खुद उनको डॉक्टर के पास ले कर गया था। हाँ में जमों को जबता है। सरकार के माध्यम से सहानुभूति भरा ज्ञापिय है।</td>
</tr>
<tr>
<td>21. अस्त्र बच्चे व उसके परिवार की दशा में सुधार के लिए, आप किन उपाय का सुझाव देंगे?</td>
<td>बच्चों के सुधार के लिए, शिक्षा का होना जरूरी है। परिवार की आकार पर सहानुभूति मिलनी चाहिए। हाँ। अस्तित्व में माफ़ित सुविधाएँ, मिलती चाहिए। हाँ। स्कूल में विशेष शिक्षक चाहिए जो इन बच्चों को समझ सके।</td>
<td>उनका इलाज करना चाहिए। सरकार से पैसे की मदद मिलनी चाहिए। ऐसे बच्चों को सुविधाएँ प्राप्त होनी चाहिए और सरकार को माता-पिता की मदद भी करनी चाहिए। इस आर्थिक सहायता दी जाये। पर परी शिक्षक आकर कुछ-कुछ बच्चों को सिखाये।</td>
</tr>
</tbody>
</table>
ANNEXURE-1
Department of Education of Groups with Special Needs
National Council of Educational Research and Training, New Delhi

Interview Schedule for Parents

Child’s Name: _______________________________
Gender: _________________________________
Date of Birth: ______________________________
Whether SC/ST: ______________________________
District: _________________________________
Block/Taluka: _______________________________
Village: _________________________________

Family Details
1. Father’s Name: _______________________________
2. Age: _________________________________
3. Education Level: _______________________________
4. Occupation: _______________________________
5. Mother’s Name: _______________________________
6. Age: _________________________________
7. Education Level: _______________________________
8. Occupation: _______________________________
9. Details of family members (siblings of the child, grand-parents, uncles and aunts):

10. Name of the tribe (if Scheduled Tribe): _______________________________
11. If ST, the language/dialect spoken in the family: _______________________________
12. Type of marriage culture followed: Monogamy or Polygamy- _______________________________


Disability of the child

1. What type of impairment and associated disability the child has?

2. When was the disability detected?

3. Was any certificate obtained from any medical board for diagnosis of disability and if yes how was it obtained?
4. Was any functional assessment/special needs assessment done by the resource person/medical practitioner/IED coordinator, etc.?

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5. What were the steps taken (medical, spiritual and other healing strategies) and what are the treatment/therapy undergone/undergoing?

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6. Were there any improvements as a result of the steps taken?

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Educational details of the child
1. How was the child identified for Home Based Education (HBE) and who took the decision regarding HBE?

2. For how many years the child has been enrolled under HBE?

3. Do you feel that this child should be under HBE or you feel there should be some other arrangements?

4. Is your child enrolled in regular school also and if yes, in which class?
5. How far is the school from home?, mode of communication, n the road condition

6. Does s/he attend this school every day, weekly, monthly or whenever he/she wants?

7. Is there any kind of participation of the child in the school?

8. Does the regular school/teacher provide any kind of support to the child?
9. What problems do the child face in the school with regard to:

a) Reaching the school

b) Movement within the school

c) Sitting arrangement in the classroom

d) Accessing to toilet and water facility in the school

e) Eating, drinking, etc. in the school

10. Do you feel that your child is bullied by others in the school/neighborhood because of his disability?
11. What do you feel about your child’s education? Do you feel he/she deserves better facilities like going to a regular school or are you happy/satisfied with him/her getting education at home?


12. Are you a member of any of the committee of the school in which your child with disability is enrolled?


**Parental Reactions/Perceptions**

1. What was your reaction when you became aware about the disability of your child?


2. Did you blame your fate/destiny/karma, anything else in your circumstances like health malpractices, lack of facilities, problems during pregnancy, ignorance about various stages of pregnancy, etc. for the birth of a child with disability in your family?
3. What was the reaction/behaviour of your husband/wife regarding the presence of this child at home and what support did you get from him/her in coping up with the circumstances?

4. What was the reaction of the elder members of the family when they came to know about the disability of the child?

5. Do you feel that your daily routine is disturbed to a great extent because of the child with disability living at home?
6. What difficulties do you face with other members of your family while looking after this child?

7. Do you face any financial constraints while looking after your child?

8. What is the greatest challenge you face in taking care of your child?

9. Do you feel the disability of the child has impacted on your other children in any manner?
10. What is the behaviour of your neighbours towards the child with disability?

11. How do the community members interact with your child? (no need of this question, same as the above)

12. Do you feel like protecting your child with disability from the outside world and don’t want him/her to go anywhere outside the house?

13. Do you feel a little hesitant in introducing the child to others? If yes, why do you feel like this?
14. Do you feel the disability of the child has impacted the relationships with the neighbours in any way?

15. What kind of relation your child has with other children in your neighbourhood?

16. How do the children in your village socialize with others and is your child a part of the process?

17. Did your family face any kind of discrimination or segregation from others in your village?
**Resource Support**

1. Do you know about the provisions under HBE programme of SSA?

2. Have you been trained by anyone for developing skills in your child?

3. Are you employed by the SSA for voluntary support for your child?

4. What are the facilities provided by the SSA for HBE of your child and are you satisfied with these?
5. Has there been any change in the provision of facilities in recent years especially after the year 2012 when HBE was included in RTE?

6. Does any teacher/volunteer visits the child at home and if yes how frequently?

7. What is the reaction of the child to the teacher’s/volunteer’s visit?

8. Is the teacher also happy while interacting with the child or she is always in a hurry to leave?
9. Do you discuss the issues faced while looking after the child with the teacher?

10. Does the teacher discuss with you about the activities of the child and advises you on how to develop skills in the child?

11. What kind of assistance do you get from the teacher in dealing with any problem you may be facing while looking after this child?

12. Are you happy with the assistance the teacher gives to you and your child?

13. What kind of activities the teacher makes the child do in her presence?
14. Does the teacher use mother tongue to interact with the child?

15. Do you feel the need for some support in looking after the child?

16. Do you think about the future of your child and what are your thoughts regarding this?

17. Do you think the child is learning and improving with HBE?

18. What suggestions you will give to make HBE more effective for the children?
Interview Schedule for teacher/resource teacher

Name: ____________________________________________________________
Regular/Special teacher/Volunteer: __________________________________________
Age: ___________________________________________________________________
Whether tribal background (if tribal area): ________________________________
Qualifications: ___________________________________________________________
Languages known: _______________________________________________________
Number of years of experience in teaching children with disability: _____________
Training for teaching children under HBE: ________________________________

1. Do you get any assistance from the resource teacher (in case of regular teacher) for
   supporting the child under HBE? If yes, describe.

   ______________________________________________________________________

2. How many children do you visit under HBE in your village/cluster/block?

   ______________________________________________________________________

3. How often are you able to visit the home of each child?

   ______________________________________________________________________
4. How do you plan the interventions for the child under HBE? Are any goals set and if yes, or are these set one time, periodically, daily, or no pattern is followed?

5. In which language do you interact with the child? Is it his/her mother tongue?

6. Do you feel the frequency of your visits is sufficient for providing the necessary resource support to each child?

7. Do you face any problem in reaching the house of the child?
8. Do you continuously monitor the progress of the child or you do not get time to do so?

9. Do you find any improvement in the child or you feel they need more intense interventions than being presently provided?

10. What do you feel about the parents’ attitude towards their child- are they hopeful, encouraging, positive, over protective, loving, depressed, indifferent, abusive or rejecting?

11. What kind of participation do the parents have in providing the support to their child?
12. Which family member is mainly responsible for looking after the daily needs of the child?

13. Do you think that the parents want their child to attend regular school or are happy with HBE?

14. Do you think this child has a scope of attending regular school now or sometimes in future?

15. Have you also given any kind of training to the parents to support in developing the skills in the child under HBE?
16. In case you have provided training to the parents how seriously do they follow your advice?

17. What are the suggestions/ideas/complaints given by the parents regarding their child’s development under HBE?

18. What is the effect of the child’s disability on the home environment of the child?

19. Do you feel that siblings, children from neighbourhood play/interact with this child? What kind of activities do they do together?
20. Are the parents welcoming to your presence at their home?

21. Do the parents ask you questions or discuss issues and concerns regarding their child?

22. Do the parents want their child to have access to any kind of additional training, education or any other type of support?

23. What are the changes that have taken place in the implementation of HBE in the last few years especially after its inclusion in the RTE in the year 2012?
24. What are your suggestions for future improvement in the programme?
Interview Schedule for the Community Member

Name of the Community member: _____________________________________________
Type of interaction with the parents/family of child with disability: __________________
Distance between his/her home and home of the child with disability: ________________
Gender: ____________________________________________________________________
Caste/Tribe: __________________________________________________________________
District: ____________________________________________________________________
Block/Taluka: __________________________________________________________________
Village: ____________________________________________________________________

1. What do you know about Home Based Education?

2. Do you often visit the house of this child with disability and purpose of visit?
3. What do you think about the mental state of the parents of this child and their interaction with their own child- are they hopeful, encouraging, positive, over protective, loving, depressed, indifferent, abusive or rejecting?

4. Did the family resort to any kind medical, spiritual or other healing strategies to cure the disability of the child?

5. Do you think the family relationships are disturbed with the presence of child with disability at home?
6. Do you have any idea about the kind of disturbance that has happened in this particular family?

7. Do you want the child with disability should study along with other children in regular school or some alternative arrangements should be made for his/her education?

8. Is any teacher/volunteer/therapist visits the child with disability and if yes how often?
9. Do the parents appear to be satisfied with the provisions/facilities being provided to their child?

10. Do the parents of the child make any effort in making the child educated and self-dependent?

11. Do you see any kind of improvement in the child after enrolment in HBE?

12. Does the work schedule of the parents have any effect on the care of the child?
13. Do your children interact in any form with this child with disability?

14. Do you think your children would have any negative effect by interacting with the child with disability?

15. Do you think these children have any kind of future?

16. Do you think disability is a curse?
17. Whom would you blame for the condition of this child? Do you think that the condition of this child is a result of the karma the parents or because of some other factor?

18. How is the behavior of other community members/neighbours towards the child with disability and the family? Do you feel that the family faces any kind of discrimination or segregation?

19. Do you or your community leaders contribute in any form-money, donation, materials, guidance, etc. to support the education/welfare of the child with disability?
20. Do you also physically help the family in any way in looking after the child with disability?

21. What measures would you suggest for improving the condition of the child with disability and the family?
विशेष आवश्यकता समूह शिक्षा विभाग
राष्ट्रीय शैक्षिक अनुसंधान और प्रशिक्षण परिषद

साक्षात्कार अनुसूची (अभिभाषक)

बच्चे का नाम : ________________________________________________________________
लिंग : ________________________________________________________________
जन्म तिथि : ________________________________________________________________
अनुसूचित जाति/जनजाति : __________________________________________________
जिला : ________________________________________________________________
ब्लॉक/तालुका : __________________________________________________________
गाँव : ________________________________________________________________

परिवारिक विवरण :

13. पिता का नाम : __________________________________________________________
14. आयु : ________________________________________________________________
15. पिता की शिक्षा : ______________________________________________________
16. पिता का व्यवसाय : _____________________________________________________
17. माता का नाम : _______________________________________________________
18. आयु : ________________________________________________________________
19. माता की शिक्षा : _______________________________________________________
20. माता का व्यवसाय : _____________________________________________________
21. परिवार के सदस्यों का विवरण (बच्चे के भाई-बहन, दादा-दादी, चाचा और चाची व अन्य) :

22. जनजाति का नाम (अगर अनुसूचित जनजाति से है तो) :

23. परिवार में बोली जाने वाली भाषा/बोली (अगर अनुसूचित जनजाति से है तो) :

24. विवाह संस्कार का प्रकार: एकांकी विवाह या बहुविवाह :

बच्चे की अक्षमता

7. बच्चे का विकार व संबंधित अक्षमता किस प्रकार की है?

8. अक्षमता को कब पहचाना गया था?
9. क्या किसी चिकित्सीय बोर्ड/संस्था से अवकास के निदान के लिए, किसी प्रकार का प्रमाण-पत्र/सर्टीफिकेट प्राप्त हुआ है और यदि हाँ तो यह सर्टीफिकेट प्राप्त करने की कार्यविधि के बारे में बताएं?

10. क्या संसाधन व्यक्ति/चिकित्सीय विशेषज्ञ/आई.ई.डी. कॉर्डिनेटर आदि, के द्वारा कोई नियामकता संबंधी आकलन/विशेष आवश्यकता संबंधी आकलन किया गया था?

11. बच्चे की अवकाश दूर करने के लिए प्रकार के प्रयास किये गये (चिकित्सीय, आध्यात्मिक और अन्य कार्यनिष्ठा) और कौन से उपचार हुए थे/हो रहे हैं?
12. क्या इन प्रयासों के परिणामवर्तुष किसी प्रकार का सुधार बच्चे में हुआ है?

बच्चे का शैक्षिक विवरण
1. बच्चा गृह आधारित शिक्षा (एच.बी.ई.) के लिए कैसे पहचाना गया और एच.बी.ई. से संबंधित निर्णय किसने लिया था?

2. बच्चा कितने साल से गृह आधारित शिक्षा के अंतर्गत नामांकित हैं?
3 क्या आपको लगता है कि इस बच्चे को गूह आधारित शिक्षा के अंतर्गत रखना चाहिए या बच्चे के लिए कोई अन्य व्यवस्था होनी चाहिए?

4 क्या आपका बच्चा सामान्य विद्यालय में भी नामांकित है और यदि हाँ तो किस कक्षा में?

5 घर से विद्यालय कितनी दूर है?

6 क्या बच्चा यह विद्यालय प्रतिदिन/साप्ताहिक/मासिक या जब वह चाहे तब जाता है?
7 क्या बच्चे की विद्यालय में किसी प्रकार की सहभागिता है?

8 क्या सामान्य विद्यालय/शिक्षक बच्चे को किसी प्रकार का सहयोग प्रदान करते हैं?

9 बच्चे को विद्यालय में, इनमें से किन समस्याओं का सामना करना पड़ता है:

   क) विद्यालय पहुँचने में

   ख) विद्यालय के अन्दर इंटर-उड़ पहुँचना/गतिशीलता में
ग) कक्षा में बैठने की व्यवस्था में

घ) विद्यालय में शौचालय और पीने के पानी की सुविधाओं तक पहुँचने में

ड) विद्यालय में खाना, पीना इत्यादि में

च) क्या आप यह महसूस करते हैं कि आपके बच्चे कि अक्षमता के कारण विद्यालय/पढ़ोस के व्यक्ति/बच्चे उसे डराते/धमकाते/परेशान करते हैं?
छ) आप बच्चे की शिक्षा के बारे में क्या सोचते हैं? क्या आपको लगता है कि आपके बच्चे को और बेहतर सुविधाएं मिलनी चाहिए जैसे कि सामान्य विद्यालय या आप उनको घर में मिल रही शिक्षा से खुश/संतुष्ट है?

ज) क्या आप बच्चे के नामांकित विद्यालय की किसी समिति के सदस्य हैं?

अभिमानकों की प्रतिक्रियाएं/समझ

a. जब आपको आपके बच्चे की अशक्तता के बारे में पता चला तो आपकी क्या प्रतिक्रिया थी?
b. क्या आप, अपने भाग्य/कर्म, या आपकी अन्य परिस्थितियों जैसे स्वास्थ्य अनाचार, सुविधाओं की कमी, गर्भावस्था के दौरान समस्या, गर्भावस्था के विभिन्न चरणों के बारे में अनभिज्ञता इत्यादि को परिवार में अक्षम बच्चे के जन्म के लिए दोषी मानते हैं?

c. आपके पति/पत्नी का इस तरह के बच्चे की घर में उपस्थिति पर क्या प्रतिक्रिया/व्यवहार था और इस परिस्थिति से निपटने के लिए आपको उनसे क्या सहयोग मिला था?

d. आपके परिवार के बड़े सदस्यों की क्या प्रतिक्रिया थी जब उन्हें बच्चे अक्षमता के बारे में पता चला?
e. क्या आपको लगता है कि आपके घर में अश्व बच्चे की उपस्थिति के कारण आपके दैनिक जीवन के कार्यक्रमों में आपको परेशानी का सामना करना पड़ता है?

f. इस बच्चे की देखभाल करते समय आपको परिवार के अन्य सदस्यों के साथ किन कठिनाइयों का सामना करना पड़ता है?

g. क्या आपको आपके बच्चे की देखभाल के समय आर्थिक कमी का सामना करना पड़ता है?

h. अपने बच्चे की देखभाल के समय आपको किन चुनौतियों का सामना करना पड़ता है?
i. क्या आपको लगता है कि इस बच्चे की अक्षमता आपके अन्य बच्चों को किसी प्रकार से प्रभावित कर रही है?


j. बच्चे की अक्षमता पर आपके पड़ोसियों की क्या प्रतिक्रियाएं हैं?


k. समुदाय के सदस्यों का आपके बच्चे के प्रति क्या व्यवहार है?


l. क्या आप अपने अक्षम बच्चे को बाहरी दुनिया से सुरक्षित रखना चाहते हैं और उसे घर से बाहर कहीं भी जाने देना नहीं चाहते?
m. क्या आप इस बच्चे का दूसरों से परिचय करवाते समय हिचकिचाहट महसूस करते हैं? अगर हाँ, तो ऐसा कैसे करें?

n. क्या आपको लगता है कि बच्चे की अक्षमता ने आपके पड़ोसियों के साथ के संबंध को किसी भी रूप में प्रभावित किया है?

o. आपके बच्चे का पड़ोस के अन्य बच्चों के साथ किस प्रकार का संबंध है?
p. आपके गाँव के बच्चे एक-दूसरे के साथ कैसे मिलते-जुलते हैं और क्या आपका बच्चा इस प्रक्रिया का हिस्सा है?

q. क्या आपके परिवार को गाँव के अन्य परिवारों से किसी प्रकार के भेदभाव या अलगाव का सामना करना पड़ता है?

संसाधन समर्थन

i. क्या आपको सर्व शिक्षा अभियान (एस.एस.ए) के गृह आधारित शिक्षा कार्यक्रम के अंतर्गत आने वाले प्रावधानों के बारे में पता है?

ii. क्या आप, आपके बच्चे के कौशलों को विकसित करने के लिए किसी व्यक्ति द्वारा प्रशिक्षित हुए हैं?
iii. क्या आप आपके बच्चे के स्वैच्छिक समर्थन के लिए एस.एस.ए. द्वारा नियुक्त किये गये हैं?

iv. एस.एस.ए. के द्वारा आपके बच्चे की गृह आधारित शिक्षा के लिए क्या सुविधाएं उपलब्ध करायी गयी हैं और क्या आप इन सुविधाओं से संतुष्ट हैं?

v. क्या पिछले कुछ वर्षों में, मुख्यतः 2012 के बाद जब एच.बी.ई., आर.टी.ई. में शामिल हुआ है बच्चे को मिल रही सुविधाओं के प्रावधान में कोई परिवर्तन आया है?

vi. क्या शिक्षक/स्वयंसेवक बच्चे को देखने पर आते हैं यदि हाँ तो कितनी बार?
vii. शिक्षक/स्वयंसेवक के घर आने पर बच्चे की क्या प्रतिक्रिया होती है?

viii. क्या शिक्षक भी बच्चे से सदैव प्रसन्नता से बात करते हैं या उनको हमेशा जाने की जल्दी होती है?

ix. क्या आप बच्चे की देखभाल के समय उत्पन्न समस्याओं को शिक्षक के साथ चर्चा करते हैं?

x. क्या शिक्षक बच्चे की गतिविधियों के बारे में आपसे बात (चर्चा) करते हैं और बच्चे में कौशलों का विकास कैसे करें, इस बारे में आपको सुझाव/सलाह देते हैं?
xi. बच्चे की देखभाल में आप जिन समस्याओं का सामना करते हैं, उनके समाधान के लिए आपको शिक्षक से किस प्रकार की सहायता मिलती है?

xii. क्या आप शिक्षक द्वारा आपको और आपके बच्चे को दिये जा रहे सहयोग से खुश है?

xiii. शिक्षक, उसकी उपस्थिति में बच्चे से किस प्रकार की गतिविधियाँ कराती है?

xiv. क्या शिक्षक बच्चे से बात करने के लिए बच्चे की मातृभाषा का प्रयोग करते हैं?
xv. क्या आपको लगता है कि आपको बच्चे की देखभाल करने के लिए किसी और प्रकार की सहायता की आवश्यकता है?

xvi. अपने बच्चे के भविष्य के बारे में आप क्या सोचते हैं?

xvii. क्या आपको लगता है कि एच.बी.ई. में बच्चा कुछ सीख पा रहा है व उसमें कुछ सुधार हुआ है?

r. एच.बी.ई. को बच्चों के लिए और प्रभावशाली बनाने के लिए आप क्या सुझाव देंगे?
विशेष आवश्यकता समूह शिक्षा विभाग
राष्ट्रीय शैक्षिक अनुसंधान और प्रशिक्षण परिषद

शिक्षक/संसाधन शिक्षक/स्वयंसेवक के लिए साक्षात्कार अनुसूची

नाम : __________________________________________________________
सामान्य/विशेष शिक्षक/स्वयंसेवक : _____________________________
आयु : __________________________________________________________
क्या अनुमूलक जनजाति से है (अगर जनजाति क्षेत्र है तो): __________________________
योग्यता : ______________________________________________________
जात भाषाएं: __________________________________________________
अक्षम बच्चों को पढ़ाने का अनुभव (वर्षों में) : __________________________
एच.बी.ई. में बच्चों को पढ़ाने का प्रशिक्षण: __________________________

1. क्या आपको एच.बी.ई. के अन्तर्गत नामांकित बच्चे के समर्थन के लिए, संसाधन शिक्षक से किसी प्रकार का सहयोग मिलता है (सामान्य शिक्षक के लिए) ? अगर हाँ तो विस्तार से बताईए।

2. एच.बी.ई. के अन्तर्गत आप अपने गाँव/क्लस्टर/ब्लॉक में कितने बच्चों को पढ़ते हैं?

3. आप कितनी बार प्रत्येक बच्चे के घर जा पाते हैं?

4. एच.बी.ई. के अन्तर्गत नामांकित बच्चों के लिए हस्तक्षेपों का नियोजन आप कैसे करते हैं? क्या कुछ लक्ष्य निर्धारित करते हैं और यदि हैं, तो क्या वे सब एक ही समय, समय-समय पर, रोज या कभी-कभी बनाए जाते हैं?

5. आप बच्चे से किस भाषा में बातचीत करते हैं? क्या वह उसकी मातृभाषा है?
6. क्या आपको लगता है कि प्रत्येक बच्चे से मिलने आप जितनी बार प्राय़ जाते हैं, वह उन्हें आवश्यक संसाधन समर्थन देने के लिए पर्याप्त है?

7. क्या आपको बच्चे के घर पहुँचने में किसी समस्या का सामना करना पड़ता है?

8. क्या आप बच्चे की प्रगति को लगातार जाँचते हैं या आपको ऐसा करने का समय ही नहीं मिलता?
9. क्या आपको बच्चे में कोई प्रगति दिखाई दी है या आपको लगता है कि उन्हें वर्तमान में मिल रहे हस्तक्षेपों से अलग कुछ विशेष हस्तक्षेपों की आवश्यकता है?


10. आपको अभिभावकों के बच्चों के प्रति दुष्कोण से क्या लगता है – क्या वह आशावादी, प्रोत्साहित करने वाले, सकारात्मक, अधिक सुरक्षात्मक, अनुरागशील, खुदन, अपमानजनक, न स्वीकार करने वाले है?


11. अपने बच्चों को समर्थन/सहयोग उपलब्ध कराने के लिए अभिभावकों का योगदान किस प्रकार का होता?
12. परिवार के कौन से सदस्य ने बच्चे की दैनिक जीवन की आवश्यकताओं को पूरा करने के लिए जिम्मेदार ली है?


13. क्या आपको लगता है कि अभिभावक चाहते हैं कि उनका बच्चा सामान्य विद्यालय में जाये या वह एच.बी.ई. से ही खुश है?


14. क्या आपको लगता है कि अब या निकटतम भविष्य में बच्चों की अब या सामान्य विद्यालय में जाने की कोई गुंजाई है?
15. क्या आपने एच.बी.ई. के अंतर्गत बच्चे के कौशलों के विकास के लिए अभिभावकों को किसी प्रकार का प्रशिक्षण दिया है?

16. अगर आपने अभिभावकों को प्रशिक्षण दिया है तो वह कितनी गंभीरता से आपको सुझावों का पालन करते हैं?

17. अभिभावकों एच.बी.ई. के अंतर्गत बच्चे के विकास के संबंध में क्या सुझाव/विचार/शिकारते देते हैं?
18. बच्चे की अक्षमता का, उसके पारिवारिक वातावरण पर क्या प्रभाव पड़ा है?

19. क्या आपको लगता है कि बच्चे के भाई-बहन, पड़ोस के बच्चे उससे बात करते हैं या उससे साथ खेलते हैं?
   वह साथ में किस प्रकार की गतिविधियाँ करते हैं?

20. क्या अभिभावक उनके घर में आपकी उपस्थिति से खुश होते हैं या वो नहीं चाहते हैं कि आप उनके घर आए?

21. क्या अभिभावक आपसे उनके बच्चों से संबंधित मुद्दों व चिंताओं पर प्रश्न पूछते या बात करते हैं?
22. क्या अभिभावक चाहते हैं कि उनके बच्चों को अतिरिक्त प्रशिक्षण, शिक्षा या कोई अन्य समर्थन मिलना चाहिए?

23. पिछले कुछ वर्षों में एच.बी.ई. को लागू करते समय क्या परिवर्तन हुए हैं? मुख्यतः वर्ष 2012 में आर.टी.ई. में इसके समावेश के बाद।

24. भविष्य में इस कार्यक्रम को उन्नत बनाने या सुधारने के लिए आप क्या सुझाव देना चाहेंगे?
समुदाय के सदस्यों के लिए साक्षात्कार अनुशरण

समुदाय के सदस्य का नाम :______________________________________________

अक्षमता वाले बच्चे के अभिभावक/परिवार से किस प्रकार का संबंध है : ______________

आपके घर व अक्षम बच्चे के घर के बीच की दूरी : __________________________

लिंग : ____________________________________________________________

जाति/जनजाति : ________________________________________________

जिला : __________________________________________________________

ब्लॉक/तालुका : _________________________________________________

गाँव : ___________________________________________________________

1. आपको गृह आधारित शिक्षा (एच.बी.ई.) के बारे में क्या पता है ?

""
2. क्या आप प्राय: इस अक्षम बच्चे के घर जाते हैं और यदि हाँ तो किस उद्देश्य से?

3. आप इस बच्चे के अभिभावकों की मानसिक स्थिति व उनके अपने बच्चे के साथ संबंध के बारे में क्या सोचते हैं - क्या वह आशावादी, उत्साहजनक, सकारात्मक, अधिक सुरक्षात्मक, अनुरोगशील, खिन्न, उदासीन, अपमानजनक या स्वीकृति न देने वाले हैं?

4. क्या परिवार ने बच्चे की अक्षमता के ईलाज के लिए किसी प्रकार की चिकित्सीय, आध्यात्मिक या अन्य कार्यनिष्ठाओं का सहारा लिया था?
5. क्या आपको लगता है कि अक्षमता वाले बच्चे की घर में उपस्थिति ने पारिवारिक संबंधों में बाधा डाली है?

6. क्या आपको इस परिवार की ऐसी किसी समस्या के बारे मे पता है?

7. क्या आप चाहते हैं कि अक्षमता वाले यह बच्चा सामान्य विद्यालय में दूसरे बच्चों के साथ ही पढ़े या उनकी शिक्षा के लिए कुछ अलग वैकल्पिक व्यवस्था होनी चाहिए?
8. क्या कोई शिक्षक/स्वयंसेवक/उपचारक अक्षम बच्चे को देखने के लिए घर आते हैं और यदि हाँ तो कितनी बार?

9. क्या अभिभावक उनके बच्चे को उपलब्ध करायी जा रही सुविधाओं/प्रावधानों से संतुष्ट है?

10. क्या बच्चे के अभिभावक उसको शिक्षित और आत्मनिर्भर बनाने के लिए किसी प्रकार का कोई प्रयास कर रहे हैं?

11. क्या आपने बच्चे में, एच.बी.ई. में नामांकन के बाद कोई सुधार देखा है?
12. क्या अभिभावकों के कार्य करने के समय के कारण बच्चे की देखभाल पर कोई प्रभाव पड़ा है?

13. क्या आपके बच्चे, इस अक्षमता वाले बच्चे से किसी भी तरह से कोई बातचीत करते हैं?

14. क्या आपको लगता है कि अक्षमता वाले बच्चे से बातचीत रखने से आपके बच्चों पर कोई नकारात्मक प्रभाव पड़ रहा है?
15. क्या आपको लगता है कि इस तरह के बच्चे का कोई भविष्य है?

16. क्या आपको लगता है कि अक्षमता एक अभिशाप है?

17. बच्चे की इस दशा के लिए आप किसको दोषी मानते हैं? क्या आप सोचते हैं कि बच्चे की यह दशा अभिभावकों के कर्मों का फल है या इसका कारण कुछ और है?
18. समुदाय के सदस्यों/पड़ोसियों का अक्षम बच्चे व उसके परिवार के साथ व्यवहार कैसा है ? क्या आपको लगता है कि इस परिवार को किसी प्रकार के अलगाव या भेदभाव का सामना करना पड़ रहा है ?

19. क्या आपने और आपके समुदाय के नेताओं ने अक्षम बच्चे की शिक्षा/कल्याण के लिए किसी प्रकार का योगदान – पैसे, सामग्रियों, मार्गदर्शन आदि के रूप में किया है ?

20. अक्षम बच्चे व उसके परिवार की दशा में सुधार के लिए आप किन उपायों का सुझाव देंगे ?