Final Report

Situation Analysis and National Plan of Action for Persons With Disabilities

Submitted to

The World Bank
Islamabad

June, 2004

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Acknowledgement

Arjumand And Associates (AAA) would like to thank all the key informants who participated in the formulation of this situation analysis and National Plan of Action, without whose participation and contribution this exercise would not have been possible.

We are especially grateful to the Directorate General of Special Education (DGSE), Government of Pakistan, its allied national institutes and centers, NCRDP, NTD, NIH, and the provincial governments in NWFP, Punjab, Sindh and Balochistan for sharing their programme experiences and very relevant information about systems and services, without which a comprehensive exercise such as this would not have been possible.

Our appreciation is also due to the Ministries of Education, Health, Labour and Manpower; to the district government officials; to the Special Education Departments in Universities; and to the private sector institutions for providing us time and information that helped immensely in formulation of this document.

We are indebted to all NGO leadership and their field staff who spent long hours in taking us around their facilities, discussing issues related to the exercise, and sharing their invaluable experiences and insights. Associations of the disabled also assisted open heartedly.

The contribution of persons with disabilities and their parents is highly valued as it helped us in understanding their needs.

Mr. Irshad Salim based in USA, a civil engineer by profession and a painter by natural gift needs recognition for his painting that appears on the cover of this report.

Our gratitude is also due to the World Bank for reposing confidence in our group for this extremely challenging assignment. It is our sincere hope that the situation analysis and the proposed draft NPA will provide a roadmap to the federal, provincial and district governments in Pakistan and other allied stakeholders in substantially improving the programme for the PWDs.

Dr. Arjumand Faisel

Team Leader, and
Lead Consultant, AAA

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Acronyms

AAA	Arjumand And Associates
ABC	Adult Blind Centre
ADAAG	Americans with Disability Act Accessibility Guidelines
ADL	Activities of Daily Living
AIDS	Acquired Immuno Deficiency Syndrome
AIOU	Allama Iqbal Open University
AJK	Azad Jammu Kashmir
APHA	All Pakistan Handicapped Adults
ARDP	Association for Rehabilitation of Physical Disabled
ARUP	Association of Road Users Pakistan
CBR	Community Based Rehabilitation
CDGK	City District Government Karachi
CRC	Convention on the Rights of Children
DFSP	District Forum for Special Persons
DGSE	Directorate General Special Education Pakistan
DHQ	District Headquarter
DISTAT	Disability Statistics Database
DoSE	Department of Special Education
DPI	Disabled Persons International
ECIP	Early Childhood Intervention Programme
EFA	Education For All
EOC	Emergency Obstetric Care
EPA	Environment Protection Agency
EPI	Expanded Programme on Immunization
ESCAP	Economic and Social Committee for Asia Pacific
ESR	Education Sector Reform
FANA	Federal Administrated Northern Area
FATA	Federal Administrated Tribal Area
FGDs	Focus Group Discussion
GoP	Government of Pakistan
HHD	High Human Development
HI	Hearing Impaired
ICD	International Classification of Diseases
ICF	International Classification of Functioning
ICIDH	International Classification of Impairments, Disabilities and Handicaps
IDD	Iodine Deficiency Disorder
IE	Inclusive Education

ILO	International Labour Organisation
ISO	International Standards Organization
IT	Information Technology
IYDP	International Year for Disabled Person
KDA	Karachi Development Authority
KII	Key Informant Interview
LABAD	Lahore Business Association for Disabled
LCCI	Lahore Chamber of Commerce and Industry
LDA	Lahore Development Authority
LGO	Local Government Ordinance
LHD	Low Human Development
LHW	Lady Health Worker
MHD	Medium Human Development
MOE	Ministry of Education
MOH	Ministry of Health
MoWD, SW & SE	Ministry of Women Development, Social Welfare, and Special Education
MR	Mentally Retarded
NBT	National Bureau of Training
NCCWD	National Commission for Child Welfare and Development
NCRD	National Council on Rehabilitation of Disabled
NCS	National Conservation Strategy
NFSP	National Forum for Special Persons
NGOs	Non-Governmental Organisations
NIH	National Institute For Handicapped
NISE	National Institute of Special Education
NLRC	National Library and Resource Centre
NPA	National Plan of Action
NTCSP	National Training Centre for Special People
NTD	National Trust for the Disabled
NWFP	North West Frontier Province
PAB	Pakistan Association of Blind
PCO	Pakistan Census Organization
PCRD	Provincial Council for Rehabilitation of Disabled
PFFB	Pakistan Foundation Fighting for blindness
PFSP	Provincial Forum for Special Persons
PH	Physically Handicapped
PHC	Primary Health Care
PHQ	Provincial Headquarter
PIDE	Pakistan Institute of Development Economics
PPAP	Pakistan Poverty Alleviation Programme
PTA	Parents Teachers Association

PWD	Person with a Disability
RI	Rehabilitation International
SA	Situation Analysis
SE	Special Education
SEC	Special Education Center
SMEDA	Small Medium Enterprise Development Agency
STD	Sexually Transmitted Diseases
UFAS	Uniform Federal Accessibility Standards
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNSO	United Nations Statistical Office
VAW	Violence Against Women
VI	Visually Impaired
VR	Vocational Rehabilitation
VREDP	Vocational Rehabilitation Employment For Disabled Persons
VTCD	Vocational Training Center for the Disabled
WHO	World Health Organization
WPA	World Programme of Action

Executive Summary

The Ministry of Women Development, Social Welfare and Special Education has launched the National Policy for Persons with Disabilities – 2002 and requested the World Bank to facilitate the process for developing the country's National Plan of Action (NPA) to implement the policy.

Objective

The purpose of the study is to prepare a draft strategic National Plan of Action (NPA) based on a comprehensive and holistic situation analysis of key priority areas identified in the policy: prevention, early detection and intervention; education and training; vocational rehabilitation; medical rehabilitation; legal and physical environment; communication and media. The document would provide a basis for initiating consultations at the provincial and federal levels to finalize NPA and develop operational plans of action.

Methodology

A desk review of national and international literature on the subject was undertaken; and Key Informant Interviews (KII) and Focus Group Discussions (FGDs) with over 100 stakeholders were held at federal and provincial levels, which included officials from Ministry of Women Development, Social Welfare and Special Education (MoWDSW & SE); Ministries of Health and Education; Provincial Departments of Special Education, Social Welfare, Health, Education; concerned officers of district governments; senior and mid level officials of Federal and Provincial institutions; and non-government organizations. Visits were also made to various public sector and NGO run institutes, centers and services. Meetings were held with the faculty members of the Departments of Special Education in Universities. In addition, meaningful consultations with individuals with disabilities and some of their parents were also held. Analysis was simultaneously carried out.

Key Findings

DGSE has played a pioneering role in promoting the programmes for persons with disabilities (PWDs). However, the SE nomenclature adopted by the Ministry (MoWD, SW, SE) is very narrow that limits the scope of work for holistic approach towards PWDs.

Definition, Magnitude and Causes: Definition for disability for use in Pakistan has only been described in the 1981 Ordinance for Employment of Disabled, which is vague. Therefore, the interpretation of disabled varies significantly that has also affected the collection of data and there is lack of agreement about the reported figures for the disabled persons in the country. There is also no information about the proportionate role of different causes in contributing to disability.

Institutional Arrangements: At the top level of the programme, there are five major bodies working for PWDs. i.e. DGSE, NCRDP, NTD, NIH and SE Departments in three universities, but there is minimal interaction between them. Furthermore, the institutional arrangement is such that the DGSE (nucleus of the programme) is working in isolation without formal intersectoral and interministerial linkages. Furthermore there is lack of integration of DGSE led services with the corresponding provincial line departments, and now with the district governments. Also, the organizational structure at DGSE has uneven distribution of responsibility and persons with non-

related background have been posted in key decision-making positions; who lack understanding about the programme needs and its developmental requirements.

DGSE has demonstrated the consistency of approach that has helped in progressive evolution of the programme and despite several shortcomings, overtime DGSE institutions have accumulated a considerable level of knowledge and experience in SE and vocational training services. However, several specialized institutes that have been established at the federal level with broad mandates, and were to be Centers of Excellence to serve as model, have not yet been able to meet the set goals. Besides institutes at federal level, 40 Special Education Centers (SECs) have been established in provinces. Provincial governments have established 91 centers that have now been taken over by the district governments with the implementation of devolution plan in 2001. Consequently, the roles of provincial line departments have been minimized and the flow of technical support to the SECs has been slowed and weakened.

NGOs share a considerable workload of the programme and they are managing 117 SECs. However, the link between NGOs and DGSE is not optimal. Furthermore, the funding to NGOs by DGSE is limited to only a few and with very small grants. Interestingly, NGOs are in mutual competition for resources and fame and the country programme has not been successful to bring NGOs on a common platform.

Financing of Services: The financing of the public sector programme is from the government budget and the allocation in current fiscal year is 95% more than that in FY 1999-00. Currently, no donor is providing assistance, except support to small-scale projects. Zakat and Bait-ul-Mal also do not provide any direct assistance to the DGSE. Parent-Teacher Associations (PTAs) are raising funds through donations to support services in SECs and their role is appreciable. NGOs are raising funds both from national and international sources for managing their programmes. About 26 of them have received small grants from DGSE ranging from Rs. 25,000 to Rs. 450,000 per annum, and a few from Bait-ul-mal and Zakat Funds. The SE cost per child is noticeably lower in SECs of the NGOs as compared to public sector centers.

Prevention of Disabilities: A broad-based multisectoral active collaboration is lacking for primary prevention of disabilities, such as among ministries/departments of health, information and mass media communication and works, National Highway Authority (NHA), police, law and justice and the MoWD, SW & SE. For example, several MOH programmes are carrying out activities of primary prevention of disabilities such as IDD control and polio eradication, however, these have no link either with MoWD, SW & SE or DGSE.

No formal programmes exist in public sector at federal or provincial level for early detection. LHWs, who follow the road map of a child's development lack knowledge and skills in detecting developmental delays. However, there are few examples of early detection services in NGO and private sectors.

Education and Training: A network of about 266 SECs has been progressively established over last 23 years by the federal and provincial governments and NGOs (44 DGSE, 92 provincial governments, 3 NTD, 117 NGOs and 10 armed forces). These provide enrolment to about 22,000 children with Special Education Needs (SEN). However, the quality of services is variable and the shortcomings needs redresssal. Out of the currently estimated 1.28 million population of disabled children of 5-19 years, only 1.7% of children with SEN are enrolled in SECs. The enrolment proportions in government SECs for male and female are 65% and 35% respectively.

All SE centers are located in urban areas while 66% disabled population resides in rural areas, and most of the children in government and NGO SECs belong to the middle or lower middle-income groups. A variety of SE curricula of variable quality are in use throughout the country, hence the education lacks uniformity. Curricula prepared by NSECs and NISE have not been adequately disseminated. The quality of training in SECs also varies from low to high depending on several factors. PTAs are playing important role in supporting public sector SECs. This has helped the management to upgrade some of them from primary to middle, matric and intermediate level.

The government of Punjab is giving higher priority to SE than other provinces and has appointed a Minister to lead the programme.

The prospective development plan 2001-2011 of Planning Commission, GoP has clearly given direction to move from SE to Inclusive Education (IE). There is general agreement to implement inclusive education among concerned officers in MOE, DGSE, provincial departments and district government, but very minimal steps have been taken in this direction. However, a few NGOs and private sector schools have shown examples of success.

DGSE has played the lead role in establishment of master's level course in 3 universities (AIOU, Karachi University and Punjab University) for training of SE teachers. More than 2,300 have acquired the degrees and are working in public, NGO and private sector schools. The master's level training is largely theoretical and lacks practical training due to lack of facilities for hands-on experience. In 18 years, NISE has conducted 298 courses of 1-2 weeks duration for SE teachers that provided training to 6610 participants (not individuals as many have attended several courses). However, these have been conducted without any needs assessment on ad hoc basis, without medium or long term planning. No follow up has been done to assess the impact of these trainings. The general impression of the trainers, trainees and their supervisors is that the current duration of the training is not adequate.

Vocational Rehabilitation: The Vocational Rehabilitation (VR) programmes and services are limited in scope and not geared to current market needs. Public sector Community-Based Rehabilitation (CBR) is limited. Both, public and NGO sectors have introduced micro credit in their VR and CBR programmes. However, there is no evidence of availability of any specifically designed micro credit programme for disabled by major institutions like SMEDA, First Women Bank, Khushhali Bank, etc.

Medical Rehabilitation: Presently, medical rehabilitation services are available at provincial and to some extent at district headquarters level. However, the existing services generally lack appropriate specialists, equipments and funding for prosthesis, orthotics and assistive aids. The existing medical rehabilitation facilities and provision of prosthesis, orthotics and other assistive aids, both in public and private sectors, are inadequate to meet the demand.

The proportion of nuclear families and elderly population is on the rise, however, no exclusive services or programmes for the aging population have been conceived with in public, NGO or private sector.

Legal and Physical Environment: A range of laws that impact prevention of disability, rehabilitation and employment of disabled have been made, but their implementation is weak. The implementation of 1% quota system has not met with much success inspite of existence of NCRDP and PCRDP network. Only 1.1 million workers out of total 39 million labour force are covered by

the Occupational Health and Safety (OHS) laws and implementation of temporary and permanent disability benefits under Workmen's Compensation Act is weak.

There is no law for providing barrier free access to PWDs in built areas. Currently, building codes for provision of access to PWDs do not exist. Similarly, Town Planning codes have not been conceived. Public, private and commercial buildings and facilities do not cater to the needs of the disabled. The environment is more suitable for persons with physical strength, agility and mental alertness. It is not user friendly for PWDs, elderly people, children, expectant and nursing women, infirm and frails. Drafts prepared by development activists for seeking legislations regarding access for PWD have been ignored. However, on the initiative of MoWD,SW&SE, the cities of Islamabad, Lahore and Peshawar have been declared by CDA and the respective provincial governments as "Disabled Friendly City" and measures are being taken in this direction. Furthermore, on the initiative of the Ministry, the Cabinet has recently approved 14 measures for improving physical access of PWDs in buildings, parks and public places, which will soon be notified.

Social Environment, Communications and Media: Attitudes towards disabled in families and communities are mixed, ranging from extra love and care to neglect and harsh treatment. Females suffer the "Double Disadvantage" of being disabled and female. In addition, mothers of disabled children face family and societal stigma. The media has played a mixed role and is partially responsible for portraying PWDs in need of pity and deserving charities. However, it has also shown positive images of PWDs, but not enough to help their integration into society. Associations of the disabled persons have played a very important role in advocating for opportunities, programmes and services for the PWD.

Proposed Draft National Plan of Action (NPA)

The draft NPA is a strategic plan that responds to the National Policy for Persons with Disabilities 2002 and is based on the findings of the situation analysis. It is based on the philosophy that access, inclusion, and equalization of opportunities for PWDs cannot be achieved by a single intervention, and the services are to be designed to provide a continuum whose goal is full inclusion. To meet the philosophical goal minor restructuring and adjustments in roles will be required, and funding will have to be mobilized through several sources. Furthermore the goal can only be met by extending the services to the rural areas (where two-third of the disabled live) that are currently neglected and unserved.

It must be noted that the NPA is a draft to initiate the dialogue and discussion at federal and provincial level to finalize an NPA for Pakistan. For translating this into provincial operational plans a consultative process should be initiated that must effectively involve all stakeholders to make it relevant to the needs of each province.

The proposed actions are directed for:

1. Enhancing the mandate of DGSE and restructuring
2. Determining the extent of disabilities and distribution of causes
3. Improving prevention of injuries, deficiencies, diseases and other factors known to cause disabilities
4. Mobilizing early detection and intervention.
5. Escalating the medical rehabilitation services.
6. Strengthening of Special Education for children with severe and moderately severe disabilities

7. Promoting Inclusive Education for children with SEN.
8. Expanding and reinforcing vocational training, employment and economic rehabilitation
9. Pursuing implementation of existing laws for PWDs
10. Creating of Barrier-free physical environment
11. Raising public acceptance and improving social integration and environment
12. Boosting capacity for production and supply of prosthetics, orthotics and assistive aids and other supporting items and facilitation in duty free imports.
13. Increasing support to the NGOs

In order to achieve the above successfully, there is a need to actively involve all stakeholders including relevant ministries, departments, district governments, associations of persons with disabilities, and NGOs working for the disabled at national, provincial and district levels.

The details of the NPA are presented in chapter 12.

Section 1: General

Chapter 1:

Purpose and Methodology of the Study

1.1 Purpose of the Study

The Government of Pakistan launched the National Policy for Persons with Disabilities – 2002, after endorsement by the Federal Cabinet and the President. The policy aims at social inclusion of persons with disabilities (PWDs) at the community and basic service provision level. The Ministry of Women Development, Social Welfare and Special Education aims to develop the country's National Plan of Action (NPA) to implement the policy. To facilitate the process, the World Bank is assisting the Ministry and has commissioned the study.

The purpose of the study is to prepare a draft strategic National Plan of Action (NPA) based on a comprehensive and holistic situation analysis of key priority areas identified in the National Policy.

The document would provide a basis for consultations at the federal, provincial and district levels to finalize the NPA and to develop operational plans of action.

Arjumand And Associates (AAA) was hired to carry out the assignment from March to June 2004. The specific tasks were to:

1. Undertake a **Situation Analysis** of the following priority areas identified in the policy: prevention, early detection and intervention; education and training; vocational rehabilitation; medical rehabilitation; legal and physical environment; communication and media. The situation analysis is to include: a review of national and international literature on the subject; assessment of access and quality of existing services; institutional arrangements of public sector service delivery; role of the private sector and NGOs; financing of the services. It is to be based on a desk review of existing studies and documents and limited number of key informant interviews and focus group discussions with stakeholders including the Ministry of Women and Development; Health and Education, Provincial Departments, senior management of relevant institutions and non-government organizations and private sector.

2. Develop a **Draft National Plan of Action** (NPA), based on the findings, that will include a statistical profile of the disabled, situation analysis of priority areas and recommendations derived from it.

1.2 Methodology

A five-member team (name listed in Annex I) carried out the situation analysis and it covered the following priority areas identified in the policy:

- prevention, early detection and intervention
- education and training
- vocational rehabilitation
- medical rehabilitation
- legal and physical environment
- communication and media

A desk review of national and international literature on the subject was undertaken; and Key Informant Interviews (KII) and Focus Group Discussions (FGDs) with stakeholders were held, which included officials from Ministry of Women Development, Social Welfare and Special Education (MoWDSW & SE); Ministries of Health and Education; Provincial Departments of Special Education, Social welfare, Health, Education; concerned officers of district governments; senior and mid level officials of federal and provincial institutions; and non-government organizations. In addition, meaningful consultations with PWDs and some of their parents were also held. Annex II provides the list of key informants.

A preliminary meeting with senior management of DGSE and World Bank was held at the start of the study in Islamabad, the purpose of the meeting was to brief the stakeholders on the work plan and to seek their administrative and facilitative support for field visits to the provinces.

From mid March to mid May 2004, field visits were undertaken to NWFP, Punjab, Sindh and Balochistan to gain insights to Government and NGO programs and consult their leadership and field workers on critical issues pertaining to their programmes in particular and provincial and national perspectives in general. National Institutes and Centers in Islamabad were also visited and useful discussions were held, and meetings were held with the faculty members of the Departments of Special Education in Universities.

Analysis was simultaneously carried out in April and May to get through the mass of information that was collected in the provinces and to document the field observations and findings of the discussion with the Federal and Provincial stakeholders, NGOs and other key informants. Based on these, a draft Situation Analysis and National Plan of Action (NPA) has been prepared, which is presented in the following chapters.

Section 2: Background Information

Chapter 2:

Definitions, Causes and Magnitude

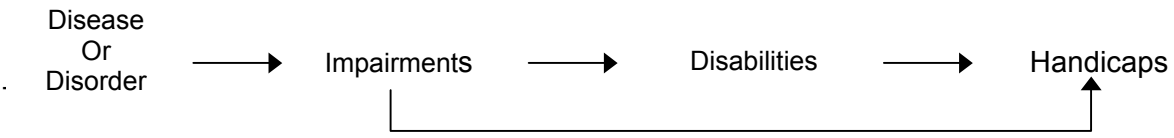
2.1 Definitions and Classification

Disability can occur due to disease, disorder or injury leading to impaired physical, mental or sensory functions that restricts the ability of an individual to perform a normal human activity. The review of literature indicates that numerous attempts have been made to define and devise disability classification by various category of professional such as epidemiologists, demographers, insurers, physicians and other health related professionals.

Currently, the most commonly followed classification of disability is the International Classification of Impairments, Activities and Participation (ICIDH-2) developed by the World Health Organization.

In the original ICIDH, disability was defined as 'a restriction or lack of ability to perform an activity in a manner or within a range considered normal for human being'[1] and the disablement consisted of three basic essentials: impairments, disabilities and handicaps. ICIDH mentioned that a disease or disorder could lead to an *impairment* that may produce a *disability* which may as a consequence result as a *handicap.* This relationship between these three elements is presented in Figure 2.1.

Figure 2.1: The Disablement Phenomena as Conceptualised in the Original ICIDH (Taken from Metts Paper referred below)



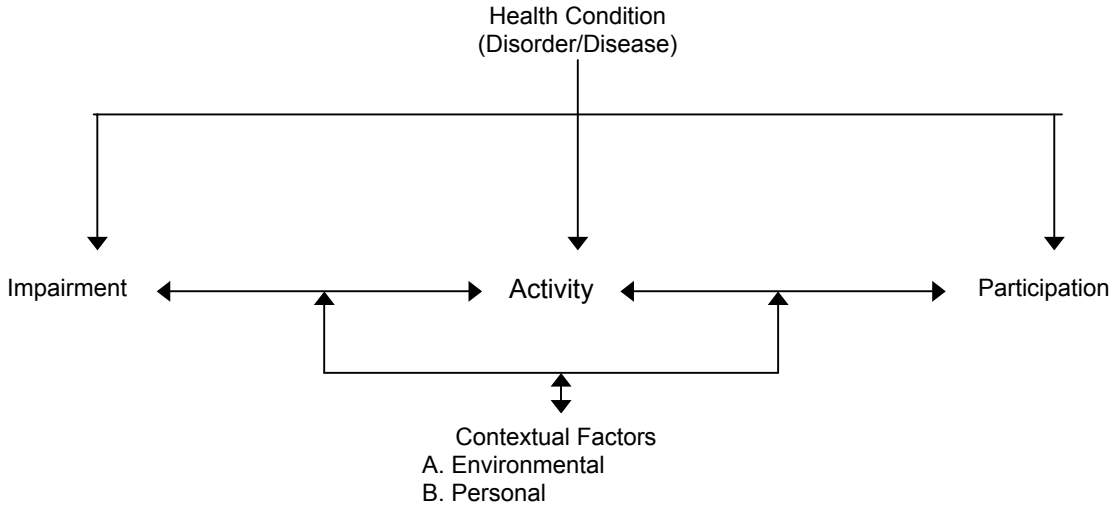
Metts has given clear examples of this in his paper for the World Bank,[2] mentioning " polio (a disease) results in paralysis (an impairment) which limits a person's mobility (a disability), which, in turn, limits the person's ability to find employment (a handicap). It is also possible for an impairment which does not result in a disability to still lead to a handicap, as is the case when a facial disfigurement (an impairment) limits a persons ability to socially interact (a handicap), even though it does not result in a functional limitation (a disability)".

The ICIDH-2 is the improvement over ICIDH. Within the ICIDH-2 framework, according to the WHO "Disablement is an umbrella term covering three dimensions: (i) body structures and

1 ICIDH definition in United Nations, Disability Statistics Compendium. New York, 1990
[2] Robert L. Metts, *Disability Issues, Trends and Recommendations for the World Bank, Discussion Paper No. 0007, Social Protection,* The World Bank. February 2000.

functions, (ii) personal activities, and (iii) participation in society"[3]. As evident, the terms disability and handicap have been replaced with the terms activity and participation, respectively. As Metts have explained that in this classification "An *impairment* is defined as a loss or abnormality of body structure or of physiological or psychological function, *activity* is defined as the nature and extent of functioning at the level of person, and *participation* is defined as the nature and extent of a person's involvement in life situations in relation to impairments, activities, health conditions and contextual factors. In this model, activity restrictions and limitations on participation are recognized to be influenced by environmental factors (e.g. natural and built environments, cultures, institutions and prevailing attitudes about people with disabilities) and personal factors (e.g. gender, age, education, social background and life experience). Figure 2.2 outlines the expanded range of possible links between health conditions and contextual factors incorporated into the ICIDH-2".

Figure 2.2: Current Understanding of Interactions Within ICIDH-2 Dimensions



Inspite of these definitions and classifications, the interpretation of disability remains variable. During the course of this situation analysis, it was stated by several key informants that in Pakistan ICIDH-2 classification is used but it became apparent that unified understanding of the concepts of definitions among disability service providers (medical professionals, psychologists, teachers and NGO workers) and managers was generally lacking.

Disability is diagnosed according to predetermined criteria, which varies from province to province. Definitions and commensurate classifications of disabilities and defining standards for disability were found to be inconsistent. This could be intentional as the assessment boards face political pressures to certify individuals for disability benefits such as for assigned job quota.

[3] World Health Organization, *International Classification of Impairements, Activities and Participation (ICIDH-2),* Geneva, 1997

2.2 Causes of Disabilities

It is important to understand the causes of disabilities for preparing the NPA. The identification of causes in the population can help to develop specific prevention and management programs. However, in Pakistan the distribution of causes of disabilities has not been determined.

The causes of disabilities can be classified into two major categories: (i) biomedical – that have basis within the body of the individual, and (ii) environmental - that are from the social, cultural, and physical environments, including life-style of individuals. Disabilities can occur at different stages of life: prenatal, perinatal, neonatal, infancy, early childhood, adolescence, adulthood and old age[4,5].

In Prenatal Period: Abnormalities of genes and chromosomes are the biomedical causes of disability in this period. Mostly, they result in abortions but may lead to the delivery of a baby with some disability[6]. For example, the incidence of 'Down Syndrome' babies is higher in mothers who are very young or above 35 years of age, a phenomenon commonly prevalent in Pakistan.

Some environmental influences can also damage a foetus in the womb. These include external agents (violent blow to the mother's abdomen or radiation such as X-rays); infections (rubella, syphilis, AIDS in mother); toxins (medications such as hormones, anticonvulsants, antibiotics, and tranquillisers); and maternal health, nutrition and age (iron deficiency, lack of vitamins and calorie intake,)[7],[8,9],[10], [11]. All the above conditions are commonly prevalent in Pakistan, providing a favourable environment for disabilities among the newborns. Besides these, as reported by Al-Shifa Trust in Karachi, marriage between cousins is a very common finding among parents of mentally retarded (MR) children.

In Perinatal Period: In this period, disabilities are primarily biomedical in nature. They may result from pre maturity of the foetus, injury, oxygen deprivation, or infections acquired during delivery[12]. Deliveries by untrained hands and lack of emergency obstetric care to the majority of the population, the two common existing conditions, can potentially have substantial contribution in perinatal causes of disabilities in Pakistan.

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[4] Abroms, K.I. & Bennett, J.W. (Eds.), *Genetics and Exceptional Children,* San Francisco: Jossey-Bass Inc, 1981.
[5] Fotheringham, J. B., Hambley, W. D., Haddad-Curran, H.ÊW, *Prevention of Intellectual Handicaps,* Toronto, 1983.
[6] Abroms, K.I. & Bennett, J.W. (Eds.), *Genetics and Exceptional Children,* San Francisco: Jossey-Bass Inc, 1981.
[7] Kopp, C.B. & Kaler, S.R, *Risk in infancy,* American Psychologist, 1989
[8] Abroms, K.I. & Bennett, J.W. (Eds.), *Genetics and Exceptional Children,* San Francisco: Jossey-Bass Inc, 1981.
[9] Fotheringham, J. B., Hambley, W. D., Haddad-Curran, H.ÊW, *Prevention of Intellectual Handicaps,* Toronto, 1983.
[10] March of Dimes Birth Defects Foundation, *Public Health Education Information Sheet: Low Birthweight,* New York, 1989.
[11] March of Dimes Birth Defects Foundation, *Fact Sheet: Facts You Should Know About Teenage Pregnancy,* New York, 1992.
[12] Santrock, J. W. & Yussen, S. R, *Child Development,* Dubuque, IA: Brown, 1989

In Childhood: Both, biomedical and environmental factors causes result in disability in childhood. Infectious diseases in this period such as meningitis, encephalitis, mumps, chicken pox, and measles can cause mental retardation. Measles can also cause visual impairment and ear infections can lead to conductive hearing loss.

Among environmental causes, injuries play the leading role, such as a newborn or infant may fall from the hands of the caretakers or from bed. Children could also fall over from objects onto which they climb; or burn themselves from hot objects or stoves; or injure themselves with broken glass, knives, razor- blades etc. They may put small objects such as buttons into their body orifices and may choke themselves. These accidents can result in suffocation and brain damage.

Environmental deprivation, as occurs in poverty, could also have a debilitating effect on the development of abilities such as language use, adaptive behaviour, and cognition. This deprivation could be in the form of poor nutrition, poor housing, lack of social interaction and limited opportunity for varied experiences. For example, protein-calorie deficiency during the first six months of life can affects the mental development[13], or severe vitamin A deficiency can cause blindness in children[14].

In Adolescence and Early Adulthood: Physical injuries are a leading cause of disability in this age group due to their acts of bravado or fighting. The males between the ages of 15 and 24 are at highest risk for sustaining brain and spinal cord injuries[15] due to falls, motor vehicle accidents, and physical violence. ARDP in Peshawar reported this to be a common cause of disability in NWFP, in this age group.

Drug problems are also contributing to disabilities. Hash, cocaine, opium, heroin, sedatives and tranquillisers are readily available. Furthermore, there is growing habit of sniffing volatile solvents, paints and glues. There are over 6 million drug users in Pakistan ranging from age 10 to 70 years.

In Late Adulthood and Old Age: In Pakistan, life expectancy has increased from 42 years at the time of independence of the country in 1947 to nearly 63 years[16], the population is thus aging. The increasing numbers of the elderly pose a challenge including those relating to their health and consequent disability principally on account of mental health problems, senile dementia, deafness, blindness, depression, etc.[17].

In Women: Violence Against Women (VAW) triggers physical handicaps coupled with mental health problems. Women also suffer significantly from physical and psychosomatic sequelae generally associated with child bearing, childlessness, menopause etc.

A comprehensive National Plan of Action for Disabled, hence, would require attention to all causes to limit disabilities. This could only be achieved with a broad-based multisectoral active collaboration and commitment.

[13] Crump, I.M, *Symposium: Nutrition. Mental Retardation*, 1984
[14] World Health Organization, *Prevention of Childhood Blindness*, Geneva, 1992
[15] Pope, A.M. & Tarlov, A.R., *Disability in America: Toward a National Agenda for Prevention. Summary and Recommendations,* Washington, DC, 1991
[16] Pakistan Census Organization, *Population Census Report*, Islamabad, 1998
[17] Campbell, I.B, *Prevention, the Beginning of the Rehabilitation Process: A View from New Zealand*, New York, 1989

2.3 Magnitude of the Problem

2.3.1 Global Proportion of the Disabled Population

The estimates of disability in countries are best "guesstimates". WHO and United Nations have suggested that about 10% of population has disabilities. But in the recent years, the author of WHO estimates proposed that this proportion is likely to be lesser and is about 4% and 7% of the population in developing countries and developed countries, respectively[18]. UNDP has also changed its stance from 10% to 5.2%. While USAID estimates the disabled proportion of the global population to be 10% or more, and the Roeher Institute in Canada estimates the global proportion to be 13% to 20%.

According to Metts, the estimates of disabled population (using data of 175 countries) in High Human Development (HHD), Medium Human Development (MHD) and Low Human Development (LHD) countries are 9.9%, 3.7% and 1.0%, respectively[19]. In the paper, the total global disabled population is estimated to be between 235.39 and 549.18 million; of HHD countries 124.23 million; the range for the MHD countries estimated to be between 93.52 – 250.22 million for the LHD countries the estimates are in the range of 17.65 – 174.74 million.

2.3.2 Proportion of Persons with Disabilities in Pakistan[20]

In Pakistan, the data on disabled persons has been collected in all the censuses held to date i.e. in 1961, 1973, 1981 and 1998. Besides these, during 1984-1985, the Federal Bureau of Statistics (FBS) conducted a national survey to collect detailed information on disabled from a sample of 5,638 households. However, the categories and definitions of disabilities were not consistent with those of the 1981 census, that restricted the comparison of disability-specific rates. In1986, a survey was conducted in Islamabad and Rawalpindi districts by the Directorate General Of Special Education (DGSE). It is important to note that variable pattern of prevalence of disability has been reported in the censuses and these surveys. The Pakistan Institute of Development Economics (PIDE), in its indepth analysis of 1998 census data on disability also noted various inadequacies and inconsistencies. According to the PIDE, the variations in the prevalence of disability were presumably due to misreporting or underreporting resulting from hesitation on the part of respondents to disclose factual information on disabled persons. Moreover, concerns have also been expressed about the likelihood of enumeration and instrument bias i.e. only severely disabled were enumerated that led to under reporting of overall prevalence of disabilities and handicaps.

Inconsistencies in data sets on disability are apparent (Table 2.1).

[18] Peter Coleridge, *Disability, Liberation, and Development,* Oxford: Oxfam,1993
[19] Robert L.Metts, *Disability Issues, Trends and Recommendations for the World Bank, 2000* Annex C National and Global Disabled Population Estimates
[20] Most of the text and data in this section has been derived from a paper "Disabled population of Pakistan" written by Abdul Razzaque Rukanuddin, July 2003, and provided to the team by the World Bank, Islamabad

Table 2.1: Estimates of Disability (1961-85) Pakistan

	1961	1973	1981	1984/85
Total population	42,880,378	60,509,535	84,253,644	-
Number disabled	135,668	1,257,454	371,420	-
Percentage of total	0.23	2.08	0.44	-
Total	100.0	100.0	100.0	100.0
Percentage: Age group				
0- 4	13.4	3.9	3.4	3.4
5- 9	-	2.6	8.3	9.2
10-14	16.7	8.8	8.1	10.9
15-19	-	3.8	6.6	9.5
20-29	21.3	12.6	12.5	13.5
30-39	-	9.5	10.4	8.7
40 +	48.6	58.8	50.7	44.6
60 +	-	40.1	34.7	24.3

Source: Asia-Pacific Population Journal Vol. 10, No. 1, March 1995

On the whole, data on the disabled population in Pakistan present a number of problems including those of definitions, reference periods, inconsistent categories, heavy dependence on the respondent's own judgment that obscures objectivity and makes enumeration of disabilities difficult. However, reporting in 1998 Census appears to be better than the previous censuses.

Disability Rate: Census 1998 recorded 3.3 million (2.56%) disabled persons in Pakistan out of a total population of 129.2 million at that time[21]. Among them, 1.9% were males and 1.4% were females out of 67.2 million and 62 million, respectively, showing more disability among males.

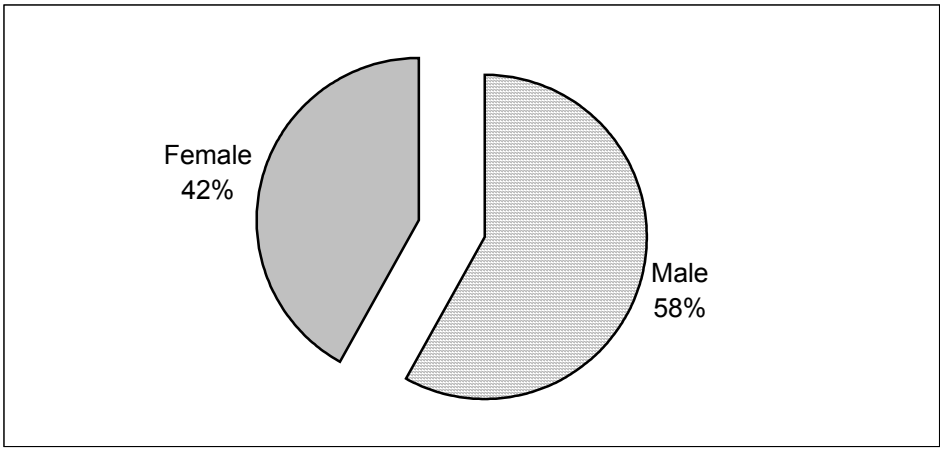
Table 2.2: Disabled Population by Gender and Residence – Pakistan (1998)

Residence	Disabled Population (in million)		
	Male	Female	Total
Urban	0.65	0.45	1.11
Rural	1.26	0.92	2.17
Total	1.91	1.37	3.28

Source: Disabled Population Of Pakistan, Dr. Abdul Razzaque Rukanuddin/PIDE, July 2003, Islamabad

[21] Pakistan Census Organization, *Population Census Report*, Islamabad, 1998

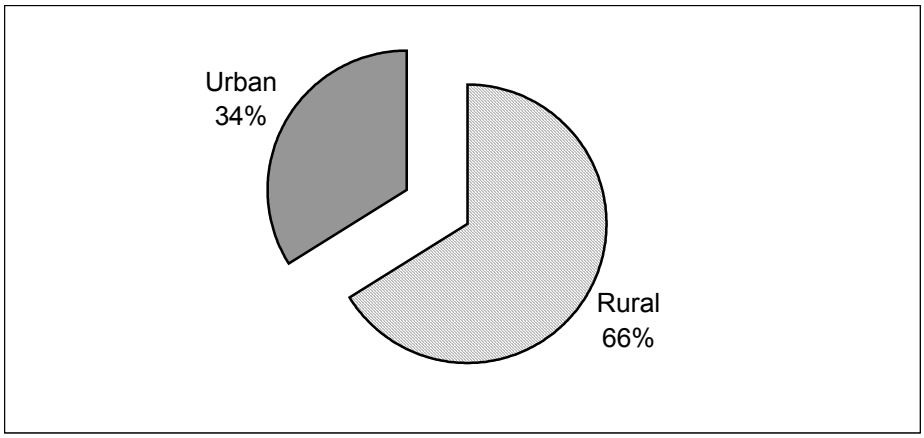
Figure 2.3



The disability rate per 1000 population was found to be 25.4 for rural and 25.9 for urban areas, however, in terms of absolute numbers, the disabled population was almost double in rural areas as compared to the urban areas.

Of the total disabled population in Pakistan 66% are living in rural areas (Census 1998).

Figure 2.4



Age-Sex Specific Disability Rates: The prevalence rates are stable in five-year age groups 0-4 to 30-34 and ranges between 19.7 to 21 per 1000 population, except in age group 5-9 where it is 24.2 per thousand population and the increase is more evident among male children. Then it increases gradually up to age 45-49 and reaches 25 per thousand population. After that, the rate begins to climb steeply and the prevalence reaches to 91 and 142 per 1000 population in age groups 70-74 and 75 years and above, respectively.

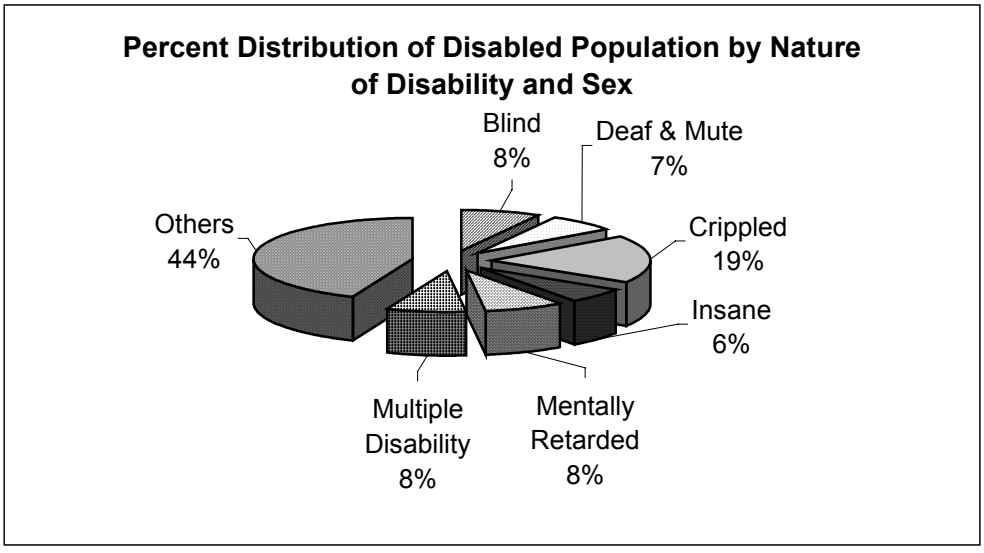
Table 2.3: Age, Gender, Residence Specific Prevalence of Disability per 1000 population

Age (Years)	Rural			Urban			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	19.9	19.4	19.7	21.1	21.6	21.3	20.2	20.0	20.0
5-9	25.7	20.9	23.4	28.5	23.4	26.0	26.5	21.7	24.2
10-14	20.6	17.2	19.0	24.0	18.9	21.1	21.5	17.8	19.7
15-19	22.1	17.8	19.8	23.4	20.3	21.9	22.5	18.5	20.6
20-24	22.6	17.9	20.2	24.6	19.7	22.3	23.4	28.5	21.0
25-29	23.3	17.2	20.2	23.9	20.4	22.3	23.5	18.3	21.0
30-34	22.5	17.3	20.0	24.9	21.1	23.2	23.4	18.6	21.0
35-39	23.0	18.8	20.9	26.8	21.6	24.4	24.5	19.8	22.3
40-44	26.3	19.8	23.0	30.1	22.0	26.3	27.8	21.5	24.2
45-49	28.2	19.8	24.1	30.8	22.0	26.8	29.1	20.6	25.0
50-54	35.0	25.2	30.4	38.3	24.8	32.0	36.1	25.1	30.9
55-59	39.7	30.4	35.4	45.9	27.0	37.5	41.8	29.3	36.1
60-64	57.8	40.6	42.8	57.6	37.8	48.6	57.7	39.7	49.4
65-69	73.7	52.6	63.5	67.5	40.8	55.0	70.8	49.0	60.9
70-74	109.8	78.9	95.3	97.6	59.2	79.8	105.8	72.9	91.1
75+	177.9	117.3	150.3	145.9	82.1	116.7	169.7	108.3	141.7
All Ages	28.3	21.9	25.2	28.8	22.7	25.9	28.5	22.1	25.4

Source: Disabled Population Of Pakistan, Dr. Abdul Razzaque Rukanuddin/PIDE, July 2003, Islamabad

Nature of Disability: The pie chart below presents the distribution of the disability by percentage.

Figure 2.5



Source: Census 1998

It is important to note that only 57% disabled persons have been classified as either blind, deaf and mute, insane, crippled or with multiple disabilities. The remaining 43% have been characterized as "others" in spite of the fact that the categories of disabilities were increased from 4 in 1972 to 6 in 1981 and to 7 in 1998 census.

Distribution of Disabled Persons by Province: At the time of Census, the highest proportion (55.6%) of the total PWDs in Pakistan were living in Punjab. Sindh had 28.3%, NWFP had 11.4%, Balochistan had 4.5% and Islamabad had 0.2%. This is astonishingly similar pattern to the distribution of population in Pakistan in 1998.

Table 2.4

Province	Distribution of General Population (percentage)	Distribution of Disabled Population (percentage)
Punjab	55.6	55.6
Sindh	28.2	28.3
NWFP	11.4	11.4
Balochistan	4.4	4.5
Islamabad	0.2	0.2
FATA	2.4	NA

Source: Reference 20

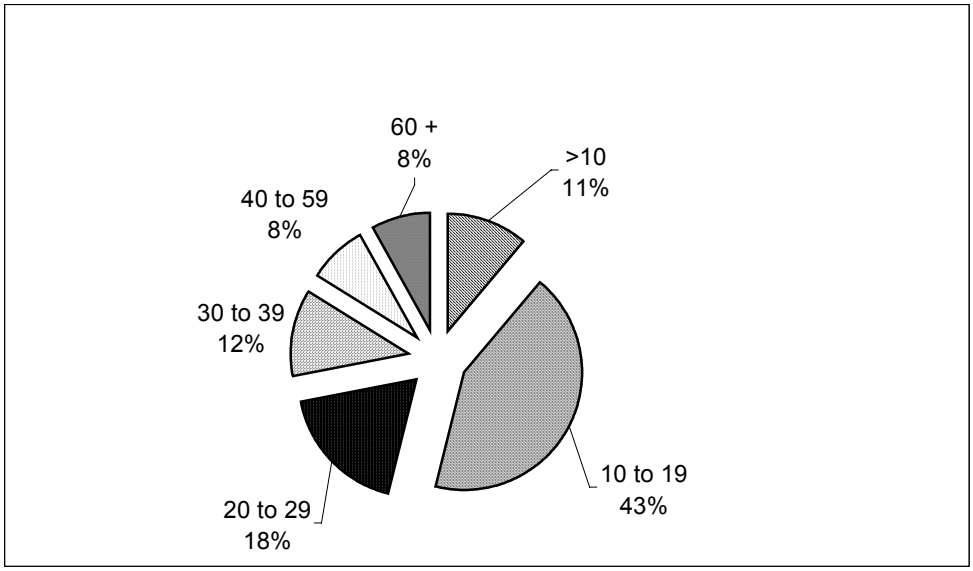
However, the prevalence rate of PWDs per 1000 population was the highest in Sindh (30.5), followed by Punjab (24.8), Balochistan (22.3), NWFP (21.2), and Islamabad (10.5).

Considering sex-wise distribution of PWDs, the male:female ratio in NWFP and Punjab was 59:41, while it was 57:43 in Sindh and Balochistan. In Islamabad, the males were 62%.

Except Sindh, the disability rate was noted more in rural than urban areas. However, the nature of disability varies in rural and urban areas of the various provinces. For example, the percent of blinds in NWFP, Punjab and Islamabad was found to be more in rural areas, while in Sindh and Balochistan it is more in urban areas.

Disability by Districts: There is marked variation in the prevalence of PWDs in districts of Pakistan. It was below 20 per 1000 population in 57 (54%) districts, 30 to 49 in 37 (35%) districts, and of 50 and above in 12 (11%).

Figure 2.6: Percent Distribution of District (106) by Various Levels of Disability Rates per Thousand Population



Source: Census 1998

Literacy & Education Among Disabled: The literacy status and educational attainment by sex and rural-urban residence is given in the Table 2.5.

Table 2.5: Literacy Rate of Total Population and Disable Population (10 years and above) and Formal Literate Disabled by Education Attainment by Sex and Residence

Residence/Sex	Literacy Rate		Formal Literate	
	Total Literate Population	Disabled Literate Population	Total Population	Disabled Population
	Pakistan			
Both Sexes	43.9	27.5	43.5	27.0
Male	54.8	31.7	54.4	31.3
Female	32.0	21.3	31.6	20.8
	Rural			
Both Sexes	33.6	19.9	33.2	79.4
Male	46.4	25.3	46.0	24.9
Female	20.1	12.1	19.7	11.6
	Urban			
Both Sexes	63.1	41.6	62.6	41.3
Male	70.0	43.3	69.6	43.1
Female	55.2	39.1	54.6	38.7

Twenty-eight percent of the total PWDs 10 years and above were literates, which is expectedly lower than the percentage among the total population. The proportion of PWDs having matric (grade 10) and above level education was the highest in Sindh. For achievement between matric

and below degree level was also highest in Sindh (28%), followed by Balochistan and Islamabad (25%), NWFP (24%) and Punjab (20%). The degree and above education level was again reported high in Sindh (11%), followed by Balochistan (8%), Islamabad (7%), Punjab (4%) and NWFP (3%).

Economic Activity Among Disabled: Only 14% of the PWDs 10 years and above were working and 5% were looking for work. The gender disparity for economic activity was evident as among those working, 22% were males and 2 % females. Among them, the higher proportions were deaf and mute (19%), followed by person who has multiple disability (15%) and crippled (11%).

Number of Disabled in the Household: Out of the total 3.3 million PWDs. 99.7% lived in households and only 0.23% (7731 individuals) lived in institutions. The remaining 0.07% (2403) were homeless. Overall, a PWD was found in 1 in 8 (13%) household.

The various correlates of disabled household indicates that disabled population is characterized by a general level of poverty. Higher proportion of disabled households are living in substandard housing units with lack of basic facilities and high housing density. They are the one who are severally burdened with high dependency and other socio-economic burden.

Disability in Other countries: The prevalence rate of disability in some developing countries is presented in Table 2.6, which shows that disability rate in Pakistan are more than other developing countries. However, rates in developed countries are reportedly much higher than the developed countries. These could be due to higher proportion of aging population and better registration due to availability of the social security services.

Table 2.6: Disability Rate (per 1000 population) in Selected Countries

Countries	Year/Source	Disability Rate (per 1000 population)
Developing Countries		
Pakistan	1998 census	25
Sri Lanka	1986 survey	20
Thailand	1991 census	14
Turkey	1995 census	14
Philippines	1995 census	13
Tunisia	1994 census	12
Jordan	1994 census	12
Zambia	1990 census	9
Bangladesh	1982 survey	8
Yemen	1994 census	5
India	1981 census	2
Developed Countries		
Australia	1993 survey	180
Canada	1991 survey	155
United States	1994 survey	150
United Kingdom	1991 census	122
Sweden	1988 survey	121
New Zealand	1996 survey	116
Germany	1992 survey	82

Source: Reference 20

Assuming Proportion of Disabled to be 10%: Based on assumed 10% disability prevalence rate as mentioned by WHO and UN, the total number of PWDs in Pakistan is estimated to be 15 million (based on current estimate of 150 million population) Table 2.7 shows such estimates by category of disability.

Table 2.7: Estimates Based on Assumed 10% Prevalence of Disability

Category of Disabled	Million	% Of Total
Physically Handicapped	6	40.00
Visually Handicapped	3	20.00
Mentally Retarded	3	20.00
Hearing Impaired	1.5	10.00
Multiple Disabled	1.5	10.00
Total	15	100

Source: Adapted from Proposals For Development of Special Needs Education in Pakistan, UNESCO, MOWD/SWD/SE

2.3.3 Importance of Reliable Data

The above analysis of 1998 Census data clearly indicates the need for further improving the disability module in the next census to avail more valid information that could help the Government to develop more meaningful programs for PWDs.

Section 3:
Systems Review

Chapter 3:

Institutional Development and Financing for the Disabled

3.1 Evolution of the Programme for Persons with Disabilities

3.1.1 1947: Situation at Independence

At the time of creation of Pakistan in 1947, only two notable institutions for the deaf, blind and physically disabled existed: (i) “Ida Rieu Centre for the Disabled” served blind, deaf and physically disabled children numbering 50 to 60 in Karachi, and (ii) “Emerson Institute for the Blind” in Lahore. Pressure from parents of deaf children resulted in the formation of a "Deaf and Dumb Welfare Society" at Lahore in 1949, and a special school for the deaf, Gung Mahal, opened afterwards. Social Welfare Department in the Government sector was given the responsibility for education, welfare, training & rehabilitation of disabled persons.

3.1.2 1950s & 60s: Slow Progress

The special education programmes grew slowly in the two decades of 1950s and1960s. Majority of the centers/schools during this period were established in the voluntary or private sector. The subject of special education was transferred from Social Welfare to Education both at Federal and Provincial levels, and it received the lowest priority (Sindh and Punjab did not comply with this change).

The National Planning Board took due cognisance of the vital need and problems of the disabled Persons, and included a specific programme “Services for the Physically Handicapped” in the very First Plan of National Development (1955-60). However, the programme could not be implemented due to lack of administrative support, funds, and trained personnel.

Children with various impairments and disabilities continued to be part of the normal enrolment throughout the primary and even secondary school classes[22]. The commission on National Education Pakistan (1960) recommended that government should be responsible for training of teachers to serve in institutions for the handicapped run by private philanthropists but serious contemplation was not given to it till 1980s.

3.1.3 1970s: Nationalization of Special Schools & Revitalization

The progress for the education, welfare, care and uplift of the disabled persons received a serious set back with the Nationalization of Education Programmes under Marital Law Regulation No. 118

[22] Rauf, A, *Dynamic Educational Psychology, 3rd edition*, Lahore, 1975

in 1972, as it stopped philanthropic investment. The spirit of selfless services with missionary zeal was turned into a bureaucratic setup and in 1970s status quo was maintained in the 65 centers of the public sector.

After the change of government in 1977, and with the special interest of the new Head of the State in disabled persons due to personal reasons, the Programme was revitalized. The fifth Five-Year Plan (1978-83) allocated a sum of Rs. 26 million for the purpose as compared to a meager sum of Rs. 2 million provided in the First Five-Year Plan. The Programme was transferred to the Ministry of Health and Social Welfare.

In 1979, the International Year of the Child was observed in Pakistan and the needs and problems of the disabled were highlighted in a workshop inaugurated by the then President of Pakistan. This was followed by a number of workshops and seminars at Divisional Headquarters. A National Consultation followed, in which the then President met a number of representatives of the voluntary organizations. These measures brought the issues of the disabled to the forefront at the national level.

3.1.4 1980s: Spurt Of Activities For The Disabled Persons

The International Year of Disabled Persons 1981 was observed for promoting and pursuing the cause of special education and training of disabled persons in pursuance of the United Nations General Assembly Resolution. It created unprecedented interest and awareness among the Government and non-government organizations, institutions, people, and above all among the disabled persons themselves. The then President of Pakistan himself provided leadership in the observance of the International Year of Disabled Persons as Patron-in-Chief of the National Committee, IYDP, 1981. He issued a number of directives to the Ministry of Health and Social Welfare to accord this sector due priority to provide organizational and administrative structures, services and delivery systems, funds, personnel, equipment, institutional buildings, transport, etc.

The Disabled Persons (Employment and Rehabilitation) Ordinance 1981 was promulgated which provided one percent quota for the compulsory employment of disabled persons in each establishment having more than 100 employees. National Council for the Rehabilitation of Disabled Persons (NCRDP) and its provincial chapters Provincial Council for the Rehabilitation of Disabled Persons (PCRDP) were created to implement and monitor the affirmative action plan for the rehabilitation and employment of disabled.

In pursuance of the U.N Assembly Proclamation, Decade for the Disabled was observed in Pakistan from 1982 to 1991, to follow-up the achievements of IYDP-1981. A National Task Force was formed to implement the directives of the President as well as recommendations and findings of the conferences/workshops/seminars and studies.

A Cabinet Committee was commissioned to assess the existing situation of disabled children and to prepare a Five-Year plan for the special education and training. Several national and international experts were invited to contribute in the development of the programme.

The main objective of the Plan was to promote and pursue special education and training of the disabled children in the country. Special attention was proposed to be given to the rural children, disabled female child, training of workers and teachers, research and evaluation in the nature and

extent of the needs and problems of disabled children, manufacturing of equipment for the various categories of disabled children and employment and rehabilitation of the disabled adolescents.

At that time, it was estimated that there were over 3.7 million disabled children of age group 0-14 in Pakistan. Of these, 740,000 children were estimated as having disabilities of the degree warranting special education services that required at least 3,700 special schools at the enrolment rate of 200 children per school. However, human, material and financial resources were limiting factors. Therefore, it was proposed to establish at least one special school for each category of disabled children at every district headquarter of the country. As such, 312 physical targets (including 280 special schools/institutions and 32 infrastructure units) were proposed to be developed during the Five-Year plan in recognition of the resource constraints.

Four model National Special Education Centers were established in Islamabad, one each for visually handicapped (VH), hearing impaired (HI), physically handicapped (PH) and mentally retarded (MR). It was decided to establish 127 new special schools in the Provinces: 102 by the governments and 25 by the NGOs at a cost of Rs. 623.90 million, and 14 special schools in FATA and FANA worth a sum of Rs. 52.9 million, while Rs. 31.5 million was proposed to be expanded to set-up 8 special schools in Azad Jammu and Kashmir. Thus a total sum of Rs. 835.225 million was the financial layout to implement the plan. Those estimates included cost of land and building, staff, equipment, transport, miscellaneous items and sundries.

There were then 89 non-government organisations (NGOs) all over Pakistan, with most of them in Province of Punjab and Sindh. They were providing good services but all those agencies were handicapped by funds and qualified or trained personnel. They were given grants through a financial assistance programme by the Ministry (A sum of Rs.11.7 million was given in 1981-82 to NGOs). It was however, considered too meager to enable them to revitalize and expand their educational and services programme to the desired standards and also to serve at least 200 children.

The **Directorate General of Special Education** was established at the federal level in Islamabad in 1985 to carry out the following functions: (i) formulate national policy for the handicapped, (ii) conduct census of disabled persons, (iii) train manpower relating to special education, (iv) provide specialized aids and equipment for the use of disabled, (v) provide vocational training, (vi) provide job opportunities to the persons with disabilities, and (vii) give legislative support for the disabled person.

The DGSE had been endeavouring to achieve its goals and to date have established several institutes, centers/schools for the education and training of disabled persons. National Institutes established at Islamabad were as follows

National Institute of Special Education (NISE) established in 1986 and is dedicated to the task of developing specialized training courses for teachers of government and non-government institutions. It conducts training of SE teachers in all four currently served disciplines viz. VH, HI, PH and MR and 298 courses have been conducted to date. .

National Library & Resource Center (NL&RC) established in 1986 serves as a resource center for printed and audio-visual material on SE and disabilities. This is attached with the NISE and is for use by the participants of different courses, and institutions in the public and private sector.

National Training Center for Special Persons (NTCSP) established in 1986 with the prime objective to provide vocational training and rehabilitation to persons falling under VH, HI, MR and PH categories. On an average, 100 students are taken on roll annually to learn skills in computer operations, typing, short hand, welding, radio and TV repair, air-conditioning and refrigeration, electrical work, carpentry, tailoring, knitting and a variety of other skills. The centers have also been opened at Karachi, Lahore, Peshawar and Quetta.

National Mobility and Independence Training Center (NMITC) was established in 1986 to conduct courses and instill confidence among visually handicapped for their independent mobility on roads, shopping areas, work place and in their community. It has conducted more than 80 courses in various parts of the country and about 4000 participants have benefited to date.

National Trust For the Disabled (NTD) was established in 1988 under the Charitable Endowment Act 1980 to establish model institutions for the care and rehabilitation of the disabled; to prescribe and undertake specialized programs of training and instructions; to conduct research about the nature and extent of the problems of the disabled; to arrange financial assistance and advisory services for individuals/families; and to deal with national and international organizations. Its functions are very similar to that of DGSE and it was envisioned that over the years DGSE would be merged within NTD, which will emerge as an autonomous body to function without bureaucratic hindrances. It has a Board of Governors (BOG) comprising very senior government officials (such as chief ministers of the provinces) and NGO leadership in the field of disability and the President of Pakistan as its Chairperson. This composition has become a hurdle in its functioning as the Board fails to meet. Currently NTD is independently running 3 SE schools, 2 in Sindh and 1 in Punjab.

The **First National Policy** for the Education and Rehabilitation of disabled was formulated and adopted in 1985-86 soon after the establishment of DGSE which was reviewed and revised on the basis of field operations in 1988.

3.1.5 1990s To Date: Infrastructure Extension

Special education and vocational training centers have been established in Islamabad and at provincial headquarters in Lahore, Karachi, Quetta and Peshawar and at several Divisional and District Headquarters. The detail of centers established is given as under:

Table 3.1: Special Education & Vocational Training Centres at Federal and Provincial Levels

Location	Special Education Centre by Type				
	Hearing Impaired (HI)	Mentally Retarded (MR)	Visually Handicapped (VH)	Physically Handicapped (PH)	Total
Islamabad	1	1	1	1	4
Punjab	5	5	5	4	19
Sindh	1	2	3	2	8
NWFP	2	2	2	2	8
Balochistan	1	1	0	1	3
Northern Areas	1	0	0	0	1
AJK	0	0	0	1	1
Total	11	11	11	11	44

Source: DGSE, Islamabad, March 2004

The services provided at the special education schools are: (i) assessment and diagnostic services, (ii) education up to primary level, (iii) pre vocational and vocational training, (iv) early intervention and diagnosis, (v) physiotherapy and audio therapy, (vi) Indoor and outdoor recreation facilities, (vii) transport to students, and (viii) parental counseling

The other programmes initiated by DGSE are:

Special Education Training at Universities: Allama Iqbal Open University (AIOU) in Islamabad and the Punjab and Karachi Universities were provided funds by the Federal Government through the efforts of DGSE to establish Departments of Special Education. The Departments have now been taken over by the respective universities and they are offering master's level degree course leading to M. Ed in Special Education.

Vocational Rehabilitation and Employment of Disabled Persons (VERDP) was established in 1993 with the objective to evolve a cost-effective model for the non-institutional community based rehabilitation (CBR) and employment of disabled persons vide skills training, micro credit etc.

National Institute For Handicapped (NIH) was planned in 1987 as a speech and hearing disorder therapy center. Subsequently it was transformed as general hospital for handicapped and became operational in 1997 to provide diagnostic, treatment and rehabilitative services to the disabled persons. It has physiotherapy, orthopedic, pediatric surgery, ENT, psychiatry, biometry and laser therapy, electrotherapy and hydrotherapy, speech and language therapy, pathology and radiology departments serving both disabled and non-disabled patients. Its management and operation has been transferred to the Ministry of Health in the year 2000.

Portage Guide to Early Childhood Education was developed through two years research project. It has been experienced that if the parents are properly guided, they can become effective teachers of their children particularly in case of children with developmental deficits. Under this project, 129 portage programme managers have been trained.

A new **National Policy for Persons With Disabilities 2002** was prepared, which is comprehensive and include the areas of (i) early interventions, assessment and medical treatment; (ii) education and training; (iii) vocational training, employment and rehabilitation; (iv) research and development; (v) advocacy and mass awareness; (vi) sports and recreation; (vii) design of buildings, parks and public places; (viii) intuitional arrangements and mechanisms; (ix) and role of private sector, including community and family involvement.

Based on the above policy this National Plan of Action is being developed in 2004.

3.2 Institutional Arrangements of Public Sector Service Delivery

3.2.1 At the Federal level

The Programmes for PWDs are dealt under the Ministry of Women Development, Social Welfare and Special Education (MoWD,SW&SE). Like other Ministries this is also headed by a Minister and implementation is managed by a Secretary who is assisted by an Additional Secretary and other officers in the hierarchy. The three components of the Ministry, as visible by its name, are clearly demarcated and function independently within their given charter of duties. It is to be noted

that three major social sector programmes are being managed under the umbrella of one Ministry, which puts a very heavy workload on top hierarchy. Hence, any programme that has stronger political backing receives priority for interventions and development.

DGSE vis-à-vis Other Key Bodies Working for PWDs: As seen in the Figure 3.1, there are 5 key bodies working for PWDs at the top level and they are (i) Directorate General of Special Education (DGSE), (ii) National Council for Rehabilitation of Disable Person (NCRDP), (iii) National Trust for Disabled (NTD), (iv) Special Education Department in Universities and (v) National Institute for Handicap (NIH).

Out of these one institute i.e. NIH was transferred to the Ministry of Health (MOH) and currently has no link with MoWD,SW&SE or any of its departments.

The Special Education Department in Universities of Karachi and Punjab were initiated and funded by the DGSE. Overtime, they have been taken over by the respective universities and are currently working without any link with DGSE. Allama Iqbal Open University also offers masters level courses, with functional link with NISE, an institute of DGSE.

NTD established in 1988, has almost similar mandate as that of DGSE, however, its functions have been minimal and very limited. According to the key informants, at the time of establishment it was visualized that DGSE will eventually merge with NTD and than would be able to function independently without bureaucratic chains, but this has not materialized. Hence, at the moment the role of NTD is parallel to that of DGSE.

The NCRDP was established in 1982 and the Secretary of the MoWD,SW&SE is the chairperson of the governing body. There is representation of both private and public sector individuals at national and provincial level councils. It has four chapters, one each at provincial headquarters that are attached to the provincial Directorate of Social Welfare. According to the key informants, this structure has a model of inter-ministerial linkages, federal-provincial liaison and public-private partnership. However, its output has been rated to be far less than expected. The major hindrances in its optimal functioning are the lack of manpower and other resources, and the lacunae in the ordinance, which does not allow effective enforcement of 1% employment quota and collection of remittance in lieu of default.

Except very minimal link with NCRDP and Special Education Department in Universities, DGSE does not have any defined link with NTD and NIH.

The DGSE is the nuclear department working for the disabled persons. A Director General, who oversees the functions of 6 directors, heads the Directorate. Director 1 is Admin and Finance, who also deals with administrative matters, finance and accounts. Director 2 supervises development of physical infrastructure. Director 3 is for Planning and Development (P & D), who monitors the ongoing projects and plans new projects in consultation with other directors. Director 4, 5 and 6 are responsible for overseeing the functioning of over 50 Special Education institutes within their jurisdiction and also maintain liaison and support for over 20 NGOs. Out of the three components of the Ministry, it is encouraging to note that the DGSE service network for education and rehabilitation of disabled has spread up to several divisional and to some district headquarters.

As evident from the Figure 3.1, the Director Northern Region (NR) is heavily overburdened with responsibilities as compared to the other two Directors (i.e. Director Southern and Central Regions).

DGSE vis-à-vis Line Ministries: The figure 3.1 succinctly shows that DGSE is working in isolation without any specified formal inter-sectoral and inter-ministerial linkage with very relevant ministries like Education, Health, Labour and Manpower, Housing and Works and Local Bodies.

DGSE vis-à-vis Provinces: There are 40 DGSE provided Special Education Centers (SECs) in the four provinces vertically functioning under its direct financing and administration. Currently, services relate to special education and vocational training. Directors/Principals of these SECs brought up the issue of lack of two-way communication. Interestingly, they themselves are not in contact with the mainstream provincial SE programmes.

It was mentioned by key informants that the functioning of DGSE has often been and is currently being affected by the appointment of not appropriately qualified personnel at the decision-making and important managerial positions

Overtime, the DGSE institutions have accumulated a considerable knowledge and experience in education and vocational training of disabled children and adolescents. Despite the above-mentioned shortcomings, the established infrastructure and services provided by DGSE has served as a motivating factor and model to the provincial governments to replicate.

However it is important to note that the lack of mandate to the DGSE (the nucleus body working for the PWDs) such as for playing a role in prevention of disabilities and in physical rehabilitation of disabled, does not allow a holistic approach towards the issue of disabilities. A broader nomenclature and wider responsibilities beyond special education should be given to this nuclear body.

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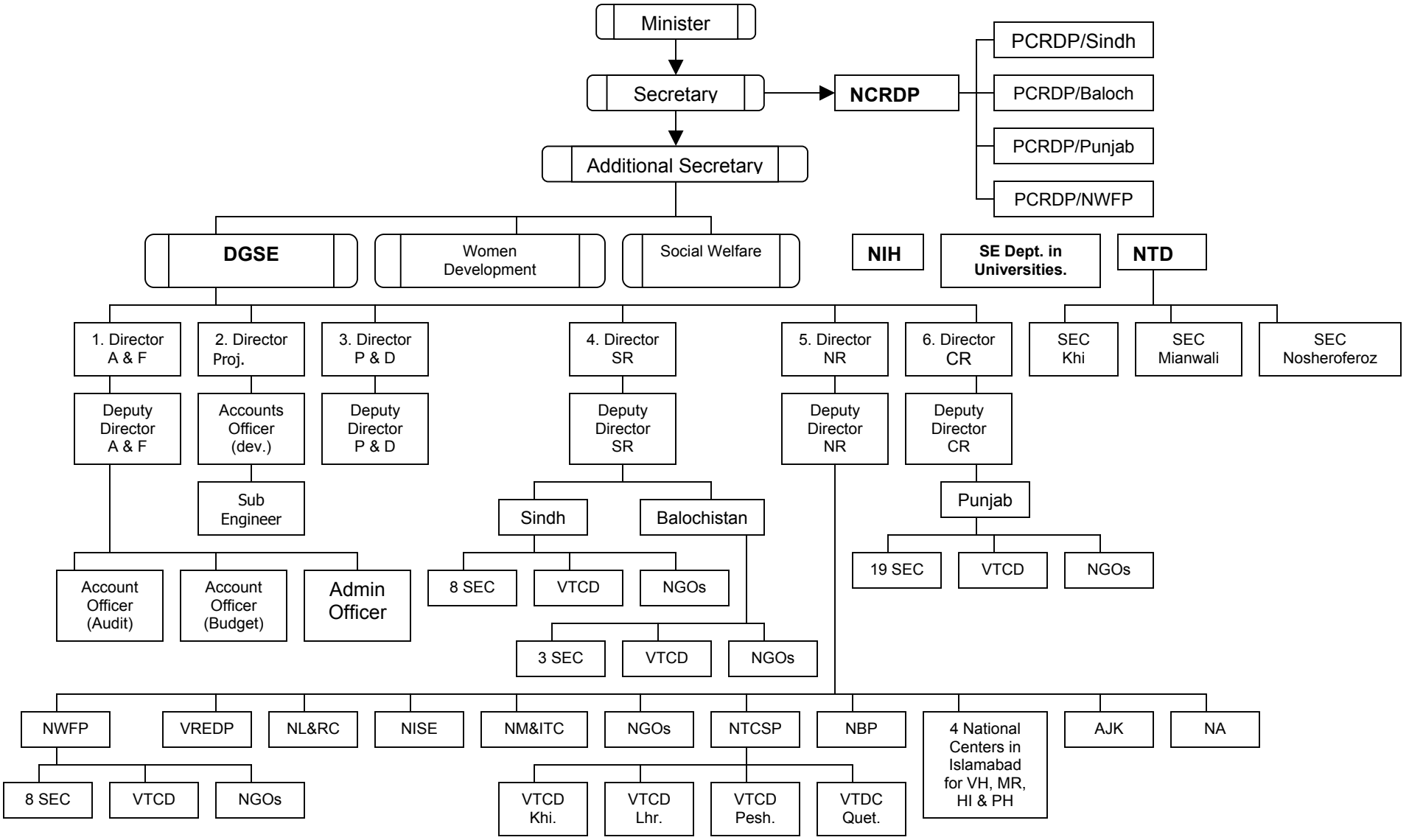
Figure 3.1: Federal Institutional Arrangements for SE Programme



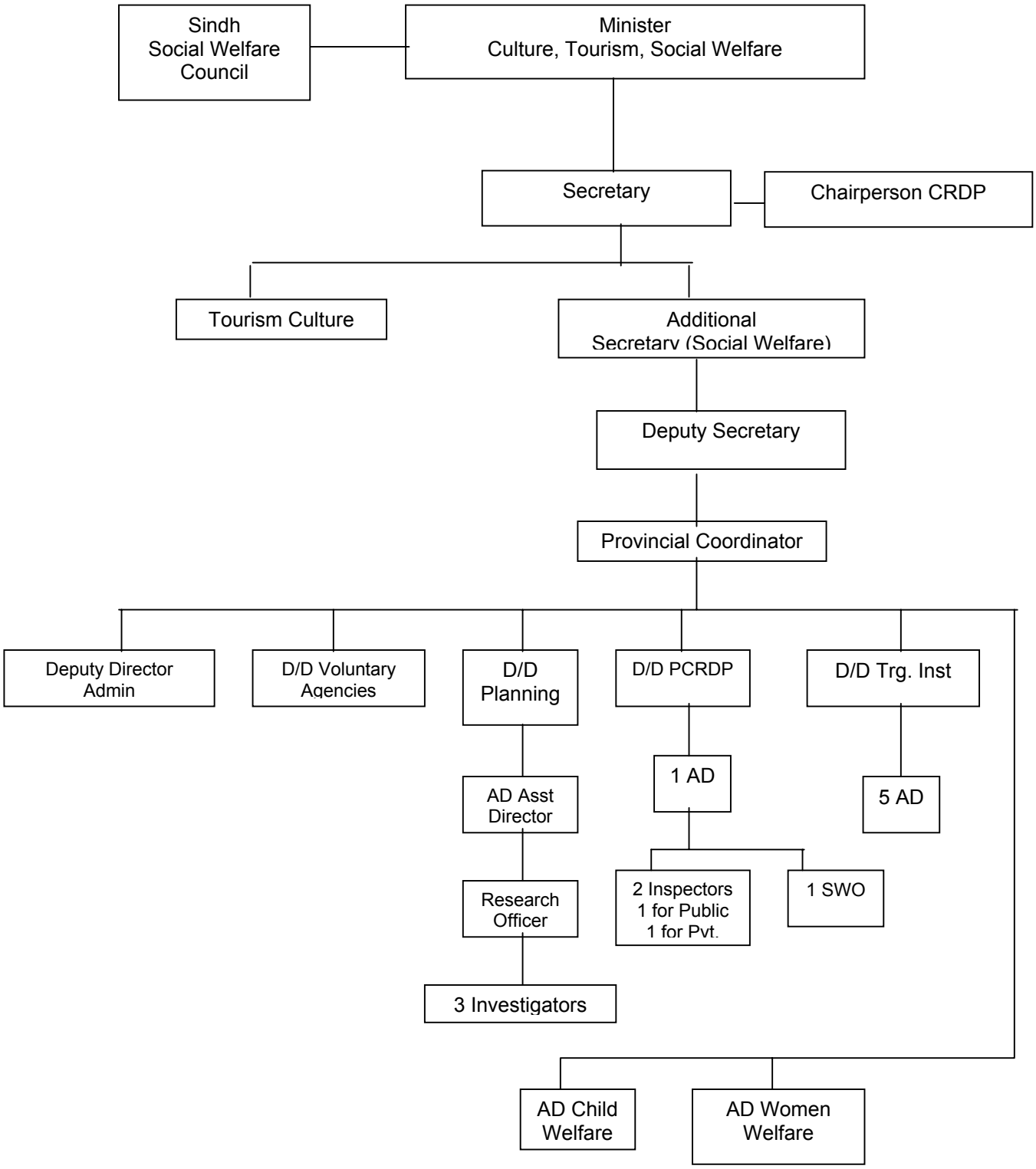
3.2.2 At the Provincial Level

In NWFP, Sindh and Balochistan: The provincial Social Welfare Departments (SWD) are overall responsible for maintaining liaison with DGSE. The provincial SWD and DoSE have their own distinct organizational structures that are presented in figures 3.2, 3.3 and 3.4. Consequent to devolution in 2001, service delivery of SE programs has been entrusted to the district governments. The district governments are now responsible for planning, funding all SE service delivery programs including maintaining liaison with programmes administered by NGO and the private sector.

The provincial line departments and the recently devolved local government organizations and their functionaries have limited knowledge with respect to the federal policies and programmes. There is overall lack of integration of DGSE led services with the corresponding provincial line departments resulting in near absence of broader exchange and collaboration. Each provincial government has individualized special education programme. In the provincial SE programs DGSE established rules and procedures do not apply in both public and NGO sectors. The provincial government departments raised the issue that they are not involved in planning process and sometimes the programmes are thrusted upon them without additional financial support. Evaluations of provincial programmes have not been carried out periodically to ensure that policies and programmes established and administered by the provinces and NGO sector are consistent with the provisions of federal policy and guidelines.

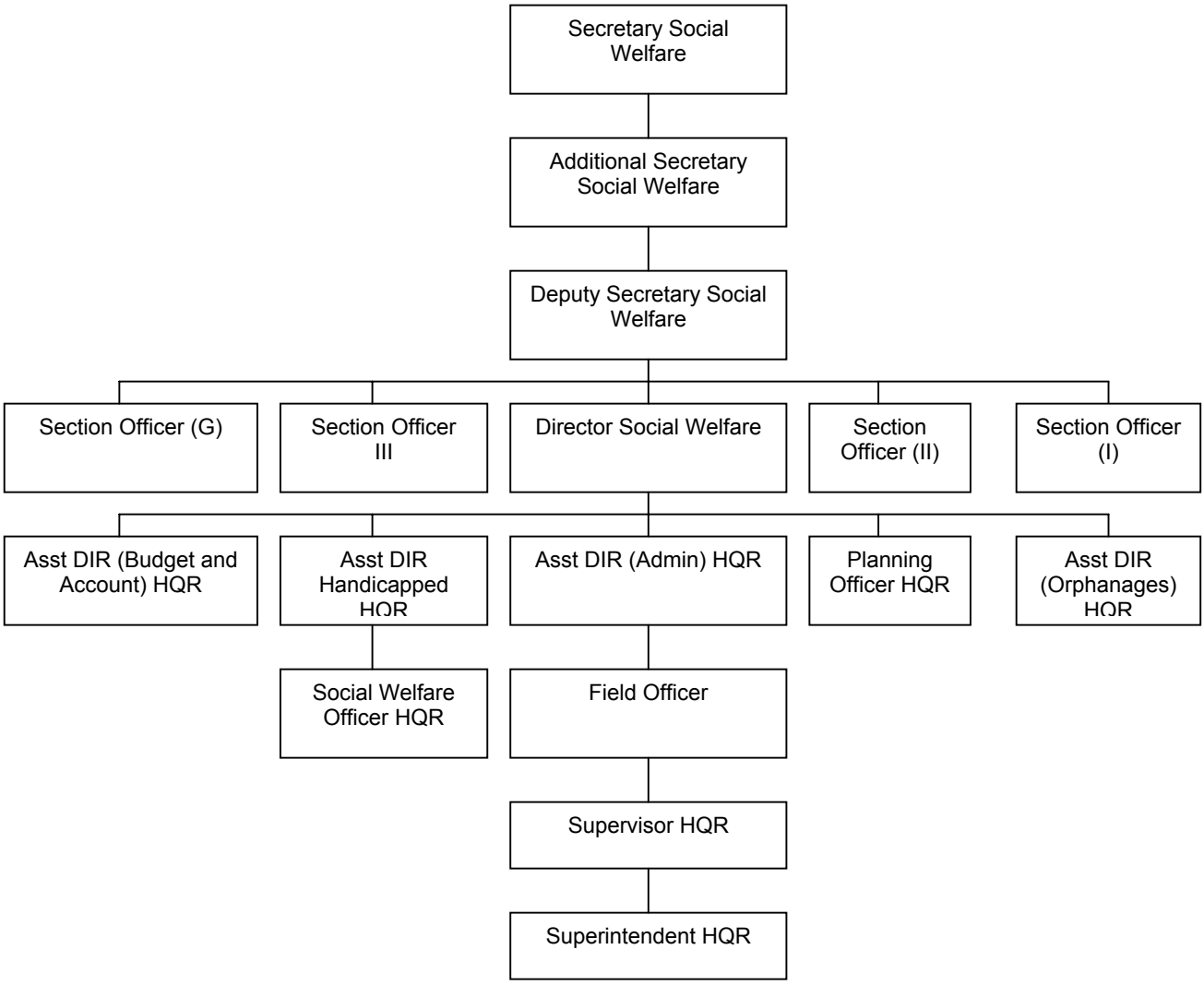
In Punjab:, An independent Department of Special Education (DoSE) has been established in 2003. The provincial DoSE has overall responsibility for policy, planning, coordination, and for in service educational programmes for the SE teachers as well as provision of diploma and degree programs. The DoSE is headed by a Minister of Special Education under whose leadership and direction the Secretary and Director of Special Education carry out the functions. It is important to note that PCRDP is under the social welfare department and is functioning independently of DoSE.

Figure 3.2: Institutional Arrangements for SE Programme - Sindh[23]



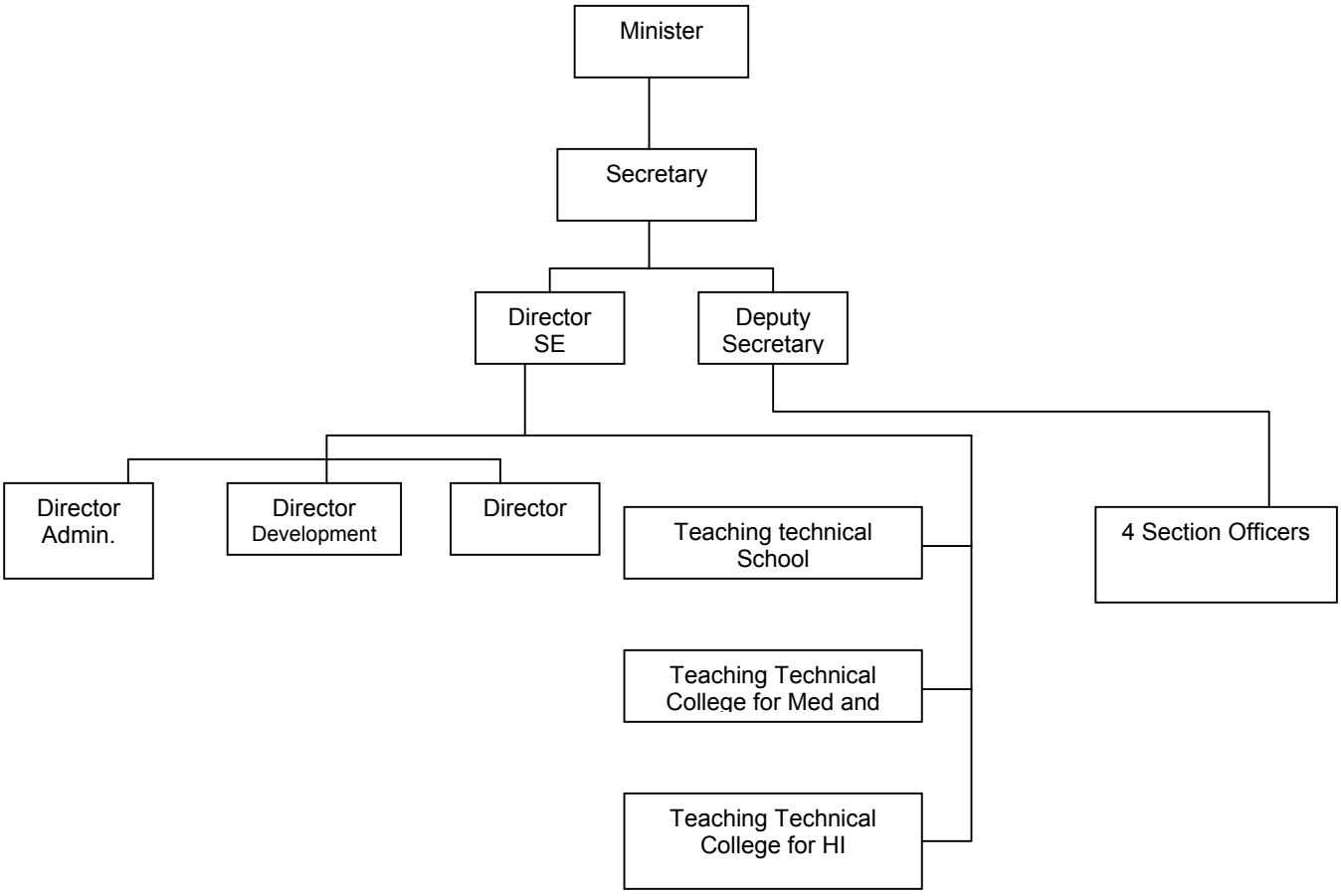
[23] Provided by the Deputy Director Social Welfare

Figure 3.3: Institutional Arrangements for SE Programme - NWFP[24]



[24] JICA, *Country Profile on disability, Islamic republic of Pakistan,* 2002

Figure 3.4: Institutional Arrangements for SE Programme - Punjab[25]

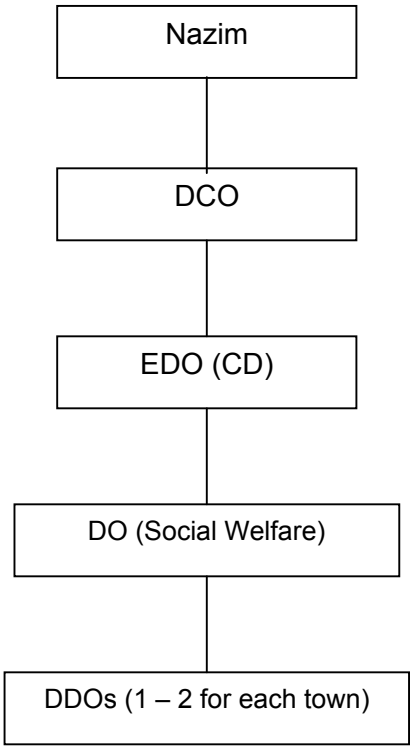


[25] Provided by Secretary Special Education - Punjab

3.2.3 At the District Level

After the implementation of the Devolution Plan in 2001 and establishment of the District Governments, the SECs established by the provincial governments have been transferred to them. The District Officer Social Welfare (DO-SW) is now responsible to oversee the functioning of these centers besides other programmes such as overseeing the Computer Centers, Ladies Socio Economic Centers, Day Care Centers, NGOs and other activities for disabled such as quota implementation and certification for disabilities. This is likely to significantly affect the performance of about 200 SECs as DO-SW lacks technical competence to monitor their performance and progress. Hence simpler and more direct mechanisms need to be established to filter down the developmental work taking place at DGSE in Islamabad to the districts, such as new curriculum or guidelines.

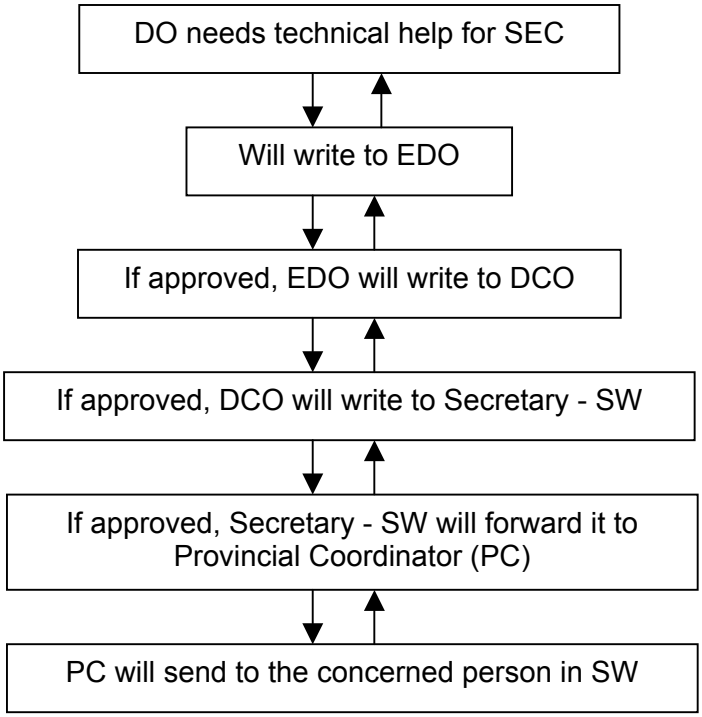
Figure 3.5: Institutional Arrangements for SE Programme – District Level



According to the current situation if a DO (SW) requires any technical help for any SECs than he will have to write to the Executive District Officer (EDO), who will forward it to District Coordinating Officer (DCO), and the DCO will write this to the Secretary -SW. If the request is approved at each level and reaches the Secretary and he approves it, he will then forward to the provincial coordinator for special education. The provincial coordinator will then forward it to the concerned

section in the social welfare department for necessary response, which will then be returned back to the DO through the same channel that it has been received[26] (Figure 3.6).

Figure 3.6



3.3 NGOs, Associations and the Private Sector

3.3.1 NGOs

The link between Non-Governmental Organizations (NGOs) and DGSE is distinctly clear in Figure 3.1, however functionally it is not optimally productive.

In general, NGOs are providing services to a large number of PWDs and share considerable workload of the government. For example, there are two NGOs in Karachi (Ida Rieu and DEWA) that have 1700 students as compared to about 4000 students in 44 centers managed by DGSE. Services are either free, at subsidized costs or in some cases on profitable charges.

According to the information collected during the study, there are about 117 NGOs working for the disabled in Pakistan, however, the information about total number of enrolment with all of them could not be obtained.

[26] This information has been provided by DO – Social Welfare Karachi

Table 3.2: Number of NGOs for Disabled in Pakistan

Location of NGOs	Number of NGOs
Islamabad	6
Northern Areas	1
Balochistan	4
Punjab	54
N.W.F.P	24
Sindh	28
Total	**117**

Source: Information collected during the study

Many NGOs share some common traits: a potential for dynamism and flexibility; a capacity to act efficiently due usually to simple organizational structures; a will to pioneer; initiative, high motivation, and devotion to their mission. The role of the founder of an NGO and her/his personal values and beliefs appear to have substantial influence on the organization's culture, the norms and legends that is leading to success. The NGO represent a sizeable group, they enjoy good working relations with the federal and provincial governments and represented on high profile national and provincial forums.

Most NGOs are providing special education and/or vocational training services with varying degree of quality ranging from fair to high. The majority of the beneficiaries belong to middle and lower middle income groups, mostly from the urban areas.

Miles reviewed the development patterns of 'Disability NGOs' in Pakistan and Bangladesh, nations with some political, cultural and socio-economic similarities. It focuses on service organizations for people with learning difficulty/disability or MR, from the early 1980s to mid 1990s, a period during which those NGOs expanded, mostly with foreign assistance. According to the study, in Pakistan several small, autonomous NGOs work locally and provincially, often centered on particular schools or service units. Some practical collaboration has taken place between them, but the NGOs are often in mutual competition for resources and renown. As the number of NGOs increased, efforts were made to achieve a Pakistan-wide platform and coordination, but geographical factors and friction between various participating groups and viewpoints prevented any lasting success. The review suggests that NGO services in Bangladesh and Pakistan have reached a broadly similar level of development, though each has strengths that are lacking in the other; The Pakistani NGOs have the strengths of diversity, in their goals, approaches and methods and the Bangladeshi national NGO and branches have the strength of unity.

The weaknesses of the NGOs in both countries are those common to NGOs worldwide: i.e. the lack of managerial competence, poor accounting and administration, narrow vision and weak planning, channelling of resources to the middle classes rather than to those in greater need, dominance of a small number of personalities, party spirit and politicking[27].

[27] Miles, M, *Enabling the disability NGOs and centralization versus competition in Bangladesh and Pakistan*, Enabling Education Network (EENET), 2001

An inventory of the province wise Government and NGO institutions providing services such as special education, vocational training and rehabilitation and in some instances medical rehabilitation has been prepared, and is presented in Annex III.

3.3.2 Associations of the Disabled

Association of Disabled People are playing a important role in service delivery, advocacy of the rights and promotion of equal opportunities. Their role is described in Chapter 10.

3.3.3 Private Sector

Special Education services such as needs assessment through early detection and commensurate interventions are reportedly available in the private sector, but at a fairly high cost. Private sector is mostly catering the needs of middle and upper income groups and SE schools and tuition centers are mushrooming in cities. Reportedly, young women join SE NGOs with a motivation to acquire experience and skills and then move out to open small centers at their home for 8-10 children. The fee rates per child ranges according to the community being served and could be as high as Rs. 4,000 per child. These are examples of entrepreneurial initiatives in the field of special education.

Not-for-profit private sector institutes, such as Ma Ayesha Center for Neuromuscular disorders, are also operating. The center offers rehabilitation services at subsidized costs and also runs a SEC at the same premises. It has carried out awareness and orientation seminars for the parents of the disabled children and has conducted short courses for the doctors. The institute has recently designed a one-year diploma course in Developmental Paediatrics that has been recognized by the SE Department of the Karachi University. Classes will be offered to the public and private sector physicians on Saturday afternoon, and arrangements for hands-on training will be made. The institute is also in the process of compiling a Karachi wide comprehensive directory of disability service providers. The directory will be available to the paediatricians, neurologists and psychiatrists for referrals.

3.4 Financing of the Services

Source of Funding: According to the DGSE sources, the Ministry of Finance is funding SE programme of federal government. No financial assistance has been received during the last five years from any donor, except for funding of small-scale projects such as those by Sight Savers. Zakat funds and Bait-ul-Mal also do not provide any assistance to the DGSE for implementation of the programme. Parent Teacher Associations (PTAs) established in SECs generate funds on a small scale through contribution from PTA members and other donors. These funds are spent in the respective SEC.

Budget Allocations: The budget allocations were made available to the team officially for the last five years, which shows the current fiscal year (FY) budget is 96% more than that allocated in FY 1999-00. However, as the total projected budget in all PC-1s of the different components of the programme were not available, it is not possible to comment whether the allocations made over the years were in line with the projected budgetary needs or not.

Analysis of period 1999-2004 shows that the allocated budgets were 56% for non-development and 44% for development purposes. It is interesting to note that overall, 75% of development

budget has been allocated for civil works (table 3.3). Expenditures against these allocations were not available, hence the utilization pattern cannot be analysed. Furthermore, with the available data, it is not possible to infer that what percent of budgets were invested in other categories such as salaries, staff capacity development, services to the handicapped, procurements, etc.

Table 3.3: Budget Allocations of 1999-2004 for SE Programme of Federal Government

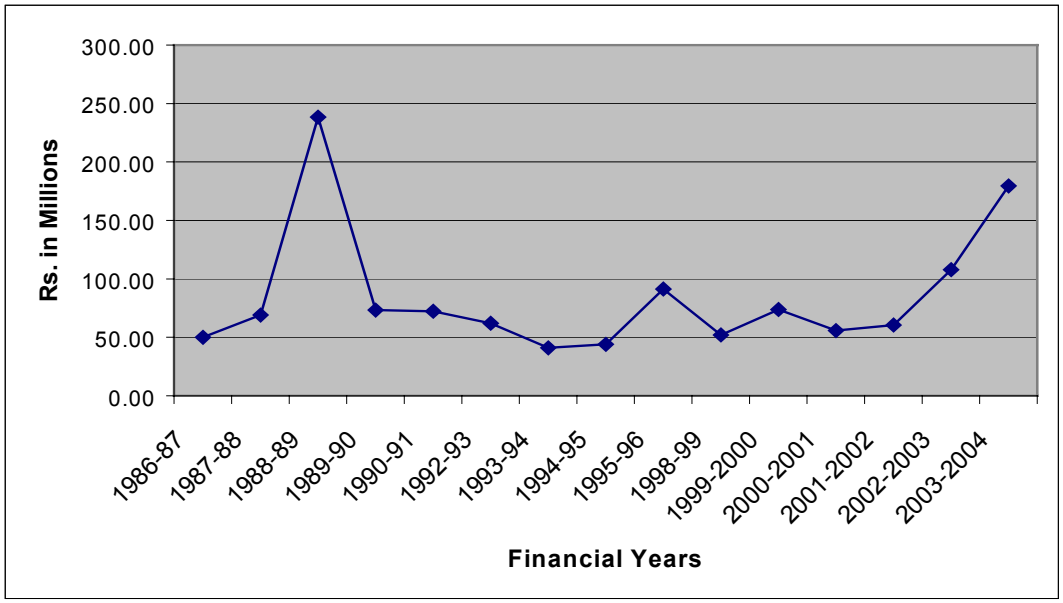
(Pak Rs. in Million)

Financial Years	Total Allocations	Non-Development	Development	Civil Works	Civil Works as % of Total Development	Other Expenses as % of Total Development	Non-Development as % of Total Budget
1999-2000	**168.771**	94.948	73.823	55.95	76%	34%	56%
2000-2001	**160.466**	104.581	55.885	44.5	80%	20%	65%
2001-2002	**166.778**	106.182	60.596	47.356	78%	22%	64%
2002-2003	**251.448**	143.52	107.928	73.044	68%	32%	57%
2003-2004	**330.498**	150.973	179.525	139.35	78%	22%	46%
Total	**1077.961**	**600.204**	**477.757**	**360.2**	**75%**	**25%**	**56%**

Source: Data provided by DGSE

Data gathered through different sources show that in FY 1986-87 (the year of inception of DGSE), the development budget allocated was Rs. 50 million. However, in 1988-89, the allocation increased steeply i.e. a sum of Rs. 238.417 million was allocated for construction of special education institutes. Again in recent years, the allocations have shown an increase (Figure 3.7) in the financial years 2002-03 and 2003-04 as civil works have been initiated in terms of new construction and up gradation of existing facilities.

Figure 3.7: Development Budget Allocations for last 5 years for Special Education Sector - Federal Government



Source: Information collected from different sources by a team member, May 2004

SE Cost per Child: Crudely, the cost of special education has been calculated by dividing the total recurrent budget for the current year with the present enrolment in different public and NGO institutes/schools and are presented in Table 3.4

Table 3.4

Name of Institute	Current Enrolment	Annual Recurrent Budget*	SE Cost per Child per Month (Rs.)
NSEC for VH	169	6,222,000	3068
NSEC for MR	180	7,200,000	3333
NSEC for HI	371	9,514,000	2137
NSEC for PH	142	4,712,000	2765
SEC for VH, Lahore	80	2,930,000	3052
SEC for PH, Lahore	135	5,426,000	3349
SEC for MR, Karachi	136	2,662,000	1631
IPHC, Quetta	87	2,927,000	2803
DEWA	900	15,000,000	1389
Ida Rieu	800	8,400,000	875

* Figures as quoted by the key informants or taken from available documents

The services that are being provided by the government centers and the NGOs are very similar i.e. transport to students, uniforms and books, classroom education and supportive aids. Apparently the services provided by the two major NGOs (that have 43% enrolment as compared to all 44 DGSE centers) are generally at cheaper cost and at no lesser quality or even better quality. A major reason for the difference in the cost is the salary structure and facilities provided to the teachers by the public sector. Other reason could also be the maintenance cost being incurred on buildings and salaries of larger number of support staff in public sector SECs. However, this is a very rough inference and the subject requires more in-depth study.

Funding for Primary and Secondary Prevention: The primary prevention activities that are being carried out by the Ministry of Health, Ministry of Labour and Manpower, traffic police, etc are part of their major service delivery programmes. Hence, ascertaining the costs of disability prevention is difficult because these are imbedded in the cost of overall services by different ministries and line departments. Unless careful studies are done, the amount of money spent on or saved through the prevention of disabilities can only be an educated guess.

Cost-effectiveness: The effectiveness of prevention programmes may be judged by estimating the reduction of incidence, but cause/effect relationships are extremely difficult to prove. The question of cost effectiveness of programmes for the prevention of disability is an area where more studies need to be done. In Pakistan, the closest one could come to a cost-effectiveness estimate is a rough comparison of government expenditures on tertiary prevention (services) for people with disabilities and the amount spent on MOH led primary and secondary prevention programmes. The cost-effectiveness of prevention of disabilities would increase exponentially if a monetary value could be placed on the cost of the frustration, pain, and guilt experienced by those who must deal with the problems posed by a disability. In terms of efficiency, primary and secondary prevention give the best return on investment because then lesser expenses are incurred on tertiary

prevention. This requires long- term commitment of funds and personnel for primary and secondary prevention.

Collections by PTAs: The SECs are required to establish Parent Teacher Associations (PTAs) that raises funds to support the centers. The data available regarding collection of funds by PTA is for variable period and duration, hence a comparative analysis is not possible. However, it is worth mentioning that the annual collections range from Rs. 1,000 to Rs. 1.5 million per year per PTA. These funds are mainly used for hiring of additional staff (teachers, speech therapist, occupational therapist), POL, computers, uniforms, books and extra curricular activities.

Funding of NGOs: NGOs are being funded by several sources, which include international donors, Pakistan Bait-ul-Mal, Central Zakat Administration, organizations, individuals, and DGSE.

An illustrative example of NGOs' source of funding is given in table 3.5.

Table 3.5: LRBT's Source of Funding during the Financial Year 2003

S. No	Source of Funding	Amount (Pak Rupees)
1	Fund raising from Donors:	
	Sight Savers International, UK	37,079,026
	Graham Layton Trust, UK	13,886,946
	INFAQ Foundation	6,000,000
	Organizations and Individuals	69,042,901
	In Kind	17,769,525
2	Pakistan Bait-ul-Mal	2,240,197
3	Central Zakat Administration	4,400,000
4	Investment Income	485,376
5	Other Income	157,850
	Total Income	**151,061,821**

Source: Annual Report LRBT, 2003

Out of the currently serving 117 NGOs, there are 26 that have almost annually received federal grants over the last 6 years (11 from Sindh, 6 from NWFP, 7 from Punjab, 1 each from Balochistan and Islamabad). The data for previous years was not collected. As per DGSE estimates for the year 2002-2003, Rs. 2.1 million were allocated to them. These allocations ranged from Rs. 25,000 to Rs. 450,000. NGOs receiving grant of Rs. 400,000 to Rs. 450,000 per annum are two, and of grants in the range of Rs.90, 000 to Rs.153, 000 are three The remaining are recipients of annual grants in the range of Rs. 25, 000 to Rs. 50,000. No grants were allocated for NGOs in the current financial budget of federal government, however, a sum of Rs. 1,000,000/- was given to DEWA by Ministry of Finance on special orders of the President of Pakistan to fund the establishment of the University for HI.

Funding under SAP: Social Action Programme (SAP), a major initiative for enhancement of services in the social sector funded primary education throughout the country, but no funds were provided for special education. Even efforts were not made to include children with disabilities in the regular schools.

Section 4:
Programmatic Review

Chapter 4:

Prevention, Early Detection and Interventions

Prevention of disabilities, like diseases, could be classified as primary, secondary, and tertiary. As the causes are both biomedical and environmental, hence, preventive actions involve both medical and social interventions.

Primary prevention is aimed at reducing the incidence of disabilities. It is applied on the general population to minimize or eliminate risk factors that cause impairment, to avoid the occurrence of disability. Secondary Prevention is implemented for the group of people who show early signs of a disease/disorder that could lead to disability or exhibit symptoms of a disabling condition. These interventions do not prevent the occurrence but help to decrease the impairment. Tertiary Prevention is applied when the disability has occurred and interventions are directed to promote adjustment to irremediable conditions and also for minimizing further complications or loss of function[28]. An example of the three types of prevention has been shown in Table 4.1 this relates to prevention, detection, referral and treatment of visual impairment.

Table 4.1: Examples of Primary, Secondary and Tertiary Prevention of Disability

Disorder	Primary Prevention	Secondary Prevention			Tertiary Prevention
		Detection	Intervention	Referral	
Trachoma	Health Education, Conjunctivitis Treatment	Conjunctival signs of trachoma	Topical Treatment with eye ointment	Systemic treatment of severe cases	Corneal transplantation, optical iridectomy or low vision care and optimal use of residual vision
Xeropthalmia	Breast feeding, Measles vaccination, vitamin A prophylaxis	Ocular signs for night blindness	High dose of Vitamin A	Cases of corneal involvement	

Source: World Health Forum, Volume 12, and Number 1, 1991

4.1 Primary Prevention: Prospects, Constraints and Interventions

Several disabilities are preventable and the primary prevention of disabilities is far more cost beneficial than secondary and tertiary prevention. The MoWD,SW&SE that deals with the disabled population has no programmes for primary prevention of disabilities. However, the Ministry of

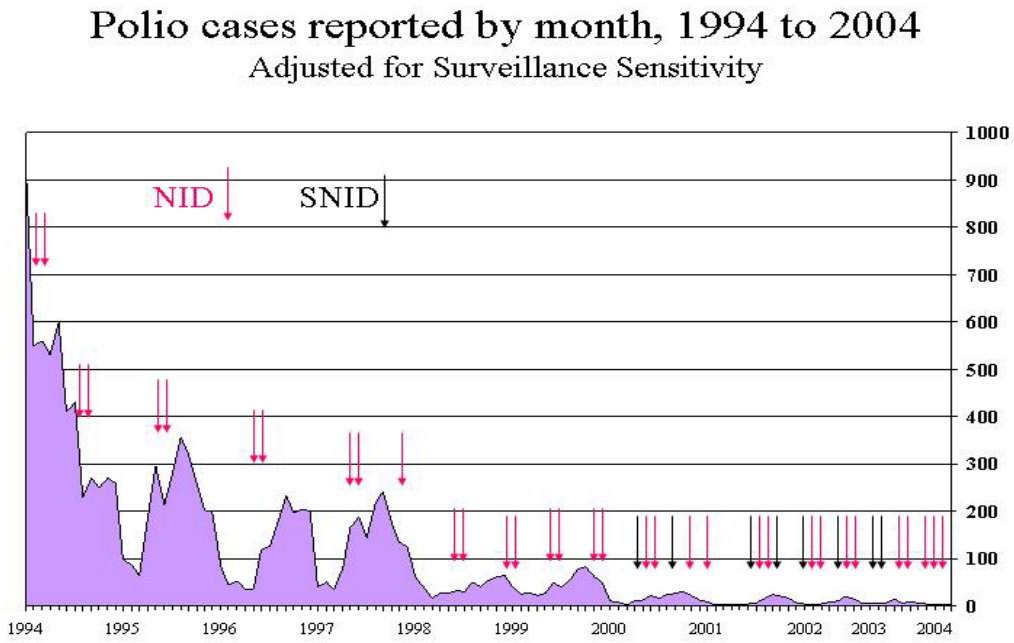
[28] Scott, K.G. & Curran, D.T, *The epidemiology and prevention of mental retardation*. 1987

Health (MOH) has some important programmes that have decreased or have potential to substantially decrease the occurrence of disabilities among general population. These are as follows:

Polio Eradication Programme: Poliomyelitis is a crippling disease that had crippled thousands of children in the world every year. World Health Assembly of the United Nations in 1988 adopted resolution of eradicating poliomyelitis from the globe by 2000. Since then focussed measures have been taken and the number of polio cases occurring globally has decreased from over 350,000 per year in 1988 to less than 800 in 2003.

Pakistan held first national polio immunization campaign in 1994 and since then 38 national and 12 sub national vaccination rounds were held. From 2000 onward vaccination is house-to-house campaign for 3 days and an elaborated surveillance system has been established.

Figure 4.1



Source: Polio Eradication Programme, MOH

Disability caused by the disease in Pakistan has tremendously reduced. As many as 15,000 to 20,000 children per year were being crippled by the disease prior to the vaccination campaigns. The last case in Balochistan was seen in October 2003, AJK in 2000 and in FANA in 1998.By the year 2003, number of cases reduced to 103. There are 11 polio cases in the year 2004 (as of April), located in three provinces, Punjab (3), Sindh (5) and NWFP (3).

EPI Programme: The Expanded Programme on Immunization (EPI) was launched in 1978. It aims at protecting children by immunizing them against Measles, Poliomyelitis, Diphtheria, Pertussis and Childhood Tuberculosis and also their mothers against Neonatal Tetanus. One of

the goals is to decrease morbidity of measles by 90 % by 2010. The disease can cause severe nervous system complications. According to the data available, the coverage for measles has increased from 2% in 1981 to 68% in 2003[29]. Information about Provision of Vitamin A was not given.

Iodine Deficiency Disorder (IDD) Control Programme: Pakistan has high iodine deficiency and some documents report that more than 50% population is at risk of IDD. Severe iodine deficiency can lead to cretinism, stillbirths and miscarriages and deaf-mutism. Mild deficiency among general population results in the lowering of IQ by 10–15 points.

IDD control programme was initiated in 1986 in the northern endemic areas through distribution of capsules but the programme had limited reach and was phased out in 1995. An attempt to produce, distribute and promote iodized salt was also under taken with the help of Utility Stores Corporation. Limited success was noted as it achieved 8% market share in the northern areas and less than 2% nationwide by 1994.

In 1994, a pilot programme for salt iodization was launched with the help of private sector and in 1995 it was transferred to a non-profit NGO. The Programme was taken over by the MOH in 1998-99 and at that time IDD appraisal revealed that about 32 % of the households were using the iodized salt. But in 2001, it declined to 19%.

Prevention of Blindness: A National Control Board for Prevention of Tuberculosis, Leprosy and Blindness has been formed at the Federal level with chapters in provinces and AJK and FANA. The National Board develops plans and provides financial, technical and programmatic support to provincial boards. Provincial boards identify the needs at district levels, implement project and hold eye-screening camps.

International and national organizations and trusts are also active in prevention of blindness on a large scale. Sight Savers International are working in Pakistan since 1950s. Currently, their main focus of work is on strengthening of infrastructure, human resource development and building capacities of partners to deliver VISION 2020. One of their partner is government and District Comprehensive Eye Care (CEC) Programme is being carried out in 16 districts. The main aim is to upgrade the existing infrastructure in the district and agency headquarter hospitals, train primary health care workers in Primary Eye Care (PEC) and raise awareness of blindness and eye health in the communities. It also seeks to promote linkages between eye care, education and rehabilitation services for the blind to develop Comprehensive Eye Services (CES) in these districts. In the NGO sector it is partnering with LRBT, Al-Shifa Eye Hospital in Rawalpindi and Sukkur, Al-Ibrahim Eye Hospital in Malir and Kharan and Munawwar Memorial Hospital in Chakwal.

Layton Rahmatulla Benevolent Trust (LRBT) began its services from a small town in Sindh in 1985. Overtime it has expanded to the current level of 9 hospitals (4 in Sindh, 2 in Punjab, 2 in NWFP and 1 in Balochistan) and 18 outreach clinics. Interestingly only 3 hospitals are in cities and 6 in rural areas.

[29] National EPI Program. *Written brief provided to the team vide letter of 18 May 2004*.

To date, LRBT has treated over 9 million clients with 850,000 surgeries. These include 20% of cataract operations being performed in the country, with an average cost of Rs. 1500 per operation including intra ocular lens.

The trust is planning to initiate community outreach programs for education, screening and minor treatment through ophthalmic technician. The recurrent budget of LRBT is Rs. 120 million and it receives support of Rs. 6 million from Baitul Mal and Rs. 3 million from Zakat Fund. The rest is generated through donations.

TBA and Midwives Training: Application of appropriate medical procedures at delivery can prevent disabilities. According to Pakistan Integrated Household Survey (PIHS) 2001-2002, 78% deliveries were taking place at homes. TBAs continue to play the major role in provision of maternity services, both in the rural and urban areas, as they conducted 58% of total deliveries and trained TBAs performed 39%. With estimated 3.2 million total deliveries per year, this cadre are apparently attending more than 2 million deliveries per year; hence they assume a significant role. The Government has supported strengthening their services over decades. The training of TBAs was initiated in 1960's and has continued to date. The strategy of training TBAs is a logical approach, however the impact evaluation of these trainings have indicated very little or no improvement in the practice of the TBAs.

The training of midwives was on-going pre-independence. No documents are available about these midwives from the records of MOH and PNC to infer about the total number trained, their performance and impact in reducing maternal deaths.

The Women Health Project (WHP), which is establishing Women Friendly District Health System in 20 underserved districts, has a component of training of midwives and TBAs. About 4000 midwives will be trained to serve in their communities and TBA training is also being reinforced. The impact of these training needs to be monitored to comment on the outcomes of the pregnancy and also on disability prevention.

Outreach Antenatal Care: Antenatal care provides both primary and secondary prevention. It prevents conditions that might put a foetus at risk, and also attempts to reverse or reduce risks that already exist.

More than 70,000 Lady Health Workers (LHWs) provide services to women and children by making regular visits to homes and providing iron supplementation to pregnant women. LHW monitor pregnancies and babies' growth and are required to refer individuals with risk or medical problem to appropriate services.

In spite of this massive effort, about 50% women in Pakistan do not get pre natal consultation and 78 % deliver their babies at home (Table 4.2).

Table 4.2: % distribution of sources of pre natal care by age of mother

Age in years	Doctor	FWW/LHV	TBA	LHW	HAKIM	OTHER	NO ONE
< 20	29.8	8.0	5.8	0.9	0	0.7	54.7
20-24	36.4	10.2	6.7	0.5	0.3	0.3	45.6
25-34	36.4	8.8	6.4	0.7	0.2	1.0	46.5
35 +	29.5	6.9	5.2	0.3	0.6	0.4	57.1
All	**34.6**	**8.7**	**6.2**	**0.6**	**0.3**	**0.7**	**48.9**

Source: Pakistan Reproductive Health and Family Planning Survey (PRHFPS) 2000-01, NIPS, Islamabad

An important area for counselling is about teen pregnancy. Babies born to extremely young mothers are more likely to be small, premature, or have neurological abnormalities; more of them die[30,31,32]. In Pakistan the median age at first marriage among ever married women is 18 years and over 50% of women are married to their first cousins[33].

Prevention of Injuries: Many Disabilities caused by injury are preventable, especially accident related injuries are an important area for preventive efforts.

Pakistan has very high road accident rates in the world, about 18.69 accidents per 10,000 registered vehicles. Taking into consideration the number of vehicles plying on the roads, it is estimated that about 10,000 people die and a considerable proportion disabled as a result of road accidents each year.

In year 2003, 9985 reported road accidents claimed 4910 lives and rendered 11863 persons injured, three-fourth (75%) of them comprise male 15-44 years and children, moreover 70% casualties were suffered by pedestrians in these accidents[34]. About 95 percent of the inland cargo movement is transported by road and about 90 percent of the passenger movements within the country are handled by road transport. Thus the relevance of having a network of safe and efficient roads is well established by these facts.

Despite the fact that policies exist to prevent road traffic accidents that include speed control, traffic laws, promotion of helmets for motorcyclists, but successive Governments have failed in their implementation. The President of Pakistan has recently issued a directive to authorities to carry out a meticulous survey of road accidents.

A NGO, the Association of Road Users of Pakistan (ARUP) is making a concerted effort to spread the message of "Road Safety and Traffic Discipline" in all parts of Pakistan. It was established in

[30] Fotheringham, J. B., Hambley, W. D., Haddad-Curran, H.ÊW, *Prevention of Intellectual Handicaps,* Toronto, 1983.
[31] Levy, S.R.; Perhats, C.; Nash-Johnson, M. & Welter, J.F., *Reducing the risks in pregnant teens who are very young and those with mild mental retardation*. *Mental Retardation,* 1992
[32] McDonough, S.C., *Intervention programs for adolescent mothers and their offspring. Special Edition; Infant intervention programs, truth and untruth. Journal of Children in Contemporary Society*, 1985
[33] *Pakistan Reproductive Health and Family Planning Survey,* 2000-01
[34] WHO, *Road Accidents Study 2004, The DAWN Karachi*, 9 April, 2004

October 1998 to address all road related issues in Pakistan. The reasons for ill managed road sector as identified by ARUP include (a) Lack of Traffic Law Enforcement;(b) Absence of General Awareness amongst Road Users of Road Safety and Traffic Discipline requirements/precautions;(c) Absence of formal/adequate training particularly for commercial vehicle drivers;(d) High rate of illiteracy amongst commercial vehicle drivers who are unable to read/comprehend traffic signs and warnings;(e) Exhaustion and driving of vehicle under influence of drugs by commercial vehicle drivers (habitual drug addicts);(f) Rash driving by juvenile delinquent drivers;(g) Propensity amongst the rich and powerful citizens to flout traffic laws. (h) Corrupt practices of driving license issuing authorities resulting in presence of unqualified drivers on the roads;(i) Overloading of commercial vehicles(j) Operation of mechanically unfit vehicles and unlit vehicles at night;(k) Speeding of buses competing for passengers in urban area;(l) Sudden appearance of stray animals on roads and highways particularly at night;(m) Uncovered manhole covers and other road hazards in urban areas;(n) Potholes and damaged road surface without any warning signs.(o) Loading and unloading of passengers from buses in the middle of the road at undesignated stops and (p) Pollution of the environment by excessive gas emissions from motor vehicles.

There are other groups like the Pakistan Association of Blind (PAB) that is concerned with particular road - safety issues of blind. The PAB is concerned with all aspects of the prevention and rehabilitation of people with visual impairments. PAB provides information through the production and distribution of pamphlets and brochures, newsletters and magazine articles, public service announcements, and videos. They also lend videos and teaching materials. Personnel from the association are involved in activism and campaigning for rights-based social inclusion throughout the country.

In 2000, the President promulgated Ordinance No. XL - National Highway Safety Ordinance. The Ordinance provides for safe driving on the national highways. Section 57 dealing with two wheeled motor vehicles states that no driver of a motorcycle driving on a national highway shall carry more than one person in addition to himself and no person shall allow oneself to be carried otherwise than sitting on a proper seat securely fixed to the motorcycle behind the drivers' seat. No person shall drive or be carried on a motorcycle except when he is wearing a crash helmet.

Under section 87 regarding compensation for death, injury or damage etc if a person suffers death, or injury to his person or damage to his property on account of the use of a road vehicle on a national highway, the insurance company or, as the case may be, the Pakistan Transporters Mutual Assistance Co-operative Society, the Pakistan Automobile Association or any other road transport co-operative society referred to in section 41 and in case the vehicle is not covered by any of the above insurers, the owner of such vehicle shall pay such compensation as may be prescribed by the Government. (a) in the case of death, to the legal heirs of the deceased person; or (b) in the case of injury to person or damage to the property, to the person who suffered the injury or damage, within thirty days of the accident.

It is ultimately the government's responsibility to implement the laws and the public's responsibility to follow road safety rules. WHO in Pakistan had set the introduction of the helmet law as its target in the year 2004.The Punjab government is planning to pass legislation that forces motorcyclists to wear helmets and introduce road safety as a subject in schools and colleges. The Punjab Police claims that the department had greatly improved road safety on the Motorway, with accidents down by 78 percent.

Recently the government of Sindh has decided to impose fines for not wearing seat belt while driving. A fine of Rs. 250/- will be levied if the driver and front seat passenger are not found wearing seat belts. All new cars, being assembled in the country are provided with seat belts[35]. Studies in developed countries have shown that strict enforcement of seat belt use rule has sharply reduced the number of traffic fertilities and injuries.

Environment Protection: Removal of the causes of disability that reside in the physical environment is also primary prevention, e.g. the reduction of pollutants in the environment is primary prevention. Untreated industrial waste- water in rivers has resulted in the risk of mercury, arsenic and cadmium poisoning, which reportedly causes neurological damage (Changa Manga near Lahore Punjab has a large proportion of disabled population that is reportedly consuming untreated factory waste water). Similarly, consumption of fish and seafood harvested from polluted shallow waters along the Arabian Sea is a high risk factor. Maritime and various other environmental protection agencies are mandated to prevent such pollution. There are legislations and laws in place intended to protect citizens from environmental pollution but not much is being done due to lack of seriousness of efforts on the part of environment protection agencies and desire for increasing corporate profits on the part of industrialists. The National Conservation Strategy (NCS) group at the Federal level and the Provincial Environment Protection Agencies (EPA) and a variety of NGO community projects are mandated to spearhead prevention of environmental pollution.

Role of NGOs: Only a few NGOs, such as the Lahore based "Pakistan Society For the Welfare of Mentally Retarded Children" have their activities centered specifically on primary prevention. The NGO provides a comprehensive range of primary and selected secondary prevention services including genetic counselling. For people with physical or sensory impairments, adaptive appliances are also available at fairly subsidized cost.

4.2 Secondary Prevention

Genetic Counseling: A good example of secondary prevention is genetic counselling in those have or carry an inherited disorder; or who have a child with a disability that has been inherited. Genetic screening and counse ling services in Pakistan are available but only at extremely high cost in the private sector, therefore available to a very limited population.

Mental Health: Mental illnesses can be amenable to preventive interventions and secondary prevention strategy play important role in common psychiatric illnesses. A series of community based epidemiological survey of rural and urban population of Pakistan found high prevalence of common mental disorders. In urban areas it was reported to be 10% among men and 25% among women. Higher prevalence was reported in the rural areas ranging from 15 %to 25 % among men and 46% to 66% among women. This has serious implications as two-third population lives in the rural areas.

In 1987, Pakistan established a National Programme for Mental Health, spear headed by the Institute of Psychiatry, Rawalpindi. The achievements have been established of several demonstration pilot projects and promulgation of the Mental Health Ordinance 2001, replacing the

[35] The Daily Dawn, May 30, 2004

earlier Lunacy Act of 1912. If implemented, this law has the potential of significantly impacting on mental health and care in Pakistan[36].

4.3 Early Detection and Intervention

Early identification of any problem followed by necessary early interventions can either reduce or avert the impact of disability.

In Developing Countries: In the last 3-4 decades, aggressive advocacy attempts have been made in several developing countries to formalize procedures for assessment, referral and early intervention. For instance in Africa, Ghana established in mid 70's a central assessment and resource center for children with learning disabilities. The school psychological services in Zimbabwe provide assessment and support to parents. In Kenya, there were 17 educational assessment and resource centers established by the m/o education, science and technology in 1987[37]. Besides using other elaborate diagnostic procedures., many countries in Asia (India, Indonesia, Sri Lanka, Bangladesh etc) have developed their screening tests and procedures.

A review of the programs in south asian countries reveals that work in the area of early detection and intervention has been carried out through (i) wide ranged massive awareness programs (ii) development of checklists and screening tests or guidance material (iii) making it a part of regular school system, through in-service teacher training program (iv) involving and empowering, parents/family members, the community and utilizing available local physical and human resources. (Videos and slides, posters, radio and tv spots, discussion of issues through comic books, puppet shows, etc.

In India District Primary Education Programme (DPEP - a centrally sponsored scheme in 14 states)[38] is using multi sectoral approach including (i) in-service orientation and training of teachers of normal schools for early detection and intervention (ii) necessary skill building of and technical support to the parents of identified children with disabilities. Under the ICDS (Integrated Child Development Scheme) multi purpose health workers attached to about 23000 primary health care centers and 131,000 sub centers were also given orientation about disabilities; and interventions for pre-schoolers identified by trained Angan Wadi workers (29 centers for their training) balsevikas (being trained since 1962 in 25 training centres). The training courses have ad at the village level equate inputs for early detection of child hood disabilities (including MR).

In Pakistan: Except the LHWs who are require to detect developmental delays (for which they lack skills), no other formal specific policies or programs at federal or provincial government level exist to make early detection, which is a pre-requisite of early intervention.

The National Institute of Handicapped (NIH) and also its provincial branches (PIH) under DGSE were planned to: (i) coordinate national efforts to prevent disabilities, to plan and develop an integrated referral system through out the country. (ii) serve as training center for those involved in prevention of disabilities. (iii) plan and develop an early disability detection system (iv) plan and

[36] MOH/WHO, *National Action Plan for Prevention and Control of Non-Communicable Disease and Health Promotion in Pakistan,* 2004
[37] UNICEF - UNESCO Cooperative Program, *Educational Assessment and Early Intervention for Handicapped Children in Developing Countries – digest 22*, Paris, 1988
[38] *Country Paper Presented at APIED Seminar*, Japan, 1998

develop a multi professional assessment and diagnostic system at district and divisional level. (iv) form a primary health care system. Besides having a comprehensive medical treatment to people with various disabilities the above 5 functions topped the list of the PC-1. The NIH started functioning from 1996 as a hospital but no work for the establishment of provincial branches has taken place. Furthermore, no formal work on the objective listed to cover the area of early detection and intervention has been taken up.

During 1992-93, the Federal government SEC for M.R. in Karachi, developed through 2 yrs. Research Project, a Pakistani Model of Portage Guide to Early Education. It is an early intervention programme for developmentally delayed children, at risk children and culturally disadvantaged children. Since 1993, through 7 Training Courses/workshops, 129 Portage Program Managers have been trained. Participants belonged to public and private sector centers, NGOs, and Universities.

For early detection of impairment a broad base of skills are required. Due to lack of competent diagnosticians in the public sector, parents are invariably seeking the services of therapists and counsellors in the private sector. At grassroots or community level the LHWs offer mothers general advice on child- care but they lack specialized skills to screen infants for sensory or developmental problems. In the public sector, at the level of Provincial Headquarters (Teaching Hospitals) and DHQ Hospitals positions are invariably available for paediatricians for medical, physical and growth concerns and psychologists for early childhood developmental assessment, however it was mentioned by key informants that many of them lack training in Early Childhood Development (ECD).

Ma Ayesha Center for treatment of neuro muscular disorders in Karachi is developing a “Diploma in Development Paediatrics” Program that has been approved by the Department of Special Education in Karachi University. This one-year program will be offered on weekend afternoon for paediatricians in public and private sector. It will help them to screen all disabilities through theoretical learning and hands-on-practice. The first course will begin this year. Hence, private sector has taken the initiative in Early Detection and Intervention (EDI). Such capacity building efforts need support of the government for wider expansion.

A variety of NGO and private sector entities are providing specialized services by employing speech and language pathologists and psychologists for concerns with the development of language; and Early Childhood Intervention Programmes (ECIP) for developmental delay, concerns about parenting skills etc. The ECIP programs provide both secondary and tertiary preventions. ECIP services are available to children and parents in some selected parts of the country particularly the large cities. Tertiary prevention is begun as soon as problem has been identified, severe disabilities are identified and appropriate programming started as soon as the child enters school.

Good day care and preschool programmes (< 5 years) prevent developmental delay by providing children with a nurturing environment, an assortment of learning opportunities, and linguistic experiences. Such programmes have proved to be very effective in the prevention of mild mental retardation among children of low socio-economic status (Bryant & Ramey, 1985); Generally, among Pakistani children belonging to low-income communities mild physical, sensory, or mental impairments’ diagnosis is not made until well after the child is ready to enter school. Medical screening for visual and auditory acuity is not done on a regular basis to identify children with slight impairments, however if admitted in a regular school their existence subsequently taken into

account in the classroom situation. Consequently placement for children who have different types and levels of disability are recommended to commensurate SE schools.

Amin Maktab, a 44 years old center for M.R in private sector in Lahore, is using PGE since 1989 as an outreach program in low-income slum areas of Lahore. With their well-trained psychologists in PGE supplemented with parent's guidance material (a booklet in Urdu), a home-based program through family empowerment and participation is being undertaken and a total of 601 children are being served[39].

The only other documented use of this home-based parental guidance empowerment program, to make early intervention possible by Spe-ed, an NGO in Karachi working for the capacity building and human resource development of existing Special Education Centers at city level. Spe-ed has set up a unit of this parent program at an urban health care center of the city health department[40].

Another wide ranged initiative has been taken by an NGO named Association for Rehabilitation of Physically Disabled (ARDP) based in Peshawar. For the early identification and intervention of children with disabilities (particularly PH) their program includes: (i) free mobile medical/rehab camps in far-flung backward areas. (ii) free dispensary service throughout NWFP, NA, AJK and Punjab (iii) Primary Health Care/Prevention of Childhood Disability Seminar. They also arrange surgeries of poor needy children, and provide cheap assistive aids produced at their orthotic, prosthetic workshops.

Another important contribution of ARDP is to assist similar community-based organizations, working in low-income sub urban areas, town or villages to start CBR Centers. In the last 12 years, the NGO has helped set up about 70 such centers throughout Pakistan including FATA, AJK and Sindh. The NGO holds a 3 months course for other NGOs for setting up the CBR Centers[41]. This NGO-CBO collaboration and networking is proving to be a successful strategy which needs support for wider replication.

[39] Amin Maktab, *Annual Report,* 2003
[40] Spe-ed, *Annual Report of 2002,* Karachi
[41] ARDP, *Annual Report 2003,* Peshawar

Chapter 5:

Education and Training

5.1 Education of Disabled

The education of PWDs began through residential institutions, often managed by charitable organizations. These were based on a medical model where the "patients" had to be diagnosed and "cured". The model was transferred from the developed to the developing countries through international NGOs and development assistance. In Pakistan, day-care institutions have mostly replaced residential institutions and led to the segregated educational system for children with disabilities.

Variations in Needs: The needs of children with disabilities vary, some have very little or no restrictions on what they can do and learn, while others require intensive help, both medical and educational. Sirvis[42] noted that one should design a programme that meets the needs of the child in five basic goal areas: (a) physical independence, including mastery of daily living skills; (b) self-awareness and social maturation; (c) communication; (d) academic growth; and (e) life skills training. Interdisciplinary services such as occupational and physical therapy and speech and language therapy are also necessary.

Extent of Special Education Needs: The exact numbers of children with special educational needs (SEN) are usually not available in countries due to lack of definitions and criteria used for classifying disabilities and problems in enumeration[43]. It is believed on the basis of studies that 10 to 15 percent children require active intervention and specialized services[44]. The Warnock Report states " planning of services for children and young people should be based on the assumption that about one in six children at any time, and about one in five at some time in their educational career will require some form of special education provisions"[45].

Enrolment Rates: The assessment of data from several countries indicates that globally majority of the children with disabilities are not enrolled in schools, and it range from less than 1% to 3%. In Philippines in 1997-98, out of 3.5 million disabled children only 1.2% were enrolled[46]. In Ethiopia in 1999, the overall enrolment of disabled children was estimated to be less than 1%[47].

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[42] Sirvis, *B, Physical Disabilities. In E. Meyen & T. Skrtic (Eds.), Exceptional children and youth: An introduction,* 1988
[43] Ture Johnson and Ronald Wiman, *Education, Poverty and Disability in Developing Countries,* A Technical Note prepared for the Povert Reduction Sourcebook, Sponsored by Thematic Group on Disability Issues and Financed by The Finnish Consultant Trust Fund.
[44] UNESCO Website
[45] Department of Education and Services, *Special Education Needs,* Warnock Report, London, 1978
[46] V. Ilagan, *Inclusive education in the Asian Pacific Region: Are the Disabled Included?,* 2000.
[47] M. Mengesha, *Special Needs Education: Emerging in Ethiopia,* 2000.

In Pakistan, the estimated number of disabled children 5-19 years is 1.28 million[48]. Currently only about 22,000 are enrolled in 266 SECs (DGSE 44, Provincial Governments 92, NGOs 117, NTD 3 and Armed Forces 10), which is 1.7% of children with SEN.

5.1.1 Special Education in Pakistan

As mentioned earlier, the Government had very limited role in provision of special education to disabled children in the decades of 50s, 60s and 70s when it only provided some financial support to the centers run by NGOs. 1981 onwards, such services received much awaited attention.

National Centers of Special Education at Federal Level: In 1982, Four Rehabilitation Centers, one each for the four main disabilities (VH, MR, PH and HI) were established in Islamabad under Ministry of Health and Social Welfare. Apart from providing educational services to students the other stated objective (as per PC-1s) for each of them included: (i) hostel facilities for 40 students from outside the city areas, (ii) In service training for teachers selected from all over the country, (iii) services for early detection and identification of children with disabilities, (iv) development of curriculum, (v) speech therapy wing for development of language and communication skills, (vi) model library in the field of special education, (vii) job oriented vocational training.

These centers were also envisaged to serve as Model Centers of Excellence providing nationwide services as: (i) National Registration Centre, (ii) carry out research in the field of relevant disability, (iii) train teachers of both special and integrated schools, (iv) develop literature and disseminate information to all concerned particularly parents and professionals[49]. In the last five years, there have been redesignated as National Special Education Centers (NSECs) for PH, VH, HI and MR. The current enrolment in these centers is presented in table 5.1.

The reported services at the center includes assessment (medical, physical, psychological), education programs, parents counseling and guidance, home-based program for children who can not attend the school regularly, referral services, co-curricular activities (outings, stage show, social gatherings), pre-vocational skills, vocational training activities, training in practical life skills (cooking etc for girls), indoor and outdoor sports. Disability specific educational aids in the centers of HI and VH are available.

Table 5.1: A profile of National SECs

National SEC	No of Students		Level of education	Average Size of Class
	Provision in PC-1	Actual M - F Total		
For MR	200	117 – 63 – 180	Formal and informal education	11-12
For HI	400	238 – 133 – 371	Nursery to College	15-20

[48] As calculated by the team based on the proportion of 1998 census for a current population of 150 million

[49] K. Eklindh, Consultant Unesco, *Proposal for the Development of Special Education in Pakistan,* Minstry of Women Development, Social Welfare, Special Education, 2001

For PH	500	93 - 49 - 142	Nursery to Matric	15-20
For VH		87 - 60 - 147	Nursery to Matric	15-20
Total		535 – 305 - 840		

Source: Monthly Report of the Centers, April 2004

National SEC for PH was planned as integrated school on 60:40 bases for handicapped and normal children, however, this has not been implemented.

Initially these National Centers were established for class 1 to 5, but with the interests of the Principals and the PTAs, the Center for PH has been extended to class VIII, for VH to Matric, and for HI to college level. As reported by Principals, about 15% HI, VH and PH children join the normal education system after finishing education from these centers.

Out of the listed objectives, hostels could not become functional due to lack of funds, hence the children from rural areas could not benefit (except for HI that has been started in Dec 2003, in collaboration with an NGO Houbara Foundation). None of the Centers initiated training courses for teacher or took concrete measures for early detection and identification of children with disabilities. Reportedly, lack of relevant professional expertise among the teachers and frequent transfers of Principals has affected the functioning. Recently the National Center for HI and PH has started work on development of curriculum. The centers also did not take any initiative to have a library of their own. All the four National Centers have prevocational and vocational training programs. Though Sports and other co-curricular activities (like drama dance, music etc) were not mentioned in PC-1, but all the centers have undertaken several activities in these areas.

According to the principals, the mandate for training of teachers and establishment of libraries became redundant after establishment of NISE and NL&RC. The research work could not be carried out due to lack of funds. It was also admitted that the quality of training suffers due to lack of necessary materials, assistive aids and also attitude and interest of teachers.

> Hence, the four National Centers for Special Education have not yet been able to assume their role of Model Centers of Excellence and are working as any other SEC

The National Center for Visually Handicapped (Al Maktoom) is starting a pilot program for social inclusion of VH in Islamabad with the assistance of Sight Savers International. Under this, 100 students of low vision will be sent to regular schools with provision of devices in next 3 years.

Federal Government SECs throughout Pakistan: After the establishment of DGSE in 1985, 40 SECs were established in all provinces, AJK and Northern Area during 1986-87. Following table shows their province and disability wise distribution.

Table 5.2: DGSE Managed SECs in Provinces

Province	SECs for MR	SECs for HI	SECs for VH	SECs for PH	Total
Punjab	6	5	4	4	19
Sindh	3	1	3	1	8
NWFP	2	2	2	2	8
Balochistan	1	1	-	1	3
AJ&K	-	-	-	1	1
Northern Area	-	1	-	-	1
Total	**12**	**10**	**9**	**9**	**40**

Source: Monthly Report of the Centers, April 2004

Table 5.3: Province Wise Current Enrolment in 40 SECs

Province	No of Students			Male--Female Ratio in %
	Male	Female	Total	
Punjab	1058	674	1732	61%--39%
Sindh	402	199	601	67%--33%
Balochistan	138	50	188	73%--27%
NWFP/N.A	379	173	552	69%--31%
Total	**1977**	**1096**	**3073**	**64.5%--35.5%**

Source: Monthly Report of the Centers, April 2004

PC-1 proposed, on an average, admission of 60 children each year from nursery to class 5. As per notification of DGSE, every SEC has formed a formal body of Parents Teachers Association (PTA) that has been registered as an NGO under the Voluntary Social Welfare Agencies (Registration and Control Ordinance) 1961. With the financial contribution by PTAs, many SECs have managed to increase the number of students over hundred. PTAs mainly provide funds for hiring of extra staff (teachers, speech therapist, occupational therapist) and funds for POL, uniforms, books and extra curricular activities.

The centers run classes from 8.30 a.m. to 1.30 p.m., 6 days a week and follow holiday schedule of the regular schools. The services provided are almost same as mentioned for National SECs. Sports as co-curricular activities are the regular and prominent feature of all the Centers.

Since the inception of Special Paralympic Committee Pakistan in 1989, several games, sports training and competitions have been organized by the Committee in collaboration with government and NGO centers. The Committee is a branch of Special Olympic Inc – Washington DC, USA, that holds Special Olympic Games after every four years for mentally retarded in which over 100 countries participate. Pakistan participated in Special Olympic World Summer Games, for the 1st. time in 1991. In three events (till 1999), 88 M.R pupils participated and won a total of over 100 medals in various track and field events. These events have helped the children to develop emotional stability, self-confidence and a healthy cheerful personality.

National cricket team of Blind Persons won 2nd position in World Blind Cricket Tournament (1998, South Africa) and won World Cup in 2003, and also the final of Regional Cricket teams of Blind (Feb 2004). Federal Government National Center for V.H. at Islamabad has played a vital and active role in building up the team and in organizing matches.

The monitoring of each center is mainly done through assessment of Monthly Progress Report by the respective Director at DGSE, or rarely by visit. NISE that trains the teacher has no role in monitoring. It was learnt that the performance of these centers vary from excellent to poor. The reasons are several, such as posting of inappropriate staff (e.g. physiotherapist working for training of HI children), non availability of assistive aids (e.g. hearing aids), lack of interest in making proper assessment of children, etc.

It is important to note that a very large number of individuals who were trained as SE teachers abroad on government expense, have not been posted in the training centers on return and are serving elsewhere, nullifying the effort made for improving the training.

During 1994-95, National Trust for the Disabled established three SECs in Karachi, Mianwali and Naushero Feroze. All these centres have classes for children with all disabilities from nursery to class 5.

Table 5.4: Profile of NTD Centers

Location	Current enrolment	Total attended till 2003	Additional Services
Karachi	115 (68-M-47F)	233	Physiotherapy, occupational therapy, home based programs, vocational training
Mianwali	98 (68M – 30F)	135	
Naushero Feroz	41 (35M – 6F)	132	

It is significant to note that the percentage of female is only about 15% in Naushero Feroz (a underdeveloped town in interior Sindh) while it is 40% in Karachi city.

To reinforce the system of Special Education, National Institute of Special Education (NISE) and National Library and Resource Centre (NL&RC) were established in Islamabad in 1986 under the DGSE.

NL&RC has over 10,000 books and materials downloaded from the internet but their utilization is very low. The books and materials are manually catalogued and due to limitation of operational budget only 160 centers are informed about the available materials. NL&RC has transcribed the three books of Sign Language on CD, which is available on payment. The new 4-storey building of NL&RC has been constructed in Islamabad and is in finishing stages. It will provide much more extensive services and it is expected that with enhancement of operational budget, the training centers all around the country will be informed about the available resources and will be able to benefit from it.

SECs of Provincial Governments and NGOs: The provincial governments and NGOs manage 209 SECs (92 provincial governments and 117 NGOs), while armed forces have established 10 SECs.

Table 5.5: SECs of Provincial Governments and NGOs

Province	Hearing Impaired		Mental Retardation		V.H		PH		Multiple Disabilities Centres	
	Govt	NGO	Govt	NGO	Govt	NGO	Govt	NGO	Govt	NGO
Punjab	32	11	3	12	11	14	3	8	1	9
Sindh	2	6	1	10	1	6	Nil	1	14*	5
NWFP	9	5	1	2	7	7	Nil	5	3	5
Balochistan	1	2	1	Nil	1	1	1	Nil	-	1
Islamabad	-	1	-	3	-	-	-	-	-	2
N.A.	-	-	-	-	-	-	-	-	-	1
Total	44	25	6	27	20	28	4	14	18	23
Grand Total	**69**		**33**		**48**		**18**		**41**	

Source: Information collected during field visits

*These 14 centres of provincial govt Sindh are call RCMH (Rehabilitation Centre for Multiple Handicapped.) They have education till primary level and as in case of other centres, also have vocational training in different trades.

About 85% of these centers have educational provision till primary level, and only 35 SECs for HI & VH have middle or matric level education. Four for HI have graduate level education and are located in Karachi, Lahore and Rawalpindi, and one (DEWA in Karachi) is being converted into a University. One (Ida Rieu in Karachi) also has degree level education for blind as well. Almost all SECs have provision for prevocational or vocational training units. Some have free boarding and lodging facilities. It is important to note that more than 70% of teachers do not have relevant educational qualification (most hold B.A or M.A degree in any subject of Arts or Science). However, over time they have acquired considerable skills for effectively meeting the needs of their jobs.

Out of 92 provincial government SECs, 33 are for HI and only 3 for MR, though the percentage of HI within the universe of disabled is half (10%) as compared to the percentage of MR (20%)[50]. The enrolment profile shows 3492 HI students attending the schools and one college and only 156 MR attending 3 schools for them. One apparent reason for this staggering difference of disability wise beneficiaries is apathetic attitude towards M.R. children. The other reason may be the presence of Teacher Training Institute for HI (Gung Mahal) since 1954. The Institute has been running 1-year diploma course (TD) for about half a century.

The DGSE has set up same numbers of SECs for M.R. as for other disabilities but because lack of relevant educational qualification in the field M.R, even well intentioned hard working and highly motivated teachers are unable to produce the desired result. The highest number of SECs for M.R is run by NGOs, ten located in Karachi and 10 in Punjab (4 in Lahore and 6 in other districts).

The special education facilities in Balochistan are nominal. There is only one education complex (having separate sections for H.I. V.H, PH, MR) of provincial government located in Quetta, and 2 centers for HI, run by NGOs.

[50] Oracle Research and Information Services, *Country Profile on Disability Islamic Republic of Pakistan,* prepared for Japan International Cooperation Agency, March 2002

Besides the SECs, other facilities for especial education include 4 Braille Press, one each in Islamabad, Karachi, Lahore and Bahawalpur. These not only print textbooks but also general books of all types. Ida Rieu in Karachi has transcribed the Holy Quran in Braille and is being used the world over.

Talking Books Libraries (books taped in audio cassettes) was established at NISE but has been discontinued. LRBT in Karachi and Lahore and Ida Rieu in Karachi have established these. IDA Rieu also has mobile library services for Braille books and audio cassettes. Audio World Program of Pakistan Foundation for Fighting Blindness (PFFB) provides free of cost school syllabus in cassettes, and other general books to blind students. Over 2400 VH students have received the syllabus.

In the major cities, all the centers for the blind have set up computer labs and the National SEC for the VH in Islamabad recently conducted a ten days special course on the use of computer for the blind.

Special Education in Punjab: There are about 600,000 special children of school going age in Punjab and only 4200 (less than 1%) are attending 49 centers run by the provincial government. Giving attention to this problem, the Government of Punjab has established the Department of SE (DoSE) with the goal of providing full educational opportunities to all disabled children through developing a comprehensive network of SE Schools up to tehsil level complemented with teachers training. A detailed road map has been developed for accomplishing the goal and a plan of action providing a description of the type and number of facilities, personnel, capacity building and services necessary to meet the goal. The provincial government has given satisfactory assurance for the funds. The newly emerged DoSE has horizontal linkages with the provincial Department of Education (DOE) through provision of in service SE training to DOE teachers and provincial Education Management Information System (EMIS).

Presently the Punjab Government has SE schools in 27 out of 34 districts and in their forthcoming Annual Development Budget (ADB) of 2004-05 there are provisions to establish SE schools in the remaining 7 uncovered districts and in each of 122 tehsils in the province. There are budgetary estimates to the tune of 400 million rupees for this purpose.

The province has developed its own curriculum based on a review and consequent adaptations from curricula of 22 countries in the world. Other innovative approaches in the offing are provision of 200 rupees per child attending the schools and doubling of salaries of SE teachers across the board ranging from BPS 7 to 18. Teachers in BPS 16 and 17 are appointed formally through the provincial public service commissions and occasionally on contract basis for a stipulated time period in some cases.

The Provincial DoSE is running 3 Teachers' Training Colleges, one for in-service training of government and NGO teachers in four classifications of disabilities viz. PH, VH, HI and MR. As of 2004, over 400 teachers have been trained through 24 courses by the training college. In addition, there is Teachers Training College affiliated with the Punjab University that offers B Ed and M Ed courses in Special Education and a Teachers Training College for teachers of Hearing Impaired (HI) that offers one-year diploma course programs.

The DoSE has a state of the art computerized Braille Printing Press that is catering to the needs of the entire province, as well as those of other provinces. Textbooks for class 1-10 are printed and

supplied free of cost. In 2004-05 ADB, there is provision for the establishment of High Technology Braille Press. Imported hearing aids procured through SIEMENS are supplied to all HI children free of cost. The program has procured 59 new buses for providing pick and drop facilities to SEC students. These buses have been purchased at ex. Factory prices through local automobile industry.

At the provincial level, a Public-Private-Corporate body called "TEFTA" has been established. TEFTA has been entrusted to conduct Research and Development (R&D) as regards skill needs in the local industries and develop skill-training programs commensurate with industries' needs. The role of a large tractor manufacturing industry "Millat Tractors" is prominent in respect of TEFTA. Currently there are 56 Vocational Training Institutes in the province. Each institute has a Board of Governors (BOG) with representation of leading industrialists in the province[51].

5.2 Alternative Options

Three options are available for provision of education to disabled persons: (i) establishing special schools (with or without boarding), (ii) through special classes/units in regular schools, and (iii) inclusion in regular schools – inclusive education.

5.3 Inclusive Education

The case for inclusive education of children with disabilities, rather than in special schools, is being advocated internationally on the basis of human rights and economic justification. The World Declaration on Education for All (EFA) at Dakar in 2000, which established the goal to provide every girl and boy with primary school education by 2015 clearly identified inclusive education as one of the key strategies to address issues of marginalization and exclusion. Accordingly, as stated by Susan in a paper prepared for the World Bank "The fundamental principle of EFA is that all children should have the opportunity to learn. The fundamental principle of inclusive education is that all children should have the opportunity to learn *together" [52].*

Features of Inclusive Education: According to the Salamanca Statement adopted at the Salamanca World Conference on Special Needs Education in 1996, Inclusive education implies that " children and youth with special educational needs should be included in the educational arrangements made for the majority of children. Inclusive schools must recognize and respond to the diverse needs of students, accommodating both different styles and rates of learning and ensuring quality education to all through appropriate curricula, organizational arrangements, teaching strategies, resource use and partnerships with their communities[53].

The main features of an inclusive education setting are: (i) school environment that takes into account children with special needs in terms of attitudinal and physical accessibility, (ii) adapted curricula allowing to individually tailored flexibility, (iii) technical aids to facilitate the participation of

[51] Government of the Punjab – Special Education Department, Fax and verbal Communications regarding Plans for up gradation and Expansion of Special Education in Punjab, 2004
[52] Susan J. Peters, *Inclusive Education: Achieving Education for All by Including Those with Disabilities and Special Education Needs,* Prepared for the Diasability Group, The World Bank, 2003.
[53] Salamanca World Conference on Special Needs Education, *The Salamanca Statement and Framework for Action on Special Needs Education*, 1996

and communication with children with physical, sensory or mental differences, and (iv) training of and support to teachers so as to enable them to deal with children with special needs[54].

It is believed that 80%-90% of children with SEN could get their education in regular schools and classrooms, if key preconditions are met. Special schools would be required to cater only for children with profound and complex difficulties.

Economic Benefits & Cost of Inclusive Education: A World Bank study by James Lynch on special educational needs has mentioned the following economic benefits from inclusive education: "(i) reduction of social welfare cost and future dependence, (ii) increased potential productivity and wealth creation provided by education of those children with impairments and disadvantages, (iii) through concomitant overall improvement of the quality of primary education, reduction in school repetition and drop-out rates, (iv) increased government revenue from taxes paid, which can, in part be used to recoup the costs of initial education, (v) reduction of administrative and other recurrent overheads associated with special and regular education, and (vi) reduced costs for transportation and institutional provisions typically associated with segregated services"[55].

Additional inputs required for SEN provisions are as follows:

Table 5.6: Additional inputs required for SEN Provision

In School Inputs	External Inputs	Parental and community inputs
Additional tuition Specialized teaching staff Special equipment Assistive personnel Adapting physical structures	External Staff e.g. Therapeutic and medical staff Special transport Tuition at home	Extra time Extra costs on clothing, food transport, accommodation

Source: Taken from Reference 56 mentioned below

The calculation of costs for these extra provisions vary significantly from place to place, hence, is not easy to calculate. Jonsson and Wiman have mentioned that " According to OECD estimates, the per capita unit cost of educating children with SEN is 2 to 4 times the average of other pupils. However, integrated schooling is usually either less expensive than, or equally costly as segregated schooling. But the achievement of children with SEN in integrated settings is superior to those in segregated schools" [56].

IE in Canada: Marsha Forest – one of the pioneers of IE, in Canada struggled for several years before succeeding in convincing the school officials to allow admission to students with mental handicaps, in Ontario. Eventually, several of these schools have become models of IE and this has had significant impact on countries of the North.

[54] http://www.unicef.org/teachers
[55] James Lynch, *Provision for Children with Special Educational Needs in the Asia Region*. World Bank Technical Paper number 261. Asia Technical Series. 1994
[56] Ture Jonsson aand Ronald Wiman, *Education, Poverty and Disability in developing countries,* June 21, 2001

IE in USA: IE programs have grown exponentially since 1975, after the passage of PL94-142 and by 1994, inclusion programs have taken place in all states and at all grades, involving students with entire range of disabilities.

IE in India: The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, places a "statutory obligation" on the government to provide free education to disabled children in appropriate environment till the age of 18 years. This is being achieved by providing education for disabled children in general school system under the "Scheme for Integrated Education of Disabled Children (SIEDC). The scheme is implemented through the Education Departments of the state government and autonomous and voluntary organizations. It includes equipping resource rooms with aids and assistive devices, organizing teacher training programs, taking steps for adaptation of curriculum, reform of examination system and promoting research. Over 53,000 disabled children in 13,674 schools were covered till 1998. District Primary Education Program (DPEP), a centrally sponsored scheme launched in 1994 gave emphasis to integrated education for all children with mild to moderate disabilities and covered 149 districts in 14 states[57]. It worked through community mobilization, early detection, in-service teacher training, resource support, educational aids and appliances, and removal of architectural barriers.

The private sector has been encouraged to start the special education center in their locality by providing 90% financial support by the Ministry of Welfare[58].

In a UNESCO study, 22 institutions and organizations from all over India collaborated in Project Integrated Education for the Disabled (PIED). A key strategy involved preparing teachers in three phases of increasingly intensive development, focused on child-centred teaching and learning strategies, and incorporated practice and feedback sessions. In follow-ups, positive attitudes were documented in teacher and pupil attitudes to teaching and learning, and pupil achievement.

IE in Bangladesh: Three key actions for integration of disabled children in the mainstream education have been taken: (i) training of teachers on special education for the disabled (ii) inclusion of disabilities issue in the syllabus of teachers education program (PTI, B.ed, M.ed. courses), and (iii) reform of education and examination methods[59].

IE in Philippine: Bureau of Disabled Persons Welfare and Development at central level works through three divisional experts, namely, Program Management, Technical cooperation, Information Education and Communication. It has its offices in all the Regions; hence an uniform program goes down from the National to provincial and district levels. From the platform of village health units there is outreach program for the developmentally delayed children in villages. Psychologists Special Education Teacher and Social Welfare officers, give the technical input and also train volunteers. Thus the impact and otherwise multiplied complications of physical and mental disabilities are reduced and the child is able to join the mainstream of education[60].

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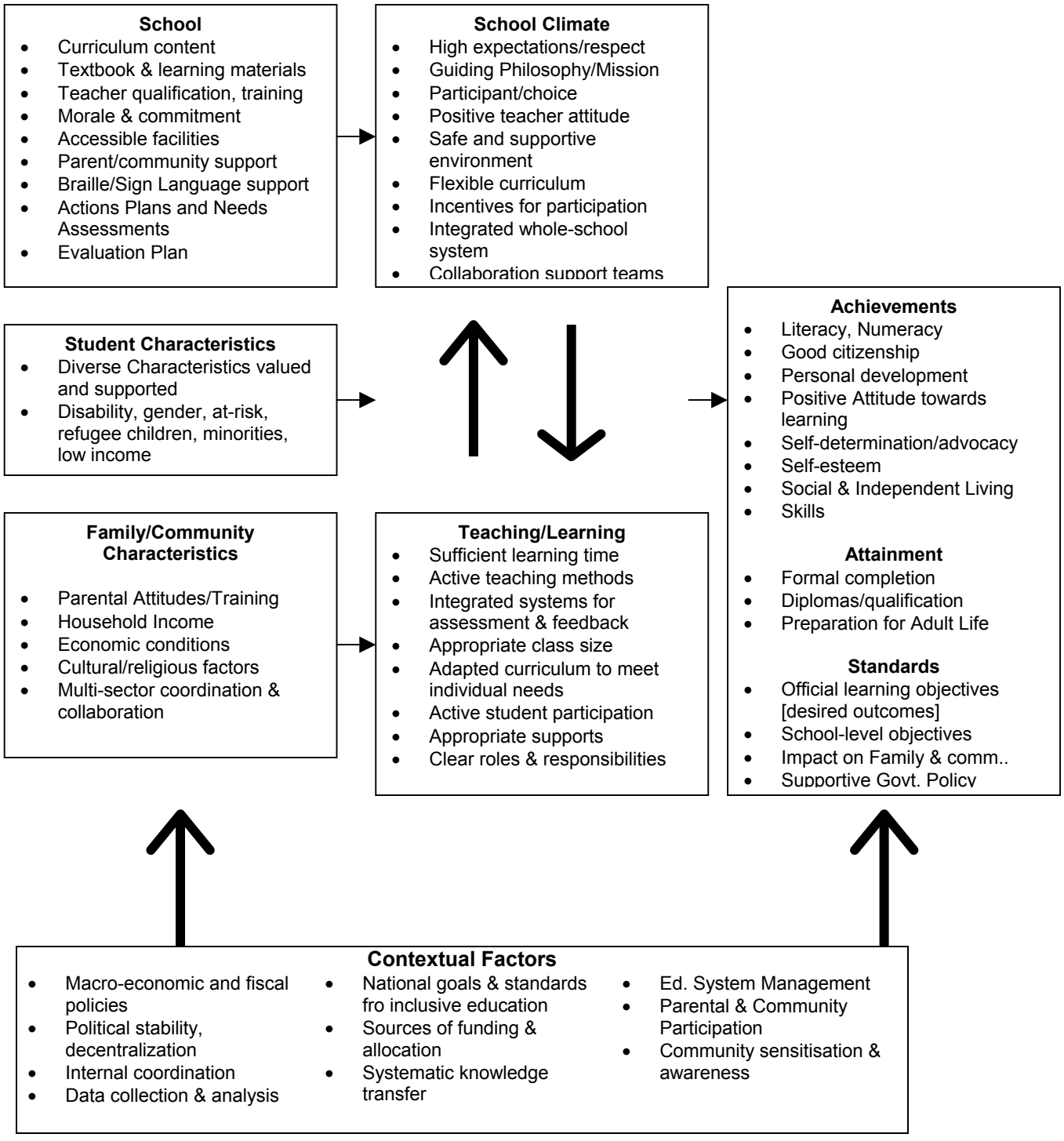
[57] *Country Paper Presented at APIED Seminar*, Japan, 1998
[58] Social Development Division ESCAP, *Asian and Pacific Decade of Disabled Persons : mid point - Country Perspectives;* India, ESCAP Home Page 1997/98 Last update 8 May 2000
[59] Task Force Report, National Action Plan for PWD, based on Bangladesh Disability Welfare Act 2001 and directive from Prime Minister's office, March 7, 2002
[60] Munavver Fatima, Report Study Tour of Philippine, DGSE, 1994.

IE in Sri Lanka: Unit of Special Education in Ministry of Education plan and work for policy making and training of personnel. This unit exists at all the divisional offices of education. Itinerary teachers are also trained to take care of special needs of children with disabilities in mainstream educational system. Trained Master teachers train pre-school and primary school teachers of regular school in both public and private sector[61].

Issues of Inclusive Education: Inclusive education in the context of EFA is a complex issue. The current existing inequalities and state of education in developing countries suggests that implementation of IE is an extremely challenging task. UNESCO implemented IE pilot projects in 12 countries out of which four were successful (Ghana, India, Vietnam, and Yemen)[62]. These provided opportunities to learn about the possibilities and also the complexities of IE. A framework is required to understand the dynamics and comprehensiveness of IE and the figure below serves as a conceptual guide.

[61] Munavver Fatima, Report of Study Tour of Srilanka, DGSE, 1995.
[62] UNESCO, *Inclusive Schools and Community Support Programs. Phase Two.* 2001

Figure 5.1: An input-process-outcome-context framework for Inclusive Education



Source: Susan J. Peters, Inclusive education: Achieving Education for all by Including those with Disabilities and Special Education Needs, 2003

The challenging and critical issues related to inclusive education framework of Input-Process-Outcome-Context are several and the key barriers identified by Susan in a paper for World Bank, are as follows[63]:

- ***Attitudes:*** negative attitudes towards SEN learners results in discrimination, prejudice, exclusion from school and/or exclusion from full participation in school.
- ***Law/policy:*** laws and policies supporting Inclusive Education have not been enacted in many countries and/or may not be enforced.
- ***Socio-economic factors:*** **i**nadequacies of school resources, not enough qualified teachers, poverty in families that make school unaffordable or force children/youth to stay out of school to work.
- ***Environment:*** inaccessible school buildings (especially for those with physical disabilities), unhealthy or unsafe means of transportation to school and/or unsafe environment within schools.
- ***Language and Communication:*** the language/format of instruction, in some cases is not the first language of learners, especially for Deaf, Blind and Deaf-Blind learners.
- ***Resources:*** lack of texts and materials needed for adaptations to the curriculum and instruction, lack of adequate supports for classroom teachers.
- ***Curriculum:*** not enough teachers trained in the pedagogy to meet the needs of diverse abilities in large classes, in many cases lacking in relevance, high repetition and drop-out rates associated with curriculum problems.
- ***Inadequate or uncoordinated human resource development:*** lack of access to quality health care; early intervention services for prevention and amelioration of disabilities are either not available, inaccessible due to distance families must travel, or not able to serve more than a fraction of those needing services.
- ***Organization and Governance:*** lacking the infrastructure, training and personnel to provide leadership and support to programs.
- ***Knowledge base:*** no accurate picture of numbers of learners excluded from the system or how many of them have impairments. Coupled with little data on IE program effectiveness – inhabits planning.

[63] Susan J. Peters, *Inclusice Education: Achieving Education for All by Including Those With Disabilities And Special Education Needs*, Prepared for the Disability Group, The World Bank, 2003

However the examples of best practices were also observed, as mentioned by Susan, which include the following quality indicators for IE in the South:
"

- Early intervention when children are still in the formative stage of development
- Small classes
- Well-trained and valued teachers
- Positive learning environments (commitment to mutual benefit)
- Strong parental involvement "

Inclusive Education in Pakistan: The GOP in its Perspective Development Plan 2001-11[64] spells out the need for integrated education of disabled in regular schools in all provinces. The plan states that all government schools would have provisions such as training of regular school teachers in Special Education and complimentary teaching aids and equipment for implementation of integration plan. Further an administrative mechanism at State level would be put on place to achieve the goals of integration during the plan period extending 2001-11. However the issue has been ignored or relegated to the background.

Existing SECs of both public and NGO sectors and armed forces are accommodating about 22,000 students, which is 1.7% of those who have special educational needs.

A majority of key informants (officials of Ministry and Departments of Education at federal and provincial levels; EDOs of Peshawar, Lahore and Quetta; and concerned staff of DGSE) were supportive for integrated education. However, at the MOE and provincial departments of education, the plan of inclusive education is currently low on the list of development priorities.

There is lack of any formal contact/collaboration between the relevant officials of DGSE and MOE, and no steps have been taken (such as sensitization and orientation of regular school teachers on the special educational needs of children with disabilities, modification and adaptation of normal school environment to make it less restrictive for special students, production of additional resource material) to start the spade work necessary to bring the plan of Inclusive education on the ground. Currently, the education departments are overloaded with carrying out plans to meet the commitments of "EFA", and many reforms in the curriculum, examination system, teachers training are being considered, but attention to IE is not being given. A sub-regional seminar with participants from Afghanistan, Iran and Pakistan was organized in December 2003 in Islamabad and recommendations were made. However, the report was not provided to the team either by UNESCO or MOE, as it has not yet been approved by the relevant authority.

Currently many children with SEN are in regular schools, without any additional or special assistance. These children experience difficulties in regular schools and find themselves eventually pushed out of the school system particularly after primary education.

A study in 4 districts of NWFP showed that among 43,416 pupils in 103 urban primary and secondary schools, 825 (1.9%) were reported by their teachers to have perceptible disability[65]. This

[64] Planning Commission, Government of Pakistan, *Ten year Perspective Development Plan 2001-11*
[65] Miles, M., *Children with Disabilities in Ordinary Schools. Peshawar: Mental Health Center.* 1985

suggests that there are far more disabled children in normal schools than in special schools. Another, unpublished study revealed that 82 children out of 862 were screened by teachers as having serious learning problems. The individual assessment (cognitive abilities, socialization etc) of 40 children, revealed mild to border line global mental retardation in most of the cases and incidence of Specific Learning Disability (SLD) in 4 cases[66].

International School of Studies, a private school in Karachi has adopted IE since 5 years and to date 80 children have passed out the matric (10th grade) exam. The fee is Rs. 2500 per month (Rs. 800 higher than for normal child). Currently they have 35 children with SEN out of 390 students in the junior section. Information about senior section was not available. According to the Principal, it has been a very good experience as parents are cooperative, teachers are taking interest and peers are very helpful. However, she admitted that initially teachers were hesitant and reluctant to have disabled children, especially mentally retarded, in the class. This attitude has changed overtime and teachers now take special interest in disabled children.

In a different process, ARDP in NWFP and Hasan Academy for HI in Rawalpindi have enrolled normal children with the children with SEN. Both report a positive and good interaction among children.

The current thinking toward inclusion of children with special needs in regular classrooms poses a considerable challenge. Currently there is no system led provision for their transition from SE into the regular school system. Such inclusion is expected to expose students to individual differences and encourage social interaction between special and normal children. A majority of key respondents of this situation analysis reacted favourably when issues of integration were discussed.

Countries of the South like Pakistan faces major challenges in terms of resources and access, and only strong commitment and co-ordinated efforts of concerned ministries will help meet the EFA goals. DGSE is initiating a pilot project “Integrated education of children with disabilities” and will be training teachers of regular schools (2 from each province, 2 Islamabad, 2 AJK, and 2 NA) for IE.

5.4 Special Education Teachers

During the first four decades after independence, there were no facilities for training teachers for special education through degree courses. NGOs were training their staff either internally or internationally.

Significant Contribution of the DGSE: The DGSE, after establishment initiated a number of schemes for manpower development, through national and foreign training. The National Institute of Special Education (NISE) was established in 1986 with the objectives of: (i) developing programmes for manpower training in Special Education, for employees in Federal or Provincial Centers or in NGO Centers, (ii) organizing short-term and long-term courses leading to certificate, diploma and degree in special education, (iii) collaborating with universities, other institutions and international agencies for the development of manpower in special education, (iv) developing and publishing material for the guidance of special education teachers and parents, (v) disseminating

[66] Unpublished Study by Munawar Fatima and Mrs. Nasreen Ikram in 2 Federal Primary School, Islamabad, 2001

information about the issues and problems of disabled people among general public through publications, seminars, conferences and mass media, (vi) promoting research activities in the field of special education.

Initially, the NISE organized workshops and short-term courses in the four categories of disabilities for teachers, managers and administrators. Assistance was provided by international experts and UNESCO, ODA (now DFID), British Council and other international organizations. Also, a group of teachers selected from institutions run by the federal government, provincial governments and NGOs was sent for long-term training in USA and UK in the field of hearing impairment. Following these, NISE developed its own faculty for imparting training within its campus and to date has conducted 298 courses, mostly of 1-2 weeks duration on all the 4 disabilities (about 20-22 every year). It has provided training to 6610 participants (not individuals, as many have attended several courses).

Table 5.7: Training Courses at NISE

S. No	Disabilities	No. of Courses	Training opportunities
1	Visually Handicap	58	1117
2	Hearing Impairment	62	1362
3	Mental Retardation	47	1064
4	Physical Disability	39	764
5	Cross Disability	92	2303
		298	6610

Source: Information provided by NISE to the team

The general impression of the trainers, trainees and their supervisors is that the current duration of the training is not adequate for developing the desired skills and the need for longer duration courses was expressed.

The institute lacks some basic books (e.g. sign language books are not available as they are out of print for a long time) and other important equipment. The teachers have no opportunities for enhancement of their knowledge and skills except through the use of internet and there are no incentives for improving performance. Furthermore, the participants do not get any credit for attending these courses during promotion or postings. Also important to note is that the training needs assessment has not been done and NISE led training programmes lack long term annual planning. There is no criteria for selection of trainees.

NISE has also developed for teachers: (I) Pakistan Sign Language with Regional Variation, (ii) Pakistan Sign Language based on primary school syllabus, and (iii) Pakistan sign Language based on general vocabulary.

Checklist/Test for age related behavioral assessment and a test for verbal comprehension has been compiled. Courses workshops have been organized for the teachers of MR for developing skills in use of these. However, these tests need adaptation to local norms.

A major issue is that a uniform pattern of curriculum does not exist for special education system in Pakistan, due to the lack of co-ordination between government and NGOs. NISE has developed

Curriculum for special Education (Primary level) and Curriculum guidelines for teachers of primary schools. Curriculum for postgraduate courses in all the four disabilities was also developed in collaboration with AIOU.

In view of peculiar requirements of PWDs, an examination system has been introduced in which the NISE has adopted a role of Board of Examination for Class-V for Federal Government Special Education Centers in the country. However, this is not implemented in special schools under provincial governments.

NISE has not been able to initiate Diploma course in the area of any disability. Lack of funds and disability specific expertise in Islamabad could be the major cause.

Post-graduate Training in SE: The arrangements for postgraduate training in special education were also made in collaboration with different universities to meet the training needs. Allama Iqbal Open University started A degree course leading to M.Ed in Special Education, initially for teachers in the field of visual impairment, which has been extended for training in the fields of hearing impairment & mental retardation also. About 1500 teachers have been trained so far. Karachi University, started a degree course leading to M.A in Special Education in 1989. Over 500 Graduates have passed out so far. Punjab University started course leading to M.A in Special Education in 1990. It has so far graduated about 300 individuals. The faculty in these universities has been trained locally by national experts through courses of varying duration (few days to three months). The concern expressed by the staff include lack of foreign training and state-of-the-art knowledge. These institutions lack necessary laboratories and also face problems in providing hands-on practical training to students, hence most of the teaching is theoretical.

Qualifications of Teachers: In the early days of SE system of Pakistan teachers were employed or assigned to teach in a field in which they were not academically certified. It is guessed that a large proportion of senior special education teachers, are not fully certified for their main teaching assignment. However, currently in the large cities (Lahore and Karachi for example) where it is not particularly difficult to secure SE degree holders, the percentage of certified teachers is expected to be higher. A considerable proportion of special education trainers and administrators working in Islamabad based national institutes have attained masters degrees in special education.

Reasons for Becoming SE Teacher: Individuals mentioned many reasons for choosing special education teaching as a career. Some have some meaningful contact with a person(s) with a disability - sibling, relative, neighbour, or a family friend. These experiences help them see the value of each person and the challenges and rewards that come from working with children with special needs. Others have adopted it in cities, as it brings good returns. Single teachers have opened school for 10-12 children in home for a return of about Rs. 4000 per child. Few have chosen this to migrate to North or work in Gulf countries. There are also some career changers--adults who decide to become special education teachers after retiring from their original profession or after finding that their first career did not have the significance and meaning they wanted.

A large proportion of the personnel shown in Table 5.8 are primarily principals, teachers and instructors employed by the DGSE at the Federal and Provincial level institutions. The career structures and in service training of these employees are governed by Federal rules and regulations. A large proportion of sanctioned posts are filled both at federal and provincial levels

largely due to the reason that SE schools are located in large cities that are most sought after places of posting in government jobs in Pakistan.

Table 5.8: Personnel Strength at Federal and Provincial levels

Location	BPS 16-20		BPS 1-15	
	Sanctioned	Filled	Sanctioned	Filled
Islamabad	109	104	368	362
Punjab	151	126	306	297
Sindh	63	56	135	128
NWFP	67	48	138	130
Balochistan	30	12	63	57
Northern Areas	8	7	12	12
AJK	7	2	12	11
Total	435	355	1034	997
% Filled		82.0		96.0

Source: DGSE, Islamabad, March 2004

Chapter 6:

Vocational Training and Rehabilitation

6.1 Definition

According to ILO, vocational rehabilitation (VR) encompasses "Action to empower the disabled individual to achieve the level of competencies and abilities required to realize an employment opportunity, and to provide required assistance that would enable them to cope with the demand of a job."

6.2 Regional Situation

Several countries in the Asia Pacific Region have taken concrete steps to institutionalize VR through policies and implementation of plans.

Philippines: The National Council for Welfare of Disabled Persons (NCWDP) has formed a governing board composed of line department with Local Body Units as lead actors to translate the policies into services. It has also formed an Executive Committee composed of technical experts to serve as think tank. These two bodies have done an assessment and upgrading of Vocational Training Course provided by existing VTCDs, relative to the needs of labour market, by conducting market and skill survey. They have involved the disabled persons, their families and neighborhood in the formulation and implementation of community based vocational rehabilitation (CBR) programs through public and NGOs[67].

Philippine has long experience of using CBR models for VR. In 1978, a Project named "Rural Rehabilitation of Blind" was taken up in collaboration with USAID and Hellen Keller International, and was later extended for HI. Community-based vocational rehabilitation of persons with all types of disabilities was started in 1985, in collaboration with ILO and UNDP. That was extended to various Regions (Philippine has 14 Regions) with the active participation of Regional Directorate of NCDWP, Local Body Units, Town Mayors and a representative of provincial Governor. The planned and committed involvement of government functionaries led the extension of services to a large numbers of disabled persons from districts to village level[68].

Indonesia: Based on a law passed in 1983, welfare efforts for the disabled are coordinated by a team consisting of representatives from Departments of Local Government, Internal Affairs, Manpower and Private Sector Organizations, with Social Welfare in Chair. Major focus is on using CBR models. Community based Rehabilitation Centre, Solo, was established in 1978. The centre has been developing experimenting and revising, various approaches of CBR. The focus of all programmes is on preparing the community to take the responsibility. The Centre tried volunteer-based model but it had its limitations. They have been replaced by paid well-trained fieldworkers who work through Village Headman, to involve and empower the community in the process of rehabilitation of the disabled, of which VR is the top most goal. Self-help Groups are encouraged. Disabled persons are provided opportunity in getting trained in local trades, mainly through on-the-

[67] Social Development Division ESCAP, *Asian and Pacific Decade of Disabled Persons: mid point - Country Perspectives; Philippines*, ESCAP Home Page 1997/98 Last update 8 May 2000
[68] Munawar Fatima, *Report of Study Tour*, Philippines, DGSE, 1994

job training as an apprentice. The Centre has also set up a revolving loan system for the disabled, at usual mark up rates of the Bank[69].

Bangladesh: The focus is on rehabilitation through skill development by involving various line departments, providing micro credit for self-employment, and enforcing the 10% quota rule for services for the disabled.

As a part of the CBR programme, the Assistance for Blind Children in Bangladesh, supported by voluntary organizations, started in 1980 a rural rehabilitation project for blind children. This was extended to blind adults in 1983. To date, 430 blind persons have been provided with cows and goats to raise with the assistance of their families. Regular technical advice is provided to all paticipants.

Nepal: In Nepal, an income-generation project to raise cattle has been implemented, with support from the World Blind Union in which the CBR includes other measures to facilitate the independence of disabled persons.

India: The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, recognized the special need to support individuals whose prospects of securing, retaining suitable employment are substantially reduced as a result of physical, mental, sensorial impairment. The Ministry of Labour through the Directorate General of Employment and Training (DGE&T) extends services to disabled through several schemes. About 47 Special Employment Exchanges established and 41 special cells created in general Employment Exchanges to ensure gainful employment for disabled and 53,000 persons with disabilities were employed through these by 1998[70].

The National Council of Vocational Training, an apex non-statutory body set up by the Ministry of Labour, has formulated a policy of reserving 3 per cent of seats for trainees with locomotor disability in all (about 3000) Industrial Training Institutes. DGE&T runs 27 Vocational Rehabilitation Centers (VRCs) throughout the country. During the decade of 80 till Dec 1996, it admitted 319,204 clients and 95,942 were rehabilitated.

The National Handicapped Finance and Development Corporation, which gives micro credits (upto Rs. 25,000) to disabled persons has been incorporated in January 1997 as a non- profit company fully funded by the Ministry of Welfare. The paid up share capital of the Corporation is Rs. 2 billion and authorized capital is Rs. 4 billion[71].

6.3 Vocational Rehabilitation Services in Pakistan

The programs and services for vocational rehabilitation for disabled persons in Pakistan are limited. Currently a variety of VR training programmes are being pursued by the government and NGO organizations to increase a disabled individual's opportunity to earn a steady income. Training programmes in tailoring, embroidery, carpet weaving, handloom, block printing, candle making etc. have been developed and implemented to prepare children with disabilities move from

[69] Munawar Fatima, *Report of Study Tour*, Indonesia, DGSE, 1994
[70] *Report of India at APIED Seminar,* Japan, 1998
[71] Social Development Division ESCAP, *Asian and Pacific Decade of Disabled Persons: mid point - Country Perspectives; India*, ESCAP Home Page 1997/98 Last update 8 May 2000

the school environment to a work situation. These programmes consist of a combination of skills instruction and practical training in a vocation.

Most available VR programs tend to be centralized in urban areas and delivered through static vocational training institutions, which are located in the large cities and their number is very small. It is estimated that among the disabled people in need of rehabilitation, only a small proportion have access to any VR services. Moreover, most institutions provide rehabilitation only for certain types of disabled people and for certain age groups. The problem is more serious for the estimated 66% of disabled poputation that lives in rural areas. According to a WHO estimate, 70 per cent of disabled persons in the community need only simple training which could be provided by the family, with guidance from community-based rehabilitation workers. It is said that only 10 per cent of disabled persons need the specialized services provided by rehabilitation institutions.

6.3.1 Vocational Training Centers for Disabled

Public Sector: The first Vocational Training Center for the Disabled (VTCD) now called National Training Center for Special People (NTCSP) was established by DGSE in 1986. It caters for person with all 4 types of disabilities for both boys and girls. It had the mandate to: (i) provide vocational training in specified trades. (ii) facilitate provision of job placement services for successful trainees**.** (iii) demonstrate to the community the ability of handicapped to become contributory members of the society. It is the only vocational centre, which gives a certificate on completion of successful training. Since 1987 to 2003, a total of 1901 (1513 male and 338 female) disabled persons have attended this center and out of these 553 passed out with a certificate. According to the limited follow up, 149 of these were found employed[72].

In the last 4-5 years DGSE has set up a VTCD at all the four provincial Headquarters, however the information about the total enrolment to date is not available. All the five centers provide training in 19 trades, including computer-training programmes. Besides these, 12 other exclusive VTCD are working in Pakistan as shown in the table 6.1.

Table 6.1: Vocational Training Centers for Disabled (VTCD)

Location	Fed Govt. Centers	Provincial Govt. Center	NGO/Private Sector	Total
Islamabad	1	-	-	1
Punjab	1	4	2	7
Sindh	1	-	3	4
NWFP	1	-	3	4
Balochistan	1	-	-	1
Total	5	4	8	17

Source: Information collected during the field visits

In Sindh 14 RCMH (mentioned in the section on special education) also have provisions for vocational training in few trades along with the classes from 1 to 5. They take children of all the four categories (PH, VH, HI, MR). The number of students reported by the concerned officers of Directorate ranges between 30 to 35 at a time.

[72] *Latest Report of NTCSP,* April 2004

In Punjab, at each district (34 in all), a District Rehabilitation Training Committee has been established under Directorate General of Social Welfare. These committees give medical/financial assistance for self-employment. The report for the year 2003, mentions that 364 persons were employed through the funds of these committees in 11 districts. No information is available for 23 districts.

NGOs: Some well organized pressure groups particularly of blind (PAB and PFFB) and to some extent HI and PH advocate for themselves, develop employment plans and identify appropriate employers. Darakhashan, a vocational training center in Rawalpindi managed by Pakistan Foundation for Fighting Blindness (PFFB) is the only vocational facility, which targets women with disabilities.

NCRDP and PCRDP: Legislative ordinance of 1981 on the employment of disabled person helped in the establishment of NCRDP and PCRDPs in 1982. The role of NCRDP and PCRDP is to take measures to ensure the implementation of this allocated quota of employment for the disabled of all categories. Moreover, with the funds collected from business organizations in lieu of non-employment of disabled person, NCRDP gives: (i) grant for self-employment, (ii) provides money for medical treatment, (iii) gives assistive aids (wheel chair, hearing aid, artificial limbs etc); and also endeavours to arrange vocational training in mainstream polytechnic institutes. Through the efforts of NCRDP and its provincial branches over 17,000 disabled persons have been employed in public and private sector[73]. Proposals are underway to ensure 5% of seats for the disabled in Technical Training Center of Departments of Labour and Manpower.

> It is important to note that no formal market survey has been taken up, either by public or by private sector, to identify particular jobs for persons with specific disabilities.

According to the key informants the performance indicators of VR training facilities indicate that the number enrolled vis-à-vis number successfully rehabilitated are only 5%-10%, physical and orthopedic impairments including amputation, or non-orthopedic physical disabilities rate highest on securing employments followed by visual and hearing impairments. Mental Retardation (MR) rates lowest in terms of potential for employability.

6.3.2 Community-based Rehabilitation

Efforts to increase the accessibility of services in a community setting are being pursued through Community Based Rehabilitation (CBR) programmes both in the public and NGO sectors. Some of CBR programs are complimented with micro credit programs.

In 1992-93, the DGSE launched, Community-based Rehabilitation (CBR) approach by the name of Vocational Rehabilitation and Employment of Disabled Persons with Community Participation (VREDP). It had four major objectives: (i) developing a cost effective, non-institutional, CBR program to reach larger number of disabled (ii) creating awareness and motivating local communities, disabled persons and their families to participate in the rehabilitation process. (iii) preparing a national policy for vocational rehabilitation of disabled persons (iv) networking of existing resources.

[73] MoWD,SW&SE*, Pakistan's Special People, Opportunities & Challenges, 2002*.

The programme works through three Service Centers, located in Islamabad, Karachi and Gujrat. The staff of Service Centers reaches out to low-income suburban localities and nearby villages, and makes contact with any established platform such as local NGOs. They select and train volunteers who work directly under NGO representative and register, assess and evaluate the disabled persons on the formats and system given by the programme officials. They also explore and help mobilize the existing community resources (human, institutional, social and financial). The training in the local trades is arranged either through apprenticeship or in the available industrial home or any training Institute in the area of work. Since February 1994 to date they have mobilized about 50 NGOs, trained over 300 volunteers and registered 2215 disabled.

The project has developed a handbook on CBR Model for Vocational Rehabilitation of the Disabled, a manual for training of CBR managers, and a Manual for training of community volunteers. It also mobilized Lahore Chamber of Commerce and Industries, which in 1995 started an Employment Cell for Disabled Persons. Recently the LCCI members have formed an NGO named Lahore Association of Businessmen for Rehabilitation of Disabled (LABARD). This initiative has help 238 disabled persons to get employment.

Villages are the focal points of CBR programmes of the Association For the Reahabilitation of the Physically Disabled (ARPD), NWFP Pakistan. The bulk of the rural population here is engaged in agriculture, rural trades, indigenous crafts, farming, including animal husbandry. ARDP establishes a network system in the community among disabled persons, support service providers and policy makers at the provincial and national levels. Presently ARDP has established 61 CBR centres by networking with 300 partner organizations in 100 towns of the country.The concept on the rights and duties of disabled persons to participate individually and collectively in the planning and implementation of services is exemplified in this community- based approach.

6.3.3 Loan Schemes for Self Employment

There are a variety of national schemes that are designed to promote self-employment - both general and specific in character. Coupled with them is a wide range of micro credit and skill development programs designed to encourage self-employment: The Small Medium Enterprise Development Agency (SMEDA) is run as public-private enterprise and is intended to encourage entrepreneurship through the provision of grants and micro loans.

> Many credit schemes and grants are available in the development sector, however, there is no evidence of any specifically designed micro credit/skill training product for disabled people. Generally disabled people either perceive themselves as ineligible or are not aware of the existence of such facilities, or are too poor to meet the conditions.

Furthermore, micro credit granting agency staff often found to be not very helpful in disseminating information. For potential disabled entrepreneurs, information and advice is hard to come by and micro credit employees are being perceived to be obstructive. Considerable confusion and apprehension has also been generated by the procedures, pre conditions and jargons used in the field. Those who provide training and advice in micro credit field also offered some interesting insights, they do not recollect any significant numbers of enquiries from disabled people about micro credits and self-employment.

Two service centres of VREDP (Islamabad and Karachi) have a small revolving loan scheme at 8% mark up rate, operating since 2000-2001. A loan of Rs. 5000/- is given and the clients are helped and guided to start a small income generation activity (mostly setting up a small shop or a tailoring enterprise). Since its inception, 33 individuals have been given loan of a total of Rs. 154,480 and the recovery has been 90%.

An NGO in Karachi (Pakistan Sports and Cultural Society) and another in Lahore (Pakistan Society for Rehabilitation of Disabled) also have Micro credit scheme to encourage self-employment of persons with disabilities.

There is a heavy VR demand, some well organized activists/pressure groups from disabled community such as PAB choose their own vocational goals; advocate for themselves; develop employment plans; and identify appropriate employers.

6.3.4 Entrepreneurship/Self-Employment

Education and vocational training facilities for the disabled seem to have remained stagnant. While science and modern technology have made tremendous leaps in the latter half of the 20th century opening up new avenues and new horizons for the able-bodied, but the disabled are still being trained in traditional crafts and for simple repetitive jobs like basketry, chair-caning, handloom weaving, packing assembly, light electircal/mechanical work etc. Sadly, the opportunities for employment even in these limited fields is dwindling rapidly. Agencies and institutions for the disabled find it easier to continue to run on traditional approaaches.

Looking at the impact of gushing Information Technology (IT) and emphasizing upon the positive aspects, it would make it possible to reduce, or even eliminate, the handicapping effect of many disabilities; it might also make it possible to make changes to the organization of many jobs; in particular, it would be possible for disabled people to tele-work (work from home using a computer terminal) so that the physical inaccessibility of many work-sites would no longer be a problem. There are currently a considerable number of disabled work in a disability related area (SE schools, VR Centres etc) a proportion of them work in offices often with an emphasis on computing. In addition, there are those who due to difficulties in the use of public transport or commute on foot have resorted to work at home and switched from unemployment to self-employment.

Currently with the exception of some, many well meaning NGO working for the disabled most have not been able to draw up professional business plans to succeed in obtaining credits or grants. Similarly professional marketing advice seems be only infrequently sought, usually being acquired through trial and error and business plans are seldom formulated. Very few public and NGO sectors have approached professional enterprise training providers that can tailor and offer specific training/skill development commensurate with disabled peoples' potential. Overall the lack of effort on marketing of products and services of disabled people show that disabled people have been unfairly kept excluded from the mainstream business.

Nevertheless, several of the potential employers realize they were not doing enough to serve people with disabilities and not one favoured any negative discrimination, though there were concerns about not understanding disabled peoples' needs and a large proportion of businesses have not received information specific to disability issues. The situation is compounded by poorly developed networking between disability service providers in both public and the private sectors.

Public sector officials have limited or non-existent professional contacts with disability NGO, they find them not very welcoming and are wary of treading on someone else's territory. More positively, however, all disability service providers are making contributions within their resources.

Since a desirable outcome of the education experience is paid employment, the statistics in the foregoing on the employment of those with disabilities are very troubling. There has been surprisingly little thought being given on how VR services need to change in order to meet the very different needs of disabled people in the twenty-first century. There is an overall lack of thinking to review traditional approaches to vocational rehabilitation**.** There is certainly a concern that disabled people are actually being affected more than others by changes in the labour market attributed to the impact of high technology. In spite of the various VR programmes and affirmative action plans such as the Disability Quota Employment Scheme, designed to ameliorate their situation. Nonetheless, there is also evidence that generally disabled people do not have the skills that are increasingly required in the present day job market and that this is also due to the barriers they face in accessing high technology based education and training.

It is important to bear in mind that the changes in labour market may be affecting disabled people more than others.

Chapter 7:

Medical Rehabilitation

Medical rehabilitation services are a powerful means for overcoming the effects of disability. Timely and effective medical rehabilitation services can contribute considerably to the quality of life, independence and productivity of the PWDs.

7.1 Role of MOH

At present, mainstream government led system does not contribute its full potential to the issues of disabilities. The prevailing emphasis of disability largely relates to special education and vocational rehabilitation while prevention and medical rehabilitation rate low in the scale of priorities. Moreover there is a relative scarcity of inter sector coordination in the system. The MOH is committed, and per se the sector does not have specialized network of disability services, but these have been integrated into secondary and tertiary levels of health services. The provision of specialized career structure and commensurate medical training in the field of disability is also absent. Generally most medical and nursing education programs in Pakistan do not teach medical rehabilitation.

> The need is that health providers are enabled at all levels of the profession to identify, manage and follow-up patients with disability problems.

It would take several decades to have disability specialist paramedic, nurses and doctors. Coverage can be only achieved through integrated, comprehensive training programs at the community level with disability /rehabilitation medicine specialists used as trainers. The LHW is the only cadre available to provide the Primary Health Care (PHC) services at the door-step level, hence, it may be considered to provide both theoretical knowledge and practical skills to them to be competent to screen and detect disabilities early. An effective LHW can assume the role of social worker and communicator to village leaders, elected councilors, faith healers, religious leaders and school teachers. They could teach them how to identify, refer, support, follow-up and generally collaborate in the management of person with disabilities in the community. Expanding the role of LHW also means incorporating into her daily activities promotional and preventive services including educating the communities about common causes of disabilities and how these can be prevented. However, this proposal needs a thorough consideration.

7.2 Available Rehabilitation Services

In Pakistan, well-documented descriptions of medical rehabilitation services are lacking from presently available literature and databases. Generally, most medical rehabilitation practices on the part of physicians, surgeons and nurses have been developed during the course of service provision rather than as part of a formal training in rehabilitation medicine. Medical rehabilitation services such those provided at Islamabad based National Institute for Handicapped (NIH) are not exclusively dedicated for the disabled. NIH would therefore not convincingly fit into the model of exclusive disability service provider.

In 1987, the National Institute of Handicapped (NIH) was planned as a speech and hearing disorder therapy center and was established in 1997, after a passage of a decade, as a hospital with facilities for service provision in ENT, orthopaedic, psychiatry, radiology, pathology, anaesthesia, psychology, pediatric medicine and surgery and ophthalmology. About 53 % patients attending the NIH belong to disabled classification, while 47% are non-disabled who are provided services as private or corporate panel patients (Table 7.1). A consultation fee of 200 rupees per visit is charged from all non-disabled patients. Most of patients attending the NIH are the residents of Islamabad and its adjacent environs.

Table 7.1

Service Type	Patient Type			
	General/Disabled	Private	Panel/Corporate	Total
Out Patient	13263	6319	5005	24587
In Patient	339	240	305	884
Surgeries	227	139	123	489
%	53.0	26.0	21.0	25960

Source: Performance Report, NIH Islamabad, 2001-2002

NIH is working like other hospitals in the Capital, such as Pakistan Institute of Medical Sciences or Federal Government Services Hospital with few additional services. It has no provisions for occupational therapy, vocational therapy or assistive aids. According to the senior staff members, none of the surgeons are specially trained in managing handicapped. There are very few hospitals that have specific departments for medical rehabilitation.

On policy level, it took several years to convince the College of Physicians Surgeons Pakistan (CPSP) to recognize “Rehabilitation Medicine” as a discipline for postgraduate training. In Punjab, the Department of Rehabilitation Medicine at Mayo Hospital Lahore came into being in 1989-90 while it was approved by CPSP as a facility for postgraduate training in 1996. Today this department provides a model that promotes interdisciplinary familiarity and interaction in medical rehabilitation education, training and research. In its emphasis areas are improving functional mobility; promoting behavioral adaptation to functional losses and developing indigenous orthotics and prosthetic technology; and training under graduates and postgraduates in the medical rehabilitation field. Among the range of 200 items currently manufactured at Mayo Hospital include artificial limbs, appliances, body - support and mobility systems. In prosthetics and orthotics, modular construction using local components and an understanding of gait and pressure distribution and higher standards of fitting and design are maintained.

Presently medical rehabilitation services including medical care, surgery, physiotherapy and occupational therapy are predominantly available in large cities at provincial and district headquarters level.

There are services available for amputation, brain injury/head injury, cerebral palsy, hand injury, inpatient rehabilitation, multiple sclerosis, muscular dystrophy, musculoskeletal injuries (pain of muscles, tendons, ligaments, joints and bones), spina bifida, spinal cord injury, spine pain (low back pain, neck pain), sports-related injuries, vestibular/balance disorders rehabilitation and work-related injuries. The existing services, however, generally lack appropriate specialists, equipment

and commensurate funding particularly in the government owned facilities. It is worthwhile to mention that existing services of the Army Medical Corp (AMC) can be said to be at the greatest advantage in terms of knowledge of medical rehabilitation, outcomes, interventions and service delivery systems. As compared to AMC that has relatively straightforward tasks, for the civilians' system for which the MOH and provincial departments of health are responsible the diversity and the multitude of populations are cited as reasons for lack of progress in terms of designing and conduct of definitive medical rehabilitation services.

Overall, medical rehabilitation and the mainstream healthcare delivery system of which it is a part is poorly and inconsistently planned and delivered. Classification systems of disabilities and consequent rehabilitation interventions, practice modes, methods of financing and consumer satisfaction and preferences are not uniformly applicable to a variety of present day disability services and systems of care.

The provision of appropriate training in the field of medical rehabilitation is extremely deficient both at undergraduate and postgraduate level. There are only 3 institutes that are recognized for postgraduate training.

Service providers below the provincial headquarter level i.e. at district and tehsil/town level lack well-substantiated guidelines on disabled patient management pivotal for the field. Medical rehabilitation of the disabled is generally perceived to have been given low priority in the districts as seen in the context of Devolution of Power Plan of August 2001. The degree to which the devolved districts are expected to bear the responsibility of the disabled depends on the order of priority and commensurate availability of funds duly approved by the elected district governments.

Physiotherapy is an important medical rehabilitation service for the disabled. An underlying constraint in the country is the shortage of physiotherapists and their concentration in provincial and district headquarter cities where salaries and work conditions are better than rural areas. For most part the hospital based physiotherapists in large cities do not provide services beyond the walls of the hospitals (unless it is regarded as private practice after official work hours). Home exercises are often included in treatment programs but there is no way of ensuring that patients would carry them out effectively. Rural areas with nearly 66% of the disabled population are being largely neglected. Patients have to travel in uncomfortable buses to the cities for treatment. Disabled people needing long-term management such as paraplegics and hemiplegics are often unable to make such journeys. Hence a majority of them opt for local treatment through traditional healers in their own localities.

The landmine problem is serious in the Federally Administrated Tribal Areas (FATA), especially in Bajaur and Kurram tribal areas. The Pakistan Campaign to Ban Landmines (PCBL) has been collecting data on landmine casualties in the country from various sources including newspapers and field visits to mine-affected areas (Table 7.2). The PCBL believes that the number of mine casualties would be higher if a comprehensive survey was carried out.

Table 7.2: Landmine Victims in Pakistan

Province/Area		Gender		Casualties		
		M	F	Total	Requiring an Amputation	Other Injuries
NWFP	64	51	13	24	9	31
Balochistan	13	12	1	6	0	7
Azad Kashmir	4	4	0	4	0	0
Punjab	6	3	3	3	0	3
FATA	755	513	242	307	311	137
Total	**842**	**583**	**259**	**344**	**320**	**178**
Percentage		**69**	**31**	**41**	**38**	**21**

Source: Land Mine Monitor Report 2002

Human Survival and Development (HSD) an NGO carried out a one-month landmine assessment survey for the United Nations High Commissioner for Refugees (UNHCR) in December 2001. The survey reported that there are no specialized/specific medical, surgical or first aid facilities available to landmine victims close to the mine-affected areas. Casualties are transferred to hospitals in large cities, mostly by private vehicles or, in some cases, by ambulances. Patients pay for medicines, treatment, and transport. Military personnel have access to services free of charge, and are treated in Combined Military Hospitals (CMH) located in the big cities. Afghan mine survivors residing in Pakistan also use the Pakistani medical infrastructure, which adds an additional strain in an already overpopulated country. In Bajaur Agency (FATA) the district hospital is only capable of providing basic first aid, and in some cases there is a problem arranging transport for the mine casualty. According to the survey conducted by HSD, the injured person reached the hospital in less than three hours in about 57 percent of cases, in three to six hours in 41 percent of cases, and in more then six hours in two percent of cases.

There are no medical rehabilitation programs for landmine survivors supported by the government in the mine-affected areas. Prosthetic facilities are available but mine survivors have to cover the costs, and many do not have adequate resources. There are no known psychological support services accessible to landmine survivors in the mine-affected areas.

HSD now provides an ambulance in Bajaur Agency to transport landmine casualties to a suitably equipped medical facility for first aid, proper treatment, and surgery. The service, which is free of charge, includes first aid, medicines, and the assistance of a trained paramedic during the evacuation. In 2001, the Swiss Foundation for Landmine Victim's Aid (SFLVA) donated US$17,000 for this service. In late 2001, the Mines Advisory Group (MAG) conducted an assessment in partnership with HSD and in 2002. Since June 2001, HSD identifies the amputees and covers all costs including transport, accommodation, and other costs related to their stay as well as the prosthesis.

Pakistan Prosthetic and Orthotic Services (PIPOS) provides the rehabilitation service. PIPOS is based in Peshawar NWFP and is linked with three workshops in Karachi, Lahore, and Quetta. In addition to prosthetic and orthotic services, PIPOS runs a four year B.Sc degree program in prosthetics for students from all over the country, as well as from abroad. The ARDP, which is supported by Action for Disability UK, provides rehabilitation and vocational training to landmine survivors in the border areas. In 2001, 759 landmine survivors were assisted and 126 prostheses, 126 crutches, and 68 walking sticks provided. The program was funded by the Diana, Princess of Wales Memorial Fund.

Mercy Corps started the Balochistan Community Rehabilitation Program in November 2000. Mercy Corps, together with the Christian Hospital Quetta, have set up an orthopedic workshop to assist disabled Afghan refugees. The workshop also provides training in physiotherapy for the families of disabled patients. In 2001, 4,583 people were assisted, including 529 landmine survivors who received 74 prostheses, 14 wheelchairs, 46 crutches and 295 other assistive devices. The program is funded by the Diana, Princess of Wales Memorial Fund. Handicap International Belgium also has a rehabilitation program for disabled Afghan refugees in camps in Balochistan province. Activities focused on physiotherapy visits and the production of 82 walking aids and 20 pairs of crutches[74].

7.3 Medical Rehabilitation Infrastructure

On the assumption that all of country's medical colleges and their attached hospitals, semi government, private and army hospitals approved by the Pakistan Medical and Dental Council for medical training are currently equipped to provide a varying range of medical rehabilitation services, it is estimated that there are about 100 such facilities. These are predominantly concentrated in provincial and district headquarter cities (See Annex IV).

7.4 Assistive Aids

There is hardly any disability that cannot be helped by a device. Today the demand for devices is outstripping the supply capacity. In a population of 3.3 million disabled, a substantial proportion of them potentially are in need of some kind of assistive aid. The current estimate of appliance use is unknown. However the magnitude of the problem is obvious. For expanding medical rehabilitation services to district and tehsil levels, there is merit in having workshops facilitated by well trained/experienced facilitators in collaboration with institutions such as Rehabilitation Medicine Department of Mayo Hospital Lahore. Its initial function would be to assess needs and if necessary design appropriate programs/projects. The Pakistan Society for the Rehabilitation of Disabled Persons could potentially play an important role in the promotion of devices and has a consultative role in this field. The society currently plays an important role to establish guidelines for education and training and adopt appropriate technology.

The existing facilities in both public and private sectors (see list in Annex V) are inadequate to meet the current demand for prosthetics[75]. Under the Perspective Development Plan 2001-11, establishment of ortho-prosthetic workshops are being pursued in large teaching hospitals.

Under the NPA, a system has to be evolved for research, evaluation and training of technicians for assembling devices. Fundamental research into the needs of disabled has to be coincided with international advances in technology and materials. In prosthetics and orthotics, modular construction using local components and better understanding of gait and pressure distribution and higher standard of fitting and design are expected. High technology devices have higher costs while simpler devices are cheaper, especially when they are produced by local labor using local materials. ARDP in NWFP has demonstrated that locally made components and devices have

[74] HSD, *Landmine/UXO Assessment Survey Report of UNHCR Campsites in FATA and Baluchistan*, November-December 2001.
[75] Planning Commission, Government of Pakistan, *Ten year Perspective Development Plan 2001-11*

proven to be the spin-off of providing local employment, the avoidance of duties and freight charges and the saving of foreign exchange. Among the range of prosthetic and orthotic devices currently available include artificial limbs, appliances, body support, mobility systems, environmental, teaching and communication aids (Table 7.3)[76]. Between 1997 and 2004 development has been accelerated by the inclusion of NGOs, private sector in the production and distribution team and by a wider participation of association of the disabled in the field.

7.5 Needs of Disabled Elderly

Currently special rehabilitation facilities do not exist for old persons. Traditionally adult sons and daughters are obliged to take care of their old parents and virtually all cared for in the traditional way. Children are expected to look after their parents those who do not are regarded with disfavor by society. Although extended family system is no more a rule particularly in the urban areas, at least one of the offspring usually looks after the parents. Neglect of the elderly is rare. Old people's homes are non-existent, almost all live with members of their family and generally satisfied with their lives. Religious faith is their main source of strength and their routine activities consist of prayers and other religious obligations. Nevertheless, the increasing numbers of the elderly pose a challenge including those relating to their health and consequent disability principally on account of aging problems, senile dementia, deafness, blindness, feeling of loneliness, uselessness and boredom. As time passes by the demand for specific geriatric care would grow. Much remains to be done in the training of more and better rehabilitation medicine care providers. There is a need for services that can be integrated into the PHC system and cover a wide range of elderly peoples' health problems. Curative, preventive and rehabilitative care for the disabled elderly should be part of PHC program.

[76] Economics and Social Commission for Asia and the Pacific (ESCAP), *Production and distribution of assistive devices for people with disabilities*: *Supplement1 - Chapter 10-13 - ST/ESCAP/1774,* UNITED NATIONS PUBLICATION, 1997, ISBN: 92-1-119775-9

Chapter 8:

Legal Environment

The International Labour Organization (ILO) promotes work for women and men with disabilities and facilitates means to overcome the obstacles preventing people with disabilities from full participation in the labour markets. The ILO approach is based on the principles of equal opportunity, equal treatment, non-discrimination and mainstreaming. These principles are underlined in the ILO Convention concerning Vocational Rehabilitation and Employment (Disabled Persons) Convention 159, 1983. It was ratified by Pakistan in 1984 along with its accompanying Vocational Rehabilitation and Employment (Disabled Persons), recommendations (No. 168) and other ILO conventions concerning equality of opportunity. ILO,through its “In focus Programme on Skills, Knowledge and Employability” promotes the following main activities: improving knowledge on disability-related matters concerning training and employment; advocacy, guidance and policy advice to governments, workers and employers’ organizations on training and organizations of/for people with disabilities and technical advisory services and cooperation activities.

8.1 Ordinance for Employment of Disabled Persons

In Pakistan, an Ordinance to provide for the employment, rehabilitation and welfare of disabled persons was promulgated in 1981. The Ordinance provides that no handicapped individual (as defined in its section 2.C) shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in the provision of employment. Section 10 of the Ordinance makes it obligatory for establishments, whether government or private, which have a strength of hundred or more persons to employ 1% disabled persons. Currently the case is under process for enhancing the employment quota to 2%. The 1981 ordinance provides that qualified handicapped persons should be given every opportunity for employment, training and promotion commensurate with their ability and qualifications to perform the specific jobs for which they have the potential.

Registration of Disabled: All individuals who consider themselves to be covered by Sections 10 and 12 of the Ordinance are required to register themselves on the local employment exchanges. Such registration is based on the disability categories under which they qualify: Blindness/visual impairment, Deafness/hearing impairment, Orthopaedic impairment and Mental disorder. It is the intent of the Ordinance that no qualified handicapped individual solely by reason of his or her handicap, be excluded from participation in employment. The Ordinance states that “the employer will not discriminate against any employee or applicant for employment because of physical or mental handicap in regard to any position for which the employee or applicant for employment is qualified. The employer will employ, advance in employment and otherwise treat handicapped individuals without discrimination based upon their physical or mental handicap in all employment”.

Disability Assessment: Candidates applying for a job position and identifying themselves as qualified handicapped persons have to undergo disability assessment and procedures which qualify/disqualify them for positions they are to be considered for. "Persons with Disabilities" (PWD) are referred in the Employment ordinance (1981) as “persons who, on account of injury, disease or congenital deformity, are handicapped for undertaking any gainful profession or employment in order to earn their livelihood, and include persons who are blind, deaf, physically handicapped or

mentally retarded and any physical or mental condition arising from the imperfect development of any organ".

Under the section 12 of 1981 ordinance, all candidates are assessed during a selection process. Here the use of the term "assessment" does not refer to a comprehensive evaluation carried out by a qualified professional team for the purposes of diagnosing and describing the functional limitations of an individual. In Principle, professional assessment should normally include a variety of diagnostic tests whose purpose should be to determine the existence and nature of an individual's disabilities and associated functional limitations, and it may also include recommendations for commensurate jobs and workplace particularly in access contexts. But in Pakistan the term "assessment" refers to the process of evaluating the competencies of candidates for the purposes of recruitment to a vacant job. This includes basic physical examinations, psychological tests, and interactive methods of assessment by a team of medical and social welfare personnel. Presently the assessment has taken the form of a physical- psycho-educational-skill assessment.

Under section 12 of the ordinance the Provincial Governments are responsible for establishing the standards, which govern how candidates are selected and assessed. As per its sub section 2 the PCRDP is responsible to assess the nature of functional disability and the aptitude and the nature of work a disabled person is fit to do. A medical officer usually the Medical Superintendent (MS) of the concerned District Headquarter Hospital (DHQ) is authorized to lead the assessment board comprising the District Social Welfare Officer, District Technical Education Officer, a Psychologist and a representative of District Employment Exchange. The assessment board submits its report to the PCRDP in such form as prescribed by the Provincial Government. If the disabled person is considered by the PCRDP fit to work, it so informs the Employment Exchange, indicating the nature of work for which he/she may be employed or the trade or vocation in which he/she may be trained, and an endorsement to that effect is made against his/her name in the Employment Exchange register. If the disabled person is not considered by the PCRDP fit to work, it informs the Employment Exchange accordingly for an endorsement to that effect to be made against his/her name in the register, and the PCRDP takes such measures for his/her rehabilitation as it deems fit. If a person is declared by the PCRDP not to be a disabled person, his/her name is struck off the register.

The Assessment Certificate[77] describes four generic categories of functional disability i.e.(i) Permanent; (ii) Temporary; (iii) Progressive and (iv) Secondary which provide a basis for assessment and recommendation for a job.

There is need to provide comprehensive guidelines for modifications to assessment tools and procedures which are currently inappropriate to accommodate candidates with a variety of disabilities. As guidelines, it is important to provide a framework of principles and recommended procedures which human resource managers and others responsible for determining job allocations can use in handling genuine cases. In addition, guidelines should provide information about appropriate jobs for specific disabilities. The aim of these guidelines should be to increase awareness and provide practical guidance for employment potentials for persons with disabilities. For the purpose of proposed guidelines, "Persons with Disabilities (PWD)" should not limit to 1981 ordinance's definition.

[77] PCRDP, *Sindh Form DLP 532*, 2003

In sum, 1981 ordinance places clear obligations on the public and private sectors in the staffing process. However the assessment boards should also bring on their team persons with disabilities or their associations in the assessment process as necessary in order to provide for selection according to merit. Assessment methods must treat all candidates in an equitable and non-discriminatory manner. Nonetheless, equitable assessment does not necessarily require the use of the generic assessment methods or sources of information for all candidates. For example, in some circumstances equitable assessment will require the modification of usual procedures. Assessment should ensure that each person is assessed according to his or her own personal characteristics rather than presumed group characteristics

Role of National & Provincial Councils to Implement the Ordinance: To implement the Ordinance, the National Council for Rehabilitation of Disabled Persons (NCRDP) and Provincial Councils for Rehabilitation of Disabled Persons (PCRDP) were created under Sections 3 and 5 of the ordinance, respectively. The NCRDP is composed of a federal office in Islamabad and has inter-ministerial membership. PCRDP are established in each provincial headquarters and have members from several departments of the provincial government. Each PCRDP is responsible for formulating its own plan for affirmative action using Ordinance 1981 as a guide. The PCRDP on their part liase with the potential recruitment and training institutions including the government employment services, public or NGO vocational rehabilitation agencies or facilities, sheltered workshops, education departments, examination boards, labour organizations and social service organizations serving handicapped individuals.

The PCRDP is also mandated to review employment records to determine that handicapped individuals are employed, and to determine whether their present and potential skills are being fully utilized or developed. They reportedly use appropriate media for institutional and employment advertising to indicate the government's commitment to non-discrimination and affirmative action in regard to the handicapped persons.

The PCRDP monitors through employment inspectors the Ordinance related obligations and intent. The PCRDP inspectors/officials are also responsible to oversee that handicapped employees are protected from coercion, intimidation, interference or discrimination. PCRDP also influences employment upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation and selection for training. If an employer is not complying with requirements of the Ordinance 1981, the PCRDP is mandated to fully investigate the complaint and take appropriate action consistent with the requirements of Section 15 and maintain files regarding the complaint and the actions taken or decisions made. PCRDP conduct investigation of complaints when a handicapped employee or employer file a complaint.

The Section 10 of the Ordinance provides provision that compensation offered to handicapped persons should not be reduced because of any disability. All disabled persons employed under sub section 1 of section 10 are entitled to the terms and conditions that are not less favourable than those of the other persons employed by the establishment against similar post. Thus income, pension or other benefits the disabled are entitled for are commensurate with those of other employees. Grievance Procedures adopted, described in Sections 15 and 16 of the ordinance cover complaints by employees including alleged discrimination on the basis of disability, or by reference, as handicapped person.

Payment in Lieu of Non-Compliance: All establishments, both public and private, are under obligation to employ 1% qualified handicapped employees. In case of non-compliance, the

employer is bound by the terms of Section 11 to pay to NCFDP's "Rehabilitation of Disabled Fund" (established under Section 17 of the ordinance) each month the sum of money it would have paid as salary or wages to a disabled person had s/he been employed. Such provisions are binding upon organizations that employ 100 and above employees. Enforcement of such provision including action for non-compliance is currently more rhetorical than practical.

Employment Statistics: NCRDP and PCRDP have been unable to collect relevant data. There are concerns that conventional national data collection mechanisms such as National Population Census, Labour Force Surveys (LFS) etc. are also not adequately capturing the employment status of the disabled. It is proposed that other approaches could be adopted, such as involvement of Employees Social Security Institutions (ESSI), or third party assessments. Human Development Index (HDI) specific to disabled persons could be compiled to monitor and assess the implementation of national policy on disability.

8.2 Laws regarding Injury/Disablement at Work Place

In the India-Pakistan sub continent the earliest work Injury/disablement law was Workmen's Compensation Act of 1923 for employees. Today, the provisions for disability are also based on 1965 Social Insurance Law and 1976 Employees' Benefit Law that provide coverage to employees in establishments having10 or more workers. Exclusions are family labour and self-employed, public employees, armed forces, police, statutory bodies, local authorities, banks, and railway employees. Commercial and industrial establishments with 50 or more employees are required to provide group insurance for temporary and permanent disability and death benefits for employees earning less than 3,000 rupees per month wherein premium payment from insured person are not required while the employer contributes 5% of payroll to this effect. The qualifying conditions for disability remuneration include 2-14 years of covered employment and loss of 2/3 of earning capacity. The law also covers work-injury related medical benefits. Services are provided mainly through social security facilities, it includes general medical care, specialist care, medicines, hospitalisation and transportation.

The responsible administrative organizations at Federal level are Ministry of Labour, Manpower and Overseas Pakistanis and the Employees' Old-Age Benefits Institution (EOBI). At provincial level Provincial Labour Departments and Employees' Social Security Institutions managed by tripartite governing body and commissioner hold the responsibility. These institutions are authorized to establish own dispensaries and hospitals, or to contract with public and private agencies for provision of medical services. For work injury benefits there is no minimum qualifying period. Temporary and Permanent Disability Benefits under Workmen's Compensation Act apply to persons with wages of less than 3,000 rupees per month, in the case of former 1/2 of monthly wage for up to 1 year. If lung disease, 1/3 of monthly wage for up to 5 years while permanent disability benefits include a lump sum of 100,000 rupees. Cost of medical examination is paid by employer.

In the year 2001 the government announced doubling the compensation money for workers, who suffer permanent disability or die during the course of employment, from Rs100, 000 to Rs200, 000. Amendments have been introduced to the Workmen Compensation Act 1923 in this regard. This amendment would apply on the workers in labour force under the Employees Social Security Ordinance, 1965, the Companies Profits Workers Participation Act, 1968, the Workers Welfare Fund Ordinance, 1971 and the Employees Old-Age Benefits Act, 1976. After the amendments, the workers would be able to enjoy welfare facilities that include increase in compensation, enhanced

scope of coverage of payment of wages act, self- assessment social security and old-age benefit schemes, re- categorization of workers, enlargement of scope of workers welfare fund ordinance and increase in minimum wage. For the implementation of these laws district tripartite committees, led by district Nazims would be formed to ensure these laws are strictly adhered to.

Overall, the Employees Old Age Benefits Institution (EOBI) disbursements have been about one billion rupees per annum in the years 2000-2003. As an illustration, Table 8.1 captures budgetary expenditure in respect of EOBI and other pro poor social safety net endeavours.

Table 8.1: Pro Poor Non-Budgetary Expenditures (Rupees in Billion)

Sectors	2000-01	2001-02	2002-03 (9 months)
Zakat Disbursements	2	5	3
EOBI Disbursements	1	1	1
Micro Credit Disbursements	1	1	2
Total	4	7	6

Source: Economic Survey of Pakistan, 2002-2003, Finance Division, Government of Pakistan

8.3 Occupational Health and Safety (OHS) Laws

The Laws: The main law governing Occupational Health Safety (OHS) is the Factories Act 1934. . The Hazardous Occupation Rules of 1978 regulate certain occupations as hazardous, and contain special provisions to regulate the working conditions in those occupations. Each province has also enacted its own rules within the mandate of the Factories Act. In addition there are other laws dealing with OHS: The Mines Act 1923; Social Security Ordinance 1965; Workmen's Compensation Act 1923; Shop and Establishment Ordinance 1969 and Dock Labourer Act 1934.
The health and safety measures prescribed in most of the above laws have not kept pace with the rapidly changing times. Furthermore the use of standard Occupational Exposure Limits (OEL) now common all over the world is missing from Pakistan's laws. These laws need revision and updating[78].

Coverage provided under the Law: The major employment venues in Pakistan are grouped into four sectors viz. agriculture, formal sector, informal sector and service sector. The labour force is currently estimated at 39.4 million of which the industrial labour force constitutes to be 6 million, agriculture represents 17million and service 10 million. About 44 percent of labour belongs to the agriculture sector and 56 percent form the service and industrial sectors of which 20 percent is formal sector and 36 percent informal.

> Only 1.1 million workers out of total 39 million labour force in the country are covered by the aforementioned labour laws.

Large proportions of workers are employed informally in unregulated sectors like construction, agriculture, mining, in small-size back street enterprises, particularly women and children are employed by the informal sector with no regard for basic OHS standards. The informal construction

[78] Asian Labour Update (ALU) Issue No. 39, April - June 2001 Occupational Health and Safety in Pakistan

sector workers are not governed by laws that apply to formal sector employees, and the rate of accidents, diseases and injuries is consequently higher. Brick kiln workers are scattered across all four provinces of Pakistan. Their working conditions are worse than most others as it is either joint family labour or, as in some areas, bonded labour.

Children work in carpet making, automobile repair garages, welding shops, solid waster collection. This poses numerous hazards to their health, inhalation and skin absorption of chemicals and gases pose multiple health and disabling hazards. Breathing petrol fumes can also be addictive. Welding is often carried out without the use of protective devices. In Southern Punjab and Sindh during the cotton-picking season, a variety of diseases; disability and even mortality are reported among women cotton pickers.

Data Collection for OHS: There are no provisions for systemic OHS related data collection and the majority of work place accidents are not reported to the Labour Department. The incidence of occupational diseases and injuries though largely unreported is high because workers are routinely exposed to hazardous air particles and chemicals. Most employers do not provide OHS guidelines and employees largely being uninformed are not aware what protective measures should be adopted for their jobs. This results in an increasing toll of work related accidents, diseases and consequent disabilities. Diseases and accidents in the work place are a commonly occurring tragedy. Working conditions are appalling in hazardous industries like textile, tanning, chemicals, paper, sugar, electrical, and electronic. The workers in those industries fall prey to lung cancer, skin and eye allergies, deafness, headaches and resultant rates of disabilities are higher.

8.4 New Measures

Many new measures for the disabled have been announced in 2004, by the present government. Among other things the disabled are now entitled to free education, free health care, and fare concessions on airlines, railways and other public transport systems. and a quota for admission to technical and professional institutes. However, at present there are no laws requiring accessibility to physical environment including public buildings for persons with disabilities.

Chapter 9:

Physical Environment

9.1 The Need

The physical environment affects every individual's ability to function, and especially of those whose physical or mental capacity is constrained, where non-friendly physical environment can be an additional hindrance to his/her life. On the other hand, a physical environment that is designed and equipped to meet the needs of both able bodied and disabled enhances participation of PWD in normal life activities and their integration into the mainstream. This measure would play a great role in minimizing frustration and emotional instability among the disabled.

According to WHO, "the group of special needs users comprises more than 25% of the world's population and it includes people with disabilities, people suffering from ill health and people in normal phases of life cycles in which physical capabilities are typically limited (e.g. infancy, childhood, motherhood and old age)"[79].

9.2 The World Program of Action (WPA)

WPA for the disabled, adopted by the General Assembly of the UN in 1982, highlighted, that disabled peoples' lives are handicapped by physical and social barriers in the society which hamper their full participation. Because of this millions of children and adults in all parts of the world often face a life that is segregated and debased. All member states of the UN have unanimously adopted the WPA.

The WPA recommends that member states should work towards making the physical environment accessible to all, including persons with various types of disability by adopting a policy of observing accessibility aspects in the planning of human settlements, including programmes in the rural areas of developing countries. Member states are encouraged to adopt a policy ensuring disabled persons access to all new public buildings and facilities, public housing and public transport systems. Furthermore, measures should be adopted that would encourage access to existing public buildings and facilities, housing and transport wherever feasible, especially by taking advantage of renovation. Governments all over the world are now under an obligation to start planning processes to reach these goals.

9.3 International Standardization Indicators

The standardized indicators of physical environment for the disabled are available in specialized organizations as Disabled Peoples International (DPI), Rehabilitation International (RI) and the Council of World Organizations (CWO) working for the handicapped. Technical work is currently in progress within the ISO Organization for example the aim of ISO/TC 59/WG 1 is to promote the incorporation of specifications meeting the requirements of the handicapped in ordinary building standards. At country level it is important to reap full benefit from this highly competent international disability networks such as RI and DPI. Moreover there are extensive ISO standards

[79] World Health Organization, *Report on Disability Prevalence,* Geneva, 1993.

and recommendations available for the design of buildings and the local environment to meet the needs of the handicapped. These recommendations are based on intensive Research and Development (R&D) undertaken globally in this field and extensive data are available to planners. Research is continually being done today to improve the physical environment with regard to orthopaedic handicaps and impairments, sensory handicaps such as vision or hearing impairments and certain types of mental retardation. The research efforts and the level of knowledge, however, differ greatly from country to country. In Pakistani context international exchange would save resources and lead to quicker application of existing knowledge.

Integration of disabled persons in regular housing and work environment requires a combination of general accessibility, special adaptation and a flexible service organization. In many countries experiments to this end are being made, with different objectives and different forms of organization. Exchange of information about such experiments would accelerate progress of special interest that includes informational materials, standardization norms, regulations and financing conditions. The experiences of in-country disabled organizations in planning and decision processes would further provide beneficial insights

9.4 Accessibility Policy and Actions

In USA: Disability activism began in the late 1960s. By the 1970s it led to the development of the Rehabilitation Act of 1974, which made discrimination against people with disabilities illegal at institutions that received federal funds. It was not until the late 1980s that the disability made the general public more aware of disability rights. And finally through the Americans with Disabilities Act of 1990, the issue moved into the policies, actions and initiatives to decrease architectural and design barriers in built environment that are in existence in USA.

The Handicapped Rights and Rehabilitation Act of 1974 and the Americans with Disabilities Act (ADA) require the development of a transition plan describing how the institution will work to assure compliance with the physical accessibility requirements of the Acts. The Acts require that physical environment be accessible; they do not necessarily require public buildings to make structural changes in existing facilities as long as accessibility can be achieved by alternate means: Targeting specific priority buildings for accessibility and concentrating efforts on renovating and retro-fitting these buildings to meet or exceed barrier removal and physical accessibility standards. Buildings identified for renovations include all those buildings are accessible from ground level, have elevators, wide hallways and doors, and meet lavatory requirements. The Acts require that new construction and alterations meet all physical accessibility requirements including installing appropriate door openers, handles, and locks, establishing handicapped parking spaces adjacent to accessible buildings, ensuring appropriate signage in all buildings etc.

Both Handicapped Rights and Rehabilitation Act of 1974 and the Americans with Disabilities Act require the Universities to develop transition plans describing how the institution will comply with the physical accessibility requirements of the Acts. As regards colleges and universities, the Acts require that the universities ensure accessibility by locating programmes and services in or transferring them to accessible priority buildings, as needed on a case-by- case basis. Students with disabilities have priority in registering for classes. if a handicapped student signs up for a class in a non-accessible building or classroom, that class is rescheduled to an accessible room and building at the same time. Currently all universities promote and monitor compliance with the Uniform Federal Accessibilities Standards (UFAS) or the Americans with Disabilities Act Accessibility Guidelines (ADAAG).

In Iran: Until 1989, Iran did not have any comprehensive legislation for access. Since then the government has started to make some planning for legislation for disabled people. The Ministry of the Interior is working on planning and implementing legislation.The Ministry of Housing and City Planning is another government agency working in this area. There is also a research center for building and construction work. Addressing the needs of the disabled. The present legislation is stipulating access to public buildings. All cities have to obey this legislation.

In Egypt: Egypt has laws guaranteeing the right of disabled persons to education, employment and social welfare. But as far as accessibility is concerned they are in th process of getting people interested and aware in the issue.

In Pakistan: The built physical environment is more suitable for persons with physical strength, agility and mental alertness. It is not user-friendly for people with disabilities, elderly people, children, expectant and nursing women, infirm, and frail. Most of the buildings, whether private, public or commercial are not accessible even the streets are very much inaccessible to PWDs. Most persons with disabilities do not have access to information disseminated through the radio, television and newspaper and other literature especially the blind and the hearing impaired people. Very few recreation and sports activities are available specifically for PWDs, the only exceptions are those offered by special schools and disability NGOs.. Government and NGO insititutes and schools in the federal capital and provincial headquarters that have been specifically designed to accommodate the needs of PWDs.

The issues of disabled people have been low on political agendas and so have been among the powerful development authorities such as the Karachi Development Authority (KDA) and the Lahore Development Authority (LDA). Under the devolution of power plan to districts, (Local Government ordinance: LGO 2001) development of cities has been entrusted to the Housing and Town Planning Departments of the City District Governments (CDG). A review of Karachi Building and Town Planning Regulations (approved vide SO (Land) HTP/KBCA-3-39/2000 dated April 4, 2002) reveals that city planning and building design byelaws regarding the requirements of the disabled have been totally ignored.

Presently in Karachi, the largest and most commercialised city in the country, most roads have non-accessible pedestrian pavements for wheel chairs and white cane users. Those that exist have been largely encroached by the vendors of various kinds and there are no public toilets even for the able bodied people. Most public and private business enterprises, schools, colleges do not have support rails, ramps, or lifts to facilitate the disabled people. For people with mobility difficulties, steps and stairs are obvious barriers, restrictive width of door- frames, height of door handles, inaccessible phones and inaccessible toilets are among many other physical deterrents. Even in buildings where there are lifts, the press buttons might be beyond the reach of a wheelchair user.

The existing building regulations and bylaws are very outdated. Presently, there are no clearly spelled out provisions in either the building code or the legislation which adequately address the issue of accessibility to persons with disabilities.It is time for drafting the new building bylaws and regulations which will also include legislation for access for persons with disabilities. Under the present building control and town planning acts and the regulations thereunder, byelaws for accessibility for disabled have not been provided for. Karachi based urban development activists at NED University of Engineering drafted such regulations and presented to CDG of Karachi (CDGK)

that control building regulations and codes of practice in Karachi. CDGK made no efforts in pursuing the document. The conern of the activists is that the disability question was ignored and forgotten in the process of political debate and negotiations.

An important aspect that is grossly ignored is the transport sector. There are no special seats reserved in public buses for the disabled people, entering and leaving a public transport becomes extremely dangerous particularly in the case of visually impaired individuals. Moreover, in addition to lack of sensitivity there is reported bias on the part of transport workers to have the handicapped as their passengers.

The government has recently announced a number of initiatives to facilitate the special people to live as independently as possible with an objective to integrate the disabled into the mainstream of life. In early 2004 the Ministry of Women Development, Social Welfare and Special Education signed an agreement with the Capital Development Authority (CDA) and officially declared Islamabad as “Disabled Friendly City”. At present however most public places in the city including government office buildings, schools, colleges and universities both in the public and private sectors do not meet the requirements of the special people. On the initiative of MOWD,SW&SE, the cities of Lahore and Peshawar have also been declared by the respective provincial governments as “Disabled Friendly City” and measures are being taken in this direction. The Punjab Government and Lahore Development Authority (LDA) is developing building access byelaws for all new constructions of public buildings.

On the initiative of MOWD,SW&SE, Federal Cabinet has recently approved 14 measures for improving physical access of PWDs in buildings, parks and public places, which will soon be notified. These are presented in Annex VI.

Chapter 10:

Social Environment, Communication and Media

The team was unable to identify any recent studies or documents about the perceptions and attitudes towards the PWDs in Pakistan and also for communication and media activities. Some students' thesis were reviewed that had data based on very small sample size. Almost, all the information recorded in this section is based on the perceptions and observations of the key informants.

10.1 Social Environment

General Perception of Disability: Disabilty is considered a taboo in Pakistan and persons are portrayed with objects of pity and charity. Presence of a disabled in the family is though recognized by many as a condition resulting from disease or injury, but is generally considered to be due to *God's Will*.

Family Attitude Towards Disabled: In general, the attitudes towards the disabled is a mixed one in the families. In majority of houses, disabled person gets extra love and care and family members take pains to take good care, while in others they are badly treated or neglected, such as putting chains on them have been reported. Similarly, some families consider a disabled member as an economic burden while many do not hold this perception. However, presence of a disabled in home appears to create tensions, especially when neighbours or others who retaliate on some of the actions of the PWD or even tease or abuse without any provocative actions. The behaviour of the PWD in the house could also lead to reactions within the family if they exhibit uncontrolled behaviour (especially by mentally retarded).

The parents suffer with worries of the present and future of the PWD. The general desire is that the child is accepted by peers and streamlined with their activities. Encouragingly, generally the families believe that disabled should also be educated, get jobs, be married, and be able to survive like others, but have difficulty in attaining this desire due to limited facilities. However, this does not apply for those who have severe types of disabilities.

An impresion was conveyed that there is difference in behaviour towards male and female disabled persons. Sons are encouraged for participation in activities both in the home and in the community, while not much attention is given to girls.

Mostly persons with physical and mental disabilities are cared for by their immediate families, but those who lack family care are forced into begging and organized criminal "beggar masters" make handsome earnings through them. Parents reportedly have given children as offerings to Baba Shah Dola, a shrine in Punjab, where the children reportedly are deformed intentionally by clamping a metal form on the head that induces microcephaly[80].

Community Attitudes: A very large number of families have expressed to the NGO and public sector workers that they face humiliation from the community members for having a disabled

[80] Bureau of Democracy, Human Rights, And Labour, *Pakistan Country Reports on Human Rights Practices* - 2002, 31 March, 2003

person in the house, and it also reduces the family's social status. Hence, minor or hidden disabilities are kept a secret.

People, due to lack of knowledge and insensitivity to disability and experience of interacting with disabled persons at the personal level, often feel uncomfortable in their presence. These negative attitudes also arise from superstition and fear, which are prevalent in many asian societies.

Even the disabled themselves complain of being teased or physically abused by community people, and this maltreatment has come from peers and others. They mention stones being thrown at them, being slapped, hit or publicly humiliated with slurs.

Discussions with community leaders show that they agree that disabled persons should be treated with dignity, given love and opportunity to realize full potentials and community should have positive attitude towards them. They agree that the disabled persons must be encouraged to participate in social and community development activities, however no serious effort has been made so far by the local governments. However NGOs working for the disabled have made demonstrable efforts to mainstream the disabled in meaningful roles. There is a need for greater community role to help the disabled, especially those who are poor and homeless.

Parental Involvement: Most public sector SE and vocational training schools work in successful cooperation with the parents through Parent Teachers Associations (PTA). The role of parents has an important bearing on education and training of disabled children.

Caretaking of Disabled: Some disabled persons can manage most of their daily activities, while others need assistance and in majority of cases it is provided by a women in the household, i.e. mother, sister, or sister-in-law. There are examples of provision of disability specific physical environment at household level to support the movement and activities of a disabled household member, examples to this effect are special furniture, provision of prosthetics or assistive aids such as walking sticks.

Expenditures on Disabled: Generally, expenditures on disabled for clothing and foods, education, training, and support equipment are minimal. Majority of extra expenditures are on treatment and all these are lesser for female as compared to male children. The nature of treatment sought varies ranging from faith healers to hospital care, type of disability, residence of the family, availability of facilities, and educational and social status of the family.

Faith healers play an important role, especially in rural settings. People also pray or make offerings at shrines seeking betterment of the disabled. Somehow, mental and mobility disabilities often get more attention than hearing or speaking disabilities. It is also important to record that in substantial number of cases no remedies are sought.

Women and Disability: Disabled women are often discriminated against not only because they are disabled but also because they are females (The Double Disadvantage). They face the same prejudices, disadvantages, and exclusions as non-disabled females face in legal, social, cultural and economic context. Disabled females are more likely to be illiterate and without vocational skills and therefore more likely to be unemployed. They have less access to social services than non-disabled females do and have comparatively less access to rehabilitation services than disabled men. They have less chance of finding a marriage partner and having a family. As disabled women they are often physically, emotionally and sexually abused or deserted by the father of the children and left to fend for themselves on their own. Because women are more likely to be the carers in the

family, disabled women who are physically unable to perform this demanding role are more likely to be left without family support (including physical, emotional and financial support) unlike their male counterparts. Superstitious beliefs and prejudices contribute strongly to the social isolation of disabled women, be it directly or indirectly.

A large number of parents face difficulties in helping their daughters with disabilities to become more self-reliant and, ultimately, independent. While the issues of independence and self-determination obviously apply to sons with disabilities as well as to daughters, however typically the degree to which daughters with a disability are encouraged to strive for an independent life is perceived to be less important in the society in general. This is obvious seeing the differences existing in how males and females are socialized, counselled, and educated. These differences have far-reaching implications for how males and females view themselves and what they achieve. Females with disabilities are achieving less in terms of employment and socialization into the mainstream of life as compared to men with disabilities, with the vast majority of women living dependent lives in comparatively impoverished circumstances. As a society, Pakistanis are committed to helping all persons with disabilities eventually live independently and with as much self-reliance as possible, but independence, particularly for girls, is a sensitive issue. The society is not founded upon a belief in personal freedom of girls and the right to make their own life choices about education, work, relationships, and so forth. Today, through research, education, and exposure to successful people with disabilities, realization is coming that individuals with disabilities irrespective of gender have the same rights as the rest of society.

Concept of Independent Living : The question is whether provision of accessible phycial environment and the concept of independent living associated with developed countries could be applied in a developing country like Pakistan . The independent living movement in the developed countries was influenced by the civil rights movement. It called for the granting to disabled persons of the prerequisites for living in the community, such as entitlement to income and medical assistance, educational rights, the right to treatment and other social services. It is generally misconstrued that in developing countries particularly in South Asia where mutual caring and support in the family is a norm, there is no need for disabled persons to live physically and financially apart from their families. Most disabled persons in these countries are too poor and illiterate and are not even aware of such enabling services. The fact is that traditional method of caring for disabled member places more burden upon the poor families, while only rich families can afford to employ domestic help to serve as attendants for the disabled.

Access of disabled persons to all opportunities, equal to non-disabled persons; self-control by disabled people of their lives and participation in decision-making are important issues. Only a few studies have been done concerning the independent living of disabled persons in the Asia-Pacific region.The region covers more than 60 per cent of the world's disabled population. Disabled persons in Pakistan have in some instances demonstrated that they can collectively exercise control over their lives through self-help activities, often through nation-wide organizations of disabled persons such as the Pakistan Association of Blind (PAB) and various other organizations in the country such as All Pakistan Handicapped Adults (APHA). They aim at the independence of disabled persons through advocacy of a positive image and human rights of disabled persons. At the State level, it is time to examine the existing laws and provisions in terms of full human rights of disabled persons.

Perceptions in Other Asian Countries: In Bangladesh, a common attitude towards disabled persons is that "disability is what God has desired for them and there is nothing that can be done

about it". This attitude condemns disabled persons to a state of dependency and inferiority. The parents of a disabled child in Nepal are reconciled to its birth as "misfortune" which has befallen the family in terms of the "coming of a criminal to a family". In Bhutan, disability is linked with the manifestation of evil spirits in this or the previous life. Experience shows that negative public attitude toward disability is less only when disability arises from combat duty or-national service. The war-disabled are, nevertheless, regarded as a burden to the family and community, if they are not self-reliant and financially contributing members.

10.2 Communications and Media

Public awareness through media and other communication channels, especially awareness of political and elected leaders, is a vital factor in the effort for attainment of full human rights of disabled persons. A lot of authority also lies with religious leaders,and village/tribal headmen. They assist, influence and mobilize in both postive and negative manner. It is often difficult to motivate these leaders to be interested in disability issues because of the prevailing misconception of disability, which is much stronger in rural than urban areas.

Changing negative attitudes through public enlightenment and information is essential. Some of the strategies recommended to promote independence of disabled persons in the region are: recognition of the roles of the judiciary, civil services, executive and community in implementing the World Programme of Action (WPA) concerning disabled persons; recruitment of men and women with disabilities who have proved to be successful as advocates for change; preparation of a handbook or manual giving an appropriate non-devaluing and non-emotive factual representation of disability and disabled persons; and more scientific and extensive utilization of the media to portray people with disability in a positive light.

Media, in the form of television, radio, print, movies and theatre is a uniquely powerful tool. It shapes the way in which society views and understands the world. Whether one uses media on a micro or macro level, it has the unequalled capacity to examine, communicate, educate and inform about people, places and ideas. Mindful of its ever-expanding nature and role in shaping society's views of itself, it is important to examine the way in which media communicates images of disadvantaged groups, minority groups, marginalized groups and one such group is the disabled.

The Role of Media In Pakistan: The role of media in changing society's view of disability and disabled people is vital. The media has played a mixed role and is partially responsible for portraying PWDs as in need of pity or deserving charities. It has not yet been able to play an effective role in helping them to integrate into society.

The media has described disabled people by using unecessary phrases such as ‘X’ “achieved this success” *in spite of being paralyzed/deaf/blind or despite his/her amputated legs*. Their intentions may be good, but phrases such as these have been felt to be discriminatory by the disabled persons. Again, the media portrays PWDs as deserving by using words such as victim, afflicted or inflicted. These words also sensationalize disability. Negative images and language by the media , make the society believe that disabled people are sick people who need to be sent to a hospital or an institution of some kind. This is a reflection of a Pakistani society where negligible numbers of disabled people are seen interacting with non-disabled people in places of employment, in schools, in sports, in politics and in the places of worship. These negative attitudes are based mainly on superstitions that have existed since time began. These attitudes have been created, re-inforced and perpetuated by what people hear, read and see in the media. As it stands, visual

media, including television and film, negates the existence of disabled people, by virtue of its portrayal. The sight of a disabled person thus becomes unusual sight, and in public they are stared, leaving disabled people feeling like outcasts in society.

Disabled suffer from the media industry's attitudinal prejudices on at least two counts. First, roles rarely portray disabled people as successful people other than the boringly predictable overcoming illness or disability. A disabled person could be a successful doctor, a lawyer, a journalist etc. Secondly, popular (i.e. commercial) entertainment that overly concentrates on romantic dramas, costume dramas and soap operas inevitably denies opportunities for disabled performers. The stereotypical roles that are there for disabled performers include those of villains, victims of crime, sick patients, etc that are not positive role models.

However, there are distinct and important but limited examples where state managed television and radio has highlighted the abilities and issues of the disabled persons. PTV World transmitted a weekly Program '*Har Dam Rawan Hay Zindagi'* for six months in 2003 that had interviews of people working for the disabled, documentaries about existing services and the success stories of and for the disabled. However, the programme was not aired during the prime time. Also PTV Islamabad Studio has recently given coverage to issues of the disabled in talk shows discussing social issues.

Radio Pakistan, Islamabad and Lahore Stations are broadcasting a weekly programme presented by or for the disabled for the last six years, titled "*Hoslay Buland Apnay".* Similarly, Peshawar Station is broadcasting a similar weekly programme' *Jawan Himmat Log".* FM 100 radio channel is also broadcasting a weekly programme presented by a physically handicapped female for the disabled from Islamabad.

A monthly magazine '*Pakistan Special'* is being published from Islamabad since 1999 that highlights the issues of disability and disabled persons. It has both English and Urdu sections.

Media in UK: The BBC was once very daring and adventurous by casting a disabled performer in a leading role in one of its soaps "Eldorado". Julie Fernandez, an actress who uses a wheelchair, looked set to pave the way for other soaps...until the "hate mail" from the viewers, who complained that she shouldn't be allowed on television. Such a response seemed to have frightened the BBC off the idea of having disabled people featured on mainstream, prime-time television. The BBC and Channel Four, forced by the Government and market forces to be ratings conscious, are providing less and less opportunities for disabled performers. In the early Nineties, the production department of the British Film Institute (BFI) started to seriously consider making movies about disability issues with disabled actors in leading roles, or films by disabled writers and disabled directors. Before they could start of on the idea BFI production was disbanded and then absorbed into the Film Council, whose mandate is to only fund commercially viable films.

Members of the Broadcasting and Creative Industries Disability Network (BCIDN) in UK have embarked upon an initiative "manifesto for change". Launched in 2002, The initiative aims at increasing the presence of disabled people on air and on screen. Ten leading TV and film companies, including the BBC, ITV, Five, Channel Four and Carlton TV are all members of the BCIDN. All ten companies have begun fulfilling their commitment in the key manifesto areas. The BCIDN's progress report in 2003 coincided with the publication of a study suggesting that nearly four out of five people questioned said they were in favour of a disabled person reading the main evening news bulletin. Viewers thought more disabled people should be seen on screen. Sixty-one per cent of viewers said there should be more portrayals of disabled people in a wide variety of

roles - including as presenters. Moves to include disabled people in TV advertising were also welcomed, especially where it challenged negative stereotypes and promoted positive images of disabled people[81].

News Coverage of Disability issues in USA: The study **"**Final Report for The Center for an Accessible Society July 1999" by Beth A. Haller, Ph.D.conducted as part of Grant No. H133A980045 from the National Institute on Disability and Rehabilitation Research investigates how the national news media presented disability. This study intended to understand what is being presented about disability in the major mainstream news media. The study comprised analysis of newspaper, news magazine, and network TV news stories about disability. Eleven newspaper and news magazines were selected on the basis of their volume of circulation in the country and four networks: ABC, NBC, CBS, and CNN were included. An important finding of the study was that during the entire year of 1998, the four major television networks presented only 34 disability-related news stories, many of which were predominantly based around two or three news events. This illustrates that TV networks do not give much priority to issues related to about 52 million Americans with disabilities.

10.3 Advocacy

Historically, actions for the disabled leading to better opportunities, more services and programmes were initiated in many cases either by the disabled themselves or by their families. Perhaps the best example of this is Louis Braille, the inventor of the Braille Script which has provided blind people with the most satisfactory means of reading and writing by touch. Braille indeed opened the flood gates of knowledge to the blind and removed one of the major obstacles in the path of equalization of opportunity for blind people. In Pakistan, invaluable pioneering work in advocacy for disabilities has undoubtedly been done by voluntary social workers running NGOs for the PWDs, as indicated in the section on Evolution of the Programme.

Organisations of the PWDS have been formed in Pakistan and are playing very useful role in advocacy of the rights and responsibilities, and promotion of equal opportunities. They serve as pressure groups and watch-dogs of the rights of the disabled. Some important examples are the following:

Pakistan Association of the Blind (PAB) launched by late Dr. Fatima Shah in January 1960, is linked with many international bodies of the disabled. From various platforms and through print and electronic media, it has advocated for the rights of disabled for the last over four decades. PAB has now about 40 registered and non-registered branches throughout Pakistan, including AJK and Northern Areas. Their main agenda includes I) creating public awareness about the rights of disabled persons ii) production of talking books & Braille books iii) provision of vocational rehabilitation through networking. Fifteen districts branches also run primary schools/vocational training to prepare blind to join the main stream. PAB has its headquarter in Karachi with branches in Peshawar, Multan, Faisalabad, Lahore, Rawalpindi, Khiarpur, Hyderabad, Nawabshah, Mirpur Khas, Swabi, Larkana, Sukkur, Ghotki, Bahawalpur, Bahawalnagar and D.G. Khan.

Pakistan Alliance of the blind is a Faisalabad self based advocacy program. Through its center called "Alminat" it provides age approach private training to the blind children and adults to enable them to join the mainstream of life.

[81] BBC NEWS UK " TV ignoring disabled people".htm. Last updated: Thursday, 12 June, 2003, 16:49 GMT 17:49 UK

In early 70's Association of Physically Handicapped Adults (APHA) was started in Karachi by a group of PH adults. It worked to promote awareness and social integration of disabled, particularly PH and MR. It held sports competition at the city level (Karachi) and cultural shows, participated by PH & MR. It has now also established , in Karachi a Prosthesis workshop based on modern technology.

Disabled Person International Pakistan (DPIP), a branch of the international body called (DPI) was launched in 1988. It has now its provincial chapters, at all provincial headquarters. It focuses on protection of rights of person with disabilities with its slogan "Voice of our Own". It occasionally organizes National Leadership and Training Program.

In 1984, parents of MR children formed an Association "Parents Voice" in Karachi. The association established a SE center (UJALA), in 1986, which now has also vocational training unit for boys and girls. Parents Voice also regularly brings out a monthly magazine to create awareness about the potential abilities of the MR and also the nature of problems faced by them and their families. During meeting with some of their some of the parent members, the most outstanding concern expressed by them is absence of provisions to ensure a safe living for severely retarded (particularly girls) needing custodial care, after the death of the parents.

Pakistan Foundation Fighting Blindness (PFFB) was started in Rawalpindi/Islamabad with focus on prevention and early detection. It has been carrying out medical research on genetically oriented retinal diseases, of which Retnitis Pigmentosa is the most common one. It also has started a VR center for disabled women of all 4 categories. A program named Audio World was launched in 1995. it provides talking books of syllabus from 5th to B.A level. It also provides leisure time general books (fiction Autobiography etc).

STEP is the most recent advocacy group launched in 1997, by young educated PH persons. Its main agenda is to develop leadership capabilities in the disabled and give them confidence and strength to develop their abilities maximally. STEP is now working on cross disability movement including person with three disabilities (HI, PH, VH) and parents of MR children. It has organized International and National seminars on independent living & leadership training. It has also provided opportunities to its members to attend leadership courses for disabled in Japan, Nepal, and Thailand.

Unfortunately, many organisations of the disabled are mostly critical of the Government offices of Special Education, Social Welfare etc., hence the advocacy efforts loose strengths. Also, the organisations of the disabled have in recent years indulged in rivalry and infighting that has contributed to the dissipation of their energies.

Any significant changes in attitudes and true equalization of opportunities will occur only when disabled people fully accept their responsibilities to contribute to the betterment of the community and society. Hitherto, they have been at the receiving end mostly asking for and receiving charity, concessions and special facilities. To achieve equalization of opportunities they need to ask for integration in services and programmes available to all in the community e.g., education in regular schools, vocational training in centres and programmes available to all members of the community and employment along side and along with non-disabled workers. The advocacy is required at all levels from top politicians to influentials in the communities.

Section 5:
Key Findings

Chapter 11:

Conclusions

General:

1. DGSE has played a pioneering role in promoting the programmes for persons with disabilities (PWDs).

2. The terminology "Special Child" used by the Programme has had a positive implication in the lives of PWDs and their families.

3. The SE nomenclature adopted by the Ministry (MoWD,SW&SE) is very narrow that limits the scope of work for holistic approach towards PWDs.

4. Two out of the three major components of the current programme i.e. education and employment have remained far apart from the respective line ministries and departments.

Definitions, Causes and Magnitude:

5. Officially, the definition for disability for use in Pakistan has only been described in the 1981 Ordinance for Employment of Disabled, which is vague. Though the programme persons mentioned that they use WHO definitions but their comprehension and interpretation varies significantly.

6. The available data about persons with disabilities is not accurate. Attempts have been made to assess the extent of disability in all population censuses conducted to date, but the modules about determining disability status have been variable. Hence time series analyses have not been possible and also there is lack of agreement about the reported figures for the disabled persons.

7. Also the proportionate share of different causes (congenital, diseases, injuries, etc) in contributing to disabilities in Pakistan is not known.

Institutional Arrangements:

8. At the top level of the programme there are five major bodies working for PWDs. i.e. DGSE, NCRDP, NTD, NIH and SE Departments in three universities, but there is minimal interaction between them.

9. The institutional arrangement is such that the DGSE (nucleus of the programme) is working in isolation without formal intersectoral and interministerial linkages. Furthermore there is lack of

integration of DGSE led services with the corresponding provincial line departments (Social Welfare in three provinces and Special Education in Punjab), and now with the district governments.

10. The organizational structure at DGSE has uneven distribution of responsibility that has significant influence on monitoring and development of the programme. Furthermore, persons with non-related background have been posted in key decision-making and managerial positions, who lack understanding about the programme needs and its developmental requirements.

11. DGSE has demonstrated the consistency of approach that has helped in its progressive evolution. Despite several shortcomings, overtime DGSE institutions have accumulated a considerable level of knowledge and experience in SE and vocational training.

12. Several specialized institutes have been established at the federal level with broad mandates. They were to be Centers of Excellence to serve as models, and to play the leading role in development of the program in their respective field, which they have not yet been able to accomplish and are working as service centers. However, they have been able to contribute in the human resource development, and to same extent in supporting employment.

13. With the devolution, SECs of provincial governments have been taken over by the districts governments. Consequently the role of provincial line departments has been minimized and the technical support to the SECs has been slowed and weakend.

14. 117 NGOs share a considerable workload of the programme, however, the link between them and DGSE is not optimal. Furthermore, the funding to NGOs by DGSE is limited to only 26 and with very small grants ranging from Rs. 25,000 to 450,000. Interestingly, NGOs are in mutual competition of resources and fame and the country programme has not been successful to bring unity among them.

Financing of the Programme:

15. The financing of the public sector programme is from the government budget. Currently, no donor is providing assistance, except support to small-scale projects. Zakat and Bait-ul-Mal also does not provide any direct assistance to the DGSE. Parent-Teacher Associations (PTAs) formed in SECs are raising donations to support services.

16. The NGOs are raising funds for managing their programmes. Some of them receive small grants from DGSE, and a few from Bait-ul-mal and Zakat Funds.

17. SE cost per child is noticeably lower in SECs of the NGOs as compared to public sector centers.

Prevention, Early Detection and Intervention:

18. A broad-based multisectoral active collaboration and commitment is lacking for primary prevention of disabilities, such as among ministries/departments of health, information and mass media communication and works, National Highway Authority (NHA), police, law and justice and the MoWD,SW&SE. For example, several MOH programmes are carrying out

activities of primary prevention of disabilities such as IDD control and polio eradication however, these have no link either with MoWD,SW&SE or DGSE.

19. No formal programmes exist in public sector at federal or provincial level for early detection. LHWs, who follow the road map of a child's development lack knowledge and skills in detecting developmental delays. However, there are few examples of early detection services in NGO and private sectors.

Education and Training:

20. A network of about 266 SECs has been progressively established over the last 23 years by the federal and provincial governments and NGOs (44 DGSE, 92 provincial governments, 3 NTD, 117 NGOs and 10 armed forces). These provide enrolment to about 22,000 children with Special Education Needs (SEN). However, the quality of services is variable and the shortcomings needs redresssal.

21. Out of the currently estimated 1.28 million population of disabled children of 5-19 years, only about 1.7% of children with special education needs are enrolled in SECs. The enrolment proportions in government SECs for male and female are 65% and 35% respectively.

22. All SE centers are located in urban areas while 66% disabled population resides in rural areas. Most of the children in government and NGO SECs belong to the middle or lower middle-income groups. Higher income groups are seeking schooling in the private sector SECs.

23. The disability specific SECs in the public sector do not commensurate with their estimated proportions in the country.

24. A variety of SE curricula of variable quality are in use throughout the country, hence the education lacks uniformity. Curricula prepared by NSECs and NISE have not been adequately disseminated.

25. The quality of training in SECs varies from low to high. It depends on the training of teachers, posting of appropriate personal, quality of curricula, availability of textbooks, other resources and assistive aids, motivation and interest of the teacher and supervision.

26. PTAs are playing important role in supporting public sector SECs. This has helped the management to upgrade some of them from primary to middle, matric and intermediate level.

27. The government of Punjab is giving higher priority to SE than other provinces and has appointed a Minister to lead the programme.

28. The prospective development plan 2001-2011 of Planning Commission, GoP has clearly given direction to move from SE to IE. There is general agreement to implement inclusive education among concerned officers in MOE, DGSE, provincial departments and district government, but very minimal steps have been taken in this direction. A few NGOs and private sector schools have shown examples of success.

29. DGSE has played the lead role in establishment of master's level course for training of SE teachers. More than 2,300 have acquired the degrees and are working in public, NGO and

private sector schools. The master's level training is largely theoretical and lacks practical training due to lack of facilities for hands-on experience.

30. In 18 years, NISE has conducted 298 courses of 1-2 weeks duration for SE teachers that provided training to 6610 participants (not individuals as many have attended several courses). However, these have been conducted without any needs assessment and without medium or long term planning. No follow up has been done to assess the impact of these trainings. The general impression of the trainers, trainees and their supervision is that the current duration of the training is not adequate.

Vocational Rehabilitation:

31. The Vocational Rehabilitation (VR) programmes and services are limited in scope and not geared to current market needs. Public sector Community-Based Rehabilitation (CBR) is limited. NCRDP and PCRDP could not play a meaningful role in arranging trainings in mainstream polytechnic institutes.

32. The corporate sector in Lahore has taken initiative to rehabilitate the disabled which could be taken as example by Chambers of Commerce and Industry, in other cities.

33. Both public and NGO sector have introduced micro credit in their VR and CBR programmes. However, there is no evidence of availability of any specifically designed micro credit programme for disabled by major institutions like SMEDA, First Women bank, Khushhali Bank, etc.

34. There is an overall lack of business/marketing plans for VR of disabled.

Medical Rehabilitation:

35. Presently medical rehabilitation services are available at provincial and to some extent at district headquarters level. However, the existing services generally lack appropriate specialists, equipments and funding for prosthesis, orthotics and assistive aids. The existing medical rehabilitation facilities both public and private sectors are inadequate to meet the demand.

36. The provision of appropriate training in the field of rehabilitation medicine is extremely deficient both at undergraduate and postgraduate levels.

37. The current facilities in public and private sector are also not sufficient to meet the current demand for orthotics and prosthetics. Under the prospective development plan 2001-2011, establishment of orthotic-prosthetic workshops are to be pursued in large teaching hospitals.

38. The proportion of nuclear families and elderly population is on the rise, however, no exclusive services or programmes for the aging population have been conceived with in public, NGO or private sector.

Legal and Physical Environment

39. A range of laws that impact prevention of disability, rehabilitation and employment of disabled have been made, but their implementation is weak. The implementation of 1% quota system has not met with much success inspite of existence of NCRDP and PCRDP network.

40. The Workmen's Compensation Act allows temporary and permanent disability benefits to workers earning less than Rs. 3000 per month, however its implementation is weak. Committees under Nazims are being formed for improving implementation of the law.

41. Only 1.1 million workers out of total 39 million labour force are covered by the Occupational Health and Safety (OHS) laws.

42. There is no law for providing barrier free access to PWD in built areas. Public, private and commercial buildings and facilities do not cater to the needs of the disabled. The environment is more suitable for persons with physical strength, agility and mental alertness. It is not user friendly for PWD, elderly people, children, expectant and nursing women, infirm and frails.

43. Building codes for provision of access to PWDs currently do not exist. Similarly, Town Planning codes have not been conceived.

44. The existing building regulations and byelaws are very out dated. Drafts prepared by development activists for new legislations regarding access for PWD have been ignored. However, CDA has taken the initiative to declare Islamabad as "Disable Friendly City" and measures are being taken in this direction. Punjab Government has also instituted measures to make Lahore a "Disable Friendly City" also.

45. Cabinet has recently approved 14 measures for improving physical access of PWDs in buildings, parks and public places, which will soon be notified.

Social Environment, Communications and Media:

46. Disability is considered a taboo in Pakistan and persons are portrayed as objects of pity and charity.

47. Attitudes towards disabled in families and communities are mixed, ranging from extra love and care to neglect and harsh treatment.

48. Females suffer the "Double Disadvantage" of being disabled and female. In addition, mothers of disabled children face family and societal stigma.

49. The media has played a mixed role and is partially responsible for portraying PWDs in need of pity for deserving charities. It has also shown positive images of PWDs but not to the extent that could help to integrate them into society.

50. Associations of the disabled persons have played a very important role in advocating for opportunities, programmes and services for the PWDs.

Section 6: Recommendations

Chapter 12:

Proposed Draft National Plan of Action (NPA)

This draft NPA responds to the National Policy for persons with Disabilities 2002 and is based on the findings of the situation analysis conducted between March to May 2004. This strategic plan has been developed after holding detailed individual and group consultations with over 100 government, NGO and private sector stakeholders at federal and provincial levels; and is more focussed for actions to be taken in next five years. However, recommendations upto 2025 have been made.

It is based on the philosophy that access, inclusion, and equalization of opportunities for PWDs cannot be achieved by isolated interventions, and the services are to be designed in an integrated manner with the goal of full inclusion. Investments in PWDs cannot be realized if services are unable to work in a coordinated manner. To meet the philosophy, some restructuring and adjustments in roles at DGSE and its allied institutions will be required; and funds will have to be mobilized through several sources. Furthermore, the goal will only be met by extending the services to the rural areas (where two-third of the disabled live) that are currently neglected.

It is important that this proposed NPA is read as a draft to initiate the dialogue and discussion at federal, provincial level and district levels. To finalize the NPA for Pakistan, and for translating it into provincial and district operational plans, a consultative process should be initiated that effectively involves all stakeholders to make it relevant to the needs of each province. The recommendations made for actions, responsible authorities identified, and time frame mentioned should be seen as suggestions for consideration by the team.

It should also be noted that the team had made an attempt to distribute the workload, for example, NTD has been assigned some new roles. Again, these should be read as suggestions.

The areas for action are:

1. Enhancing the mandate of DGSE and restructuring
2. Determining the extent of disabilities and distribution of causes
3. Improving prevention of injuries, deficiencies, diseases and other factors known to cause disabilities
4. Mobilizing early detection and intervention.
5. Escalating the medical rehabilitation services.
6. Strengthening of Special Education for children with severe and moderately severe disabilities
7. Promoting Inclusive Education for children with SEN.

8. Expanding and reinforcing vocational training, employment and economic rehabilitation
9. Pursuing implementation of existing laws for PWDs
10. Creating of Barrier-free physical environment
11. Raising public acceptance and improving social integration and environment
12. Boosting capacity for production and supply of prosthetics, orthotics and assistive aids and other supporting items and facilitation in duty free imports.
13. Increasing support to the NGOs

In order to achieve the above successfully, there is a need to actively involve all stakeholders including relevant ministries, departments, district governments, associations of persons with disabilities, and NGOs working for the disabled at national, provincial and district levels.

Action 1: Enhancing the Mandate of DGSE and Restructuring

Goal / Outcome:	The core national body entrusted to work for the disabled is empowered to adopt a holistic approach towards the issues of Persons with Disabilities (PWDs).
Identified Barriers:	The current mandate of DGSE is focused on primary level Special Education (SE), Vocational Rehabilitation (VR) and Employment.
Performance Indicators:	Implementation of the identified necessary steps to bring in the desired expansion of DGSE's mandate and restructuring.

Immediate Steps (January – December 2005)	Responsibility	Timeframe
1.1 The Ministry should be renamed as "Ministry of Women's Development, Social Welfare and Special Persons".	Minister of Women's Development, Social Welfare and Special Education & Federal Cabinet	January –June 2005
1.2 DGSE should be renamed as Directorate General of Special Persons (DGSP) and restructured to provide an umbrella to all priority aspects of the disability services. The suggested new structure comprises one director each for the following six areas: • Prevention, Early Detection, Intervention and Medical Rehabilitation • Education and Training • Vocational Training and Rehabilitation • Physical Access • Legislation • Advocacy, Communication and Media The responsibility of each Director will be to hold policy dialogue, plan new initiatives, provide technical guidance and conduct monitoring to ascertain quality and progress.	Secretary and Director General	January – June 2005

1.3 Persons with relevant qualifications be placed in key decision making and management position.	Secretary of MoWD,SW&SE and Establishment Division	January – June 2005
1.4 DGSP should establish a National Forum for Special Persons (NFSP) with membership of relevant ministries represented by their secretaries such as Health, Labour & Manpower, Sports and Culture and Media. Similar chapters should be established at provincial (PFSP) and district levels (DFSP). Representatives of Associations of Disabled and NGOs working for Disabled should be included as members with proportionate representation. This is important to establish formal interministerial linkages at federal, provincial and district levels.	Federal and Provincial Secretaries and District Nazims	July – December 2005
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
1.5 Role of each ministry should be defined in the holistic disability services programme and formal inter-ministerial institutional arrangements be established.	NFSP/PFSP/DFSP	January – June 2006
1.6 To strengthen the work for special persons, orientation of the Nazims, EDO Community Development, DO-SW to be organized at provincial levels.	NTD	July 2006 – June 2009

Action 2: Determining the Extent of Disabilities and Distribution of Causes

Goal / Outcome:	Accurate assessment of magnitude of the problem and their causes at district level for efficient planning and effective implementation of disability services.
Identified Barriers:	The available data on PWDs are not accurate and distribution of causes is not determined.
Performance Indicators:	Reliable mechanisms instituted for collection of district level information.

Mid Term Steps (January 2006 - June 2009)	Responsibility	Timeframe
2.1 Adapt WHO-ICF for measuring disabilities and propagate the same at all levels i.e. from federal policy levels to service delivery points in the community.	Director General DGSP, MOH with WHO's Technical Support	January – June 2006
2.2 Sample surveys be conducted in selected districts, based on standardized definitions to determine the distribution of causes and extent of the disabilities.	Provincial counterparts of DGSP through professional firms	July 2006 – June 2007
2.3 A databank on disability be established at federal and provincial level, which should include statistics on causes, types and frequencies of disabilities, as well as available services and programmes.	Federal and Provincial Bureau of Statistics	July 2007 to June 2008 and onwards
2.4 Data generated to be disseminated by posting on the web, through associations of persons with disabilities, and actively sharing with the government and NGOs officials working for the programme.	NL&RC	January 2008 onwards
2.5 Carefully designed modules based on ICF to be introduced in National Population Census and other public sector household surveys.	Director General DGSP, FBS and PCO	2008

Action 3: Improving Prevention of Injuries, Deficiencies, Diseases and other factors known to Cause Disabilities

Goal / Outcome:	Reduction in incidence of disabilities through primary and secondary prevention.
Identified Barriers:	The current programme has no role or linkage with prevention programmes.
Performance Indicators:	Formal inter-sectoral linkages are established at all programme levels.

Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
3.1 Aggressively pursue the strict enforcement of relevant road safety laws such as those for helmet, car seat belt use and mobile use etc.	NFSP/PFSP, NHA, Traffic Police, ARUP	January 2006 onwards
3.2 Amicable collaborative efforts with MOH should be initiated to strengthen current disability prevention programmes and take new initiatives: • Measles Immunization • IDD Control • Iron Supplementation • Training of skilled birth attendants • Genetic Counseling at Teaching Hospitals • Genetic Counseling at DHQ Hospitals • Genetic Counseling at THQ Hospitals	Secretary MoWDSW&SE and NFSP	January 2006 onwards
3.3 Plan and conduct in collaboration with associations of disabled and NGOs working for disabled, a series of seminars and workshops in schools and colleges on prevention of disabilities, both in rural areas and urban areas.	NISE, District Nazims, EDOs Education, Community Development and Health	January 2008 (After survey of causes of disabilities)
3.4 Introduce disability prevention as a subject of training for boy scouts and girl guides all over the country at district level.	NISE, District Nazims, EDOs Education and Community Development	January 2007 onwards
3.5 Implement programmes to raise public awareness of consequences of Violence Against Women (VAW) that lead to disabilities in them or foetuses in their womb.	Federal and Provincial Minister of Women Development, and Women NGOs	July 2006 onwards
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
3.6 Forcefully advocate the implementation of Occupational Health and Safety (OHS) laws in industries in both formal and informal sectors, particularly those that are hazardous.	NFSP/PFSP, Ministry of Labour, ESSI, PILER and Labour Unions/Activists	July 2010 onwards

3.7 Vigorously pursue the Mental Health Ordinance 2001, which has a potential in significantly impacting psychiatric impairments.	NFSP/PFSP/DFSP & Pakistan Society of Psychiatrist	July 2010 onwards

Action 4: Mobilizing Early Detection and Intervention.

Goal / Outcome:	Minimize the incidence and impact of disabilities
Identified Barriers:	Early detection and interventions are being carried out at a minimal level in public and NGO sectors.
Performance Indicators:	Enhanced rates of early detection and intervention in public service delivery system and NGO centers.

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
4.1 A course should be developed/adopted for refresher trainings conducted at on-the-job teachers' training centers such as TRCs.	DGSP & DoE	July – December 2005
4.2 NGOs who have demonstrated successful implementation of out reach and mobile services in early detection and interventions in difficult to reach areas should be financially supported for further expansion.	NTD, Provincial SW/SE Depts. & District Nazim	July 2005 onwards
4.3 Work done on Portage Guide to Early Education by NGOs to be evaluated, and if successful, NGOs be supported for its successful implementation in rural areas and urban slums	NTD and private sector	July 2005 onwards
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
4.4 Modules to be developed and in-service training of pediatricians, psychiatrist, clinical psychologists and speech therapist at DHQ Hospitals on ECD should be initiated.	DGSP & DoH	January 2006 onwards
4.5 Initiatives being taken in the private sector for training of medical and paramedical staff on ECD, should be evaluated and if feasible be supported for countrywide expansion.	DGSP, MOH & NGOs	January 2007

4.6 A course focusing early detection should be developed in collaboration with NGO sector and incorporated in the curriculum of regular B. Ed and M. Ed courses.	DGSP, MOE & NGOs	January 2007
4.7 DHQ Hospitals should be strengthened to provide early intervention with necessary trained staff and provision of assistive aids including orthotics and prosthetics.	DGSP & MOH/DoH	July 2007
4.8 Initiate establishment of referral service delivery points and propagate at district level.	District Nazims, DCO, MS DHQH	January 2008
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
4.9 Early Childhood Development (ECD) should be incorporated in the curricula of paramedical, nursing and medical colleges.	DGSP, PMDC & PNC	July 2009
4.10 Training of MOs and LHVs at RHCs and BHUs on ECD should be planned and conducted.	DGSP, DoH and EDO Health	July 2009 onwards
4.11 Modules for LHWs to be developed and provided training in screening early childhood developmental delays. (Should be conducted in those areas where doctors at BHU, RHC and consultants at DHQ have been trained).	DGSP & NPFP & PHC	January 2012 onwards

Action 5: Escalating the Medical Rehabilitation Services

Goal / Outcome:	Provision of timely and effective medical rehabilitation services for people disabled by disease, injury or congenital impairments.
Identified Barriers:	At present, mainstream government led system is not fully geared and hence does not contribute its full potential in addressing the issue.
Performance Indicators:	A specialized network of medical rehabilitation services are established at district level in next 10 years.

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
5.1 Criteria for various levels of rehabilitation services (Basic and Comprehensive) should be established in consultation with professionals in the field.	Rehabilitation Medicine Department, Mayo Hospital, Lahore and AFIRM and DGSP	July – December 2005

Mid Term Steps (January 2006 - June 2009)	Responsibility	Timeframe
5.2 Initiate expansion of Departments of Orthopaedic at DHQ Hospitals be expanded to minimally provide basic medical rehabilitation services.	DoH, District Nazims, MS DHQH, DGSP	July 2006 onwards
5.3 The NIH should be restructured and reorganized to serve as rehabilitation medicine training center for various discipline. The current courses should be upgraded for accreditation nationally or externally.	MOH, CPSP and DGSP	January – December 2006
5.4 At provincial level, at least one institute should be identified and strengthened for training of paramedics for medical rehabilitation.	DoH and DGSP	July 2006 - June 2009
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
5.5 Steps should be taken to establish "Rehabilitation Medicine" departments in all public and private teaching hospitals.	Higher Education Commission (HEC), CPSP & DGSP	July 2009 to December 2020

Action 6: Strengthening of Special Education for Children with Severe and Moderately Severe Disabilities

Goal / Outcome:	All children with SEN have opportunity for quality education from kindergarten to class 10 level and develop fullest capacity for economic and social integration that promote self confidence and empowerment.*****
Identified Barriers:	About 1% children with disabilities have access to commensurate SE centers (SEC). Rural children have no access to SEC.
Performance Indicators:	By year 2025 all children with SEN have access to quality educational services

***** An important point to note is that it has been assumed that severely handicapped and moderately severely handicapped children will continue to require special education centers, while moderately handicapped and mildly handicapped can acquire inclusive education in regular schools. Hence, it is being proposed to work in both directions, i.e. increase the number of SECs and also promote inclusive educations. Based on the assumption that effective actions for primary and secondary preventions will be instituted that will reduce the incidence or severity of disabilities, the goal of having one SEC per 50,000 population (5 Union Council) in 2025 has been proposed.

Immediate Steps (January – December 2005)	Responsibility	Timeframe
6.1 Steps should be taken to ensure that the four national SECs based in Islamabad function as per their role envisaged in PC1.i.e. Centers of Excellence. This will require posting of appropriate staff and ensuring funds.	Minister/Secretary of SW, WD & SP	January – December 2005
6.2 Define criteria for classifying the degree of disability into five categories such as profound, severe, moderately severe, moderate and mild.	NISE/DGSP	January – July 2005
6.3 Develop assessment and diagnostic tools for assessment of type and extent of disability.	NISE/DGSP	January – December 2005
6.4 Formation of National Technical Advisory Group (NTAG) for standardizing disability specific curricula for education and diploma courses. The NTAG members be leading experts from public, NGO and private sectors.	NISE/DGSP	June 2005
6.5 NISE to establish chapters in provinces in collaboration with professional institutions or leading NGOs such as TRCs, DEWA, Idu Rieu, ARDP, Amin Maktab, Hamza Foundation etc.	NISE/DGSP	January - December 2005
6.6 The approach for in service training courses for SEC teachers requires overhauling. Training needs assessment to be conducted, and annual training plans to be developed accordingly. Curricula to be prepared under guidance of NTAG and be approved by it.	NISE/DGSP	July – December 2005
6.7 Well-trained staff with skills to manage libraries and resource centers be posted at NL&RC. Cataloguing to be computerized, website of services to be created, funds for new acquisitions be made available and six monthly newsletter to be initiated for informing the public and NGO sector about new acquisitions. Other necessary equipment such as CCTV, Braille Embosser along with scanner to be made available.	DGSP	January – December 2005
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
6.8 Evaluation and if necessary revision of post primary syllabus in consultation with concerned boards of education and examination.	DGSP, DoE and Boards of Education	January - December 2006

6.9 Mechanisms for monitoring and follow up of teachers to be instituted for ensuring quality education.	NISE , its provincial chapters and EDO Community Development, Provincial SWD/ SED	July 2006 onwards
6.10 The curricula of masters' level courses offered by the universities to be updated and laboratories and model schools to be established (or formally linked with existing SECs) for providing hands on training. These measures are necessary for producing competent new teachers.	HEC, Universities, and DGSP	January 2006 - June 2009
6.11 The serving faculty members in Department of SE in Universities need to be sent abroad for higher education to acquire state-of–the–art knowledge and skills.	HEC, Universities and DGSP	July 2006 onwards
6.12 Information sharing conferences to be held at national level biannually.	NISE/DGSP	July 2006 onwards
6.13 Incremental upgradation of SECs from primary level to matric.	DGSP, MOE, District Nazims, NGOs	January 2007
6.14 NTAG to identify operational research areas to strengthen the programme. Provide small grants to students of departments of sociology, social works, anthropology, psychology, public health etc. for this purpose.	NTAG and NISE/DGSP	July 2007 onwards
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
6.15 Existing 40 SECs under management of DGSE located in districts be handed over to the respective district government.	Minister of SW, WD & SP	July – December 2009
6.16 At least one SEC per 5 union council (50,000 population) to be established by provincial/district government or NGOs over a period of 15 years.	DGSP, Provincial SW/SEC Dept., District Nazims, NGOs	July 2010 – December 2025
6.17 To meet the increasing demand of SEC teachers for the new schools at Union Council level, a diploma course in special education for teachers be initiated at provincial level.	NISE/DGSP and its Provincial Chapters	July 2010 onwards

Action 7: Promoting Inclusive Education for Children with Moderate and Mild Disabilities

Goal / Outcome:	Inclusive Educational opportunities are available to larger number of children with moderate and mild level disabilities from kindergarten to class 10 in cost effective ways.
Identified Barriers:	Regular schools are not geared to accommodate children with special needs.
Performance Indicators:	All regular schools have provision for children with special needs.

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
7.1 In light of Perspective Development Plan (2001-11) and EFA 2015, the MOE should bring out a written policy on Inclusive Education (IE) in collaboration with DGSE.	MOE and DGSP/MoWD	January – July 2005
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
7.2 Initiate modifications in physical environment of regular schools to make them less restrictive for special children.	DGSP, District Nazims, NGOs and EDO Education	January 2006 onwards
7.3 Sensitization, orientation and training of regular school teacher on the special (educational) needs of children with disabilities. These should be initiated in those districts where SECs exist and incrementally expanded to other districts keeping pace with establishment of new SECs. This will allow the SECs to train teachers of normal schools for educating disabled children.	DGSP, District Nazims, NGOs and EDO Education	July 2006 onwards
7.4 Provision of resource material and specialized aids in selected districts to be followed by wider expansion.	Provincial SW/SEC Dept., District Nazims and EDO Education	July 2006 onwards
7.5 Incremental provision of IE in regular schools from kindergarten to class 10.	DGSP, MOE, District Nazims, NGOs	January 2006 onwards
7.6 Evaluation and if necessary revision of post primary syllabus in consultation with concerned boards of education and examination.	NISE/DGSP, DoE and Boards of Education	July 2007

Action 8: Expanding and Reinforcing Vocational Training, Employment and Economic Rehabilitation

Goal / Outcome:	Empowerment of disabled to achieve the level of competencies and abilities required to generate income leading to economic empowerment.
Identified Barriers:	Limited vocational training and vocational rehabilitation opportunities available for PWDs in Pakistan.
Performance Indicators:	The ratio of disabled generating income for their needs should be proportionate to that of comparable general population.

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
8.1 Conduct labour market surveys in collaboration with professional marketing firms and business schools to identify disability specific vocations at district level.	Provincial SW/SE Depts., and district Nazims	January – July 2005
8.2 Pursue and implement 5% quota for admission of PWDs in government sector technical training institutions.	DGSP, MoLMP&OP; Provincial SW/SE Depts. & DOE	January 2005 onwards
8.3 Financially support NGOs to replicate successful CBR models such as that of VREDP, ARDP and others.	NTD	July 2005 onwards
8.4 Reinvigorate NCRDP and PCRDP by providing necessary qualified manpower, required logistic resources and effective mechanisms for successful implementation of the employment ordinance.	Secretary MoWD, SW&SE and Provincial Secretaries SW	July – December 2005
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
8.5 All SECs that are upgraded to class 10 to have a strong vocational training programme based on their district market research survey.	District Nazims, Provincial SW Dept. and NTCSP	July 2006 onwards
8.6 For CBR, create opportunities for on the job apprenticeship for different vocations in association with business unions like trader's union, shopkeeper's union, agricultural and dairy producers union, and chambers of commerce etc.	PCRDP, Provincial SW/SE Depts., District SWO	January 2006 onwards
8.7 Take necessary steps to actively involve ministry/ departments of labour in implementation of 2% employment quota through Employees Social Security Institutions (ESSI) and district employment exchange offices.	NCRDP, PCRDP, Ministry and Depts. Of Labour & Manpower	July 2006 onwards

8.8 Include assessment of employment status of PWD in annual Labour Force Survey (LFS).	DGSP and FBS	January 2007
8.9 The existing VTCDs are to revise their training programmes and provide trainings in market appropriate trades.	NTCSP and Provincial SW Dept.	July 2006
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
8.10 All micro credit institutions and banks should develop and promote a special micro credit product with simplified procedures for disabled.	DGSP, SMEDA, FWBL, Khushali Bank, NRSP, First Micro Credit Bank etc.	July 2009 onwards

Action 9: Pursuing Implementation of Existing Laws for PWDs

Goal / Outcome:	All existing laws for prevention of disabilities or rehabilitation/employment of disabled be implemented in letter and spirit and required new laws are drafted and enforced.
Identified Barriers:	Current implementation status of Disabled Employment Ordinance 1981, Workmen Compensation, Social Security and OHS Acts is weak.
Performance Indicators:	Tangible progress in enforcement of all relevant laws.

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
9.1 Take effective measures to remove known constraints (administrative, financial and logistical) hampering functioning of PCRDPs.	Secretary MoWD, SW & SE	January – December 2005
9.2 Modify and improve the currently used disability assessment tools to accommodate candidates with a variety of disabilities.	NCRDP in collaboration with Professors of Rehab Medicine	January – July 2005
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
9.3 Actions required for expediting processing of employment applications of PWD in all District Employment Exchanges.	PCRDP, District Nazim and DCO	July 2006 onwards

9.4 Expand the membership of the assessment board by including members from associations of disabled and NGOs.	PCRDP	January 2006
9.5 Pressurize informal and unregulated sectors employing women and children to obey disability protection laws.	DGSP, NCCWD, NGOs and Associations of disabled and PILER	January 2006 onwards
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
9.6 Pursue the full implementation of Workmen Compensation, Social Security, and OHS Acts.	NFSP/PFSP/DFSP, Ministry and Departments of Labour & Manpower	July 2009 onwards

Action 10: Creating Barrier-Free Physical Environment

Goal / Outcome:	Barrier free access for PWD in all public, private and commercial buildings and public places.
Identified Barriers:	The built physical environment is not user friendly for people with disabilities, elderly, children, expectant women, infirm and weak.
Performance Indicators:	Physical environment designed and equipped for PWDs in all new development/civil works.

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
10.1 Implement the 14 actions approved by the federal cabinet for improving access in buildings, parks and public places (offices, shops, factories, schools, universities, hotel, restaurants, cinemas, bus and train stations, airports).	NFSP/PFSP/DFSP	January 2005 onwards
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
10.2 Sensitize key policy makers such as city planners and developers, building control authorities and professional associations of architects and engineers.	DGSP, Pakistan Engineering Council (PEC), Pakistan Council of Architects and Town Planners (PCATP), and NESPAK and District Governments	July 2006 onwards

10.3 Ministry of Law and Justice to draft laws for provision of barrier free access to PWDs in new public, private and commercial buildings and public places in urban and rural areas for approval and promulgation by the President.	Minister for MoWD, SW & SE and Ministry of Law	July 2006 onwards
10.4 The legal departments of town planning and building control authorities in districts should approve all new designs that are based on the requirements of barrier free access law.	District Government	January 2008 onwards
10.5 Local NGOs, Associations of the Disabled and Association of Architects and Engineers to be consulted in the process of designing, implementing and monitoring access to physical infrastructure.	DGSP	July 2008 onwards
10.6 All aircraft on domestic route to have the provisions for wheelchair passengers. Airports to have appropriate facilities such as tactile guide ways to and within transit terminals and stops.	Minister for WDSW&SE and Civil Aviation Authority	July 2008
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
10.7 Design new buses, taxis, minibuses and wagons as far as practical to include facilities which can accommodate PWDs.	DGSP, Ministry of Transport and Communication and District Motor Vehicle Fitness Office	July 2009 onwards
10.8 Incentives-disincentives approach be applied in implementation of barrier free access policy. Incentives to be given like soft loans, government subsidies, tax reductions etc. to implementers of barrier free access policy.	DGSP, Central Board of Revenue, HBFC, Nationalized Commercial Banks	July 2009

Action 11: Raising Public Acceptance and Improving Social Environment and Integration

Goal / Outcome:	Socially supportive environment for PWDs and their inclusion in all aspects of life.
Identified Barriers:	Disability is stigmatized and considered a taboo and PWDs are marginalized from the social mainstream and often perceived as objects of pity and charity.
Performance Indicators:	Positive perceptions and attitudes towards PWDs.

Immediate Steps (January – December 2005)	Responsibility	Timeframe
11.1 Develop a Media Brief highlighting the extent and gravity of issues and their solutions for use and propagation by mass media personnel (journalists, radio and TV producers, advertising firms etc.) and organizers of advocacy workshops. The Brief could be developed on the pattern of the media brief prepared by the Pakistan Child Survival Project in 1992.	DGSP, Associations of Disabled and NGOs	July – December 2005
11.2 Encourage the invitation of representatives of Associations of Disabled in high level political, social and cultural gatherings and events including diplomatic and UN functions.	Minister of WDSW&SE	January 2005 onwards
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
11.3 Studies be conducted to assess the perceptions and attitudes towards the persons with disabilities.	DGSP, Anthropology, Psychology, Sociology and Social Work Departments of Universities	July 2006 onwards
11.4 Reserve seats for PWD at National and Provincial Assemblies and District Councils.	Minister of WDSW&SE	Initiate action by January 2007
11.5 The media (both in public and private sector) to develop and air programmes including dramas reflecting very positive images of the PWDs benefiting from role models in Pakistan.	NFSP/PFSP	January 2006 onwards
11.6 Sensitivity to issues of disability should be inculcated in school children through cross visits, interactions and mentoring programs with their counterparts in the special schools.	District EDO Community Development and Education Private Schools' Associations	January 2007 onward
11.7 Civil society at large and youth in particular should be encouraged to attend sports events of special people (currently the attendance of general public in special sports is extremely low).	Sports Clubs, NGOs and Associations of Disabled	January 2006
11.8 Sensitize traffic police departments with instruction to help PWD in road crossing and necessary assistance in other public places.	DGSP and Police Departments	July 2006

11.9 Add to the existing list of presidential awards, special awards for work on disability and/or for the PWD attaining outstanding achievements.	Minister of WDSW&SE	January 2006
Long Term Steps (July 2009 - June 2025)	**Responsibility**	**Timeframe**
11.10 Schemes such as "adopt a special child" or "mentor a special child" should be launched in all public and private SECs in collaboration with NGOs and Media.	District EDO Community Development and Education Private Schools' Associations	January 2010 onwards
11.11 Secure membership for PWD in social forums providing opportunities for fellowship, public speaking, drama and intellectual discourse.	NGOs for Disabled Rotary and Lions Clubs, Readers' Clubs	July 2010 onwards

Action 12: Boosting Capacity for Production and Supply of Assistive Aids including Prosthetics, Orthotics and other supporting items and facilitation in Duty Free Imports

Goal / Outcome:	All disabilities are helped by assistive aids i.e. prostheses, orthotics and other supporting items.
Identified Barriers:	The existing production facilities in both public and private sectors are deficient in quantity and quality and have not kept pace with international technological advances.
Performance Indicators:	Research and Development (R&D) capacity building and enhanced production capability of quality products up to tehsil level.

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
12.1 Improve distribution of free of cost supplies to students in public sector SECs.	PCRDPs	July 2005 onwards
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
12.2 Conduct Research and Development (R & D) in collaboration with international disability NGOs and technical institutes.	NCRDP and PCRDPs	January 2007 onwards
12.3 Interest free or soft loans be given to NGOs and private entrepreneurs at tehsil level to set up manufacturing units for assistive aids including prosthesis, orthotics.	Secretary MoWD, SW & SE, SMEDA, Khushali Bank and First Micro Credit Bank	July 2007 onwards

12.4 Obtain tax exemptions for public and NGO sectors for the import of buses for SECs, equipment and assistive devices/parts/raw material and teaching aids and books.	Secretaries MoWD, SW & SE and CBR	July 2006

Action 13: Increasing Support to the NGOs for Service Delivery in Rural Areas

Goal / Outcome:	Disability services available in rural areas through NGO participation
Identified Barriers:	Currently less than 25% disability NGOs are receiving very small grants from the government
Performance Indicators:	Service delivery in rural areas at union council level by NGOs

Immediate Steps (January – December 2005)	**Responsibility**	**Timeframe**
13.1 Conduct listing and in-depth review of existing NGOs to identify their capacity, services and potential for delivering services in the rural areas.	NTD through private sector	July - December 2005
Mid Term Steps (January 2006 - June 2009)	**Responsibility**	**Timeframe**
13.2 Form an Autonomous Board (AB) at the federal level to fund NGOs. The board be structured in such a way that it has full autonomy and works without political or bureaucratic influence of the Ministry. The board to invite EOIs through the newspapers and to fund national, provincial and district level NGOs that have access to underserved and poor populations either directly or through CBOs. Representative of NGOs and Associations of Disabled to be members of AB on annual rotational basis and to nominate their chairperson. The NGOs and Associations of the disabled represented on the board will not be eligible for grants in that year. NTD will serve as the Secretariat.	NTD	January 2006 onwards
13.3 The proposed AB be made responsible to bring disability specific NGOs and Associations under a common platform for exchange of technical and program related issues and problem solving.	NTD	July 2006 onwards
13.4 Disability specific NGOs and associations of higher stature and experience should train and mentor rural based CBOs for disability related work.	NTD, NGOs and Associations of Disabled	January 2007 onwards

Progress against the NPA should be reviewed annually at the federal level and reported in the GOP's Annual Report to the Parliament. The NPA should be reviewed and updated every three years.

Annexes

Annex I:

Team For The Assignment

1. Dr. Arjumand Faisel – Team Leader
2. Ms. Fouzia Rehman – Project Manager
3. Ms. Munawar Fatima - Consultant
4. Mr. Izhar Hussain - Consultant
5. Mr. Khurram J. Khan – Project Officer I
6. Ms. Nadia Abid Khan – Project Officer II
7. Mr. Ahsan Abbas Qureshi – Project Coordinator

Annex II:

Persons Met

S. No	Name of Persons	Designation	Organization
	ISLAMABAD		
1.	Mr. Khalid Saeed Haroon	Director General	DGSE
2.	Mr. Pervaiz Iqbal	Director Planning	DGSE
3.	Mr. Mohammed Majid Qureshi	Director Northern Region	DGSE
4.	Mr. Fazil Iqbal Cheema	Director Central Region	DGSE
5.	Mr. Khalid Naeem	Director Southern Region	DGSE
6.	Mr. Malik Mohammed Ashraf	Director Projects	DGSE
7.	Dr. Khalil Hashmi	Deputy Director Planning	DGSE
8.	Mr. John Walls	Country Director	The World Bank
9.	Ms. Shehnaz Qazi	Senior Social Sector Economist	The World Bank
10.	Mr. Shahzad Sharjeel	Senior External Affairs Officer	The World Bank
11.	Mr. Atif Rafique	Trust Funds & Small Grants Administrator	The World Bank
12.	Dr. Fayyaz Bhatti	Director	VREDP
13.	Mr. Ashfaque Ayaz	Deputy Director	VREDP
14.	Dr. Arshad Ali	Director	NIH
15.	Dr. Khuram Habib	Orthopaedic Surgeon	NIH
16.	Mr. Syed Hassan Raza		NIH
17.	Dr. Javed Iqbal Syed	Former Vice Chancellor	AIOU
18.	Dr. Haroona Jatoi	Joint Education Adviser	MOE
19.	Mr. Syed Fayaz Ahmed	Deputy Education Adviser	MOE
20.	Mr. Abdul Rasheed	Assistant Education Advisor	MOE
21.	Mr. Mulazim Hussein	Deputy Director	ESR/MOE
22.	Mr. Shabir Nawaz	Acting Director	NISE
23.	Dr. Ghulam Haider	Deputy Director	NISE
24.	Ms. Mehmood Awan	Senior Teacher – Cross Disabilities	NISE
25.	Ms. Farah Naz Qasim	Senior Teacher - MR	NISE
26.	Mrs. Aquila Manzar	MR Faculty In charge	NISE
27.	Mrs Meena Asad PH	Senior Teacher - PH	NISE
28.	Mrs. Musarrat Abid	Deputy Director - HI	NISE
29.	Ms. Rubina Anjum	Principal	NSEC – VH
30.	Mr. Abdul Mannan	Deputy Director	NSEC – VH
31.	Dr. Arshad Owais Qazi	Principle/Director	NSEC - IH
32.	Ms. Shehnaz Bano	Vice Principal	NSEC - IH
33.	Dr. Shahbaz A. Khalid	Principal/Director	NSEC - PH
34.	Ms. Naeema Bushra	Acting Principal	NSEC - MR
35.	Dr. Ahmed Nadeem	Medical Officer	NSEC - MR
36.	Dr. Fahim Arshad Malik	DDG Planning & Development	MOH
37.	Mr. Mohammad Shafique Afridi	Director HRD	NBT
38.	Mr. Amjad Ali	Director	NCRDP
39.	Mr. Nasir Qureshi	Director	NTD
40.	Mrs. Aasiya Iqbal	Director	NTCSP
41.	Mr. Pirzada Saulat Farid	President	PTA NTCSP
42.	Mr. Khadim Hussain Shah	Librarian	NL&RC

43.	Mr. M. Ahsan Akhtar Malik	Joint Secretary	Ministry of Labour, Manpower & Overseas Pakistanis
44.	Mr. Mushtaq Hussain	Senior Social Security Advisor	Ministry of Labour, Manpower & Overseas Pakistanis
45.	Mr. Raja Faiz ul Hassan Faiz	Central Labour Advisor	Ministry of Labour, Manpower & Overseas Pakistanis
	N.W.F.P.		
46.	**Mr. Sibghat ur Rahman**	Director	FG/SE Institute
47.	**Mrs. Farhat Rahman**	President	ARDP
48.	**Mr. Zahid Ali Shah**	Deputy Director	FG/SE Institute
49.	**Mr. Hakim Khan Afridi**	DO, SWD	SW Dept.
50.	**Mr. Mohammad Adil Khan**	Assistant Director SWD	SW Dept.
51.	**Mrs. Rubina Riaz**	Assistant Director	SW Dept.
52.	**Mr. Fakhrul Islam**	Director	SW Dept.
53.	**Ms. Syeda Nudrat**	Superintendent	Provincial Govt. School for blind girls, Peshawar
54.	**Ms. Anila Haroon**	Teacher	Provincial Govt. School for blind girls, Peshawar
55.	**Ms. Noreen**	Braille Teacher	Provincial Govt. School for blind girls, Peshawar
56.	**Ms. Fouzia**	Teacher	Provincial Govt. School for blind girls, Peshawar
57.	**Mr. Shamroze Khan**	Manager	Provincial Govt. Center for MR and PH Children Peshawar
58.	**Mr. Haleem Shirazee**	EDO	Education CDG Peshawar
59.	**Mr. Jamaluddin**	Provincial Coordinator	EFA Dept. of Education NWFP
	PUNJAB		
60.	**Mr. Mubarak Ahmed**	Director/Principal	FG/SE/VR Center Lahore
61.	**Mr. Sohail Masood**	Secretary	SE Govt. of Punjab
62.	**Mrs. Afifa Iftikhar**	Principal	Govt. In service Teachers Training College Lahore
63.	**Mr. Mohammad Sadiq**	Director	SE Govt. of Punjab
64.	**Major Haroon Rashid**	Secretary	SW Govt. of Punjab
65.	**Mr. Mazhar Ali Khan**	Director General	SW Govt. of Punjab
66.	**Ms. Muniza Bashir Tarar**	Consultant	SW Govt. of Punjab
67.	**Mrs. Abida Khalid**	PCRD Officer	SW Govt. of Punjab
68.	**Justice (Retd.) Aamer Raza**	Founder/President	Amin Maktab Lahore
69.	**Dr. Khalid Jamil**	Head of the Dept. of Rehabilitation Medicine	Mayo Hospital Lahore
70.	**Mr. Sultan Mahmood**	Manager Prosthesis and Orthotics Workshop	Mayo Hospital Lahore

71.	**Dr. Surraiya Yasmin Shah**	Director	Amin Maktab Lahore
72.	**Mr. Munawar Abbas**	Additional Secretary	DoE, Punjab
73.	**Mrs. Parveen Tawab**	Principal	Rising Sun School for Handicapped
74.	**Dr. Abdul Tawab Khan**	Director	Rising Sun School for Handicapped
	SINDH		
75.	**Mr. Qurban Ali Memon**	Director	SW Dept.
76.	**Ms. Riaz Fatima**	Social Welfare Officer	SW Dept.
77.	**Mr. Lakho**	District Officer, Social Welfare	SW Dept.
78.	**Mr. Raees Ahmed Alvi**	EDO Education	DoE
79.	**Dr. Hussain Bux Memon**	DG Health	DoH
80.	**Ms. Rashida Khanum**	Deputy Director	PCRDP
81.	**Mr. Raja Mohammed Akram**	Assistant Director	PCRDP
82.	**Ms. Fiza Viqar Hashmi**	Assitant Professor	SED
83.	**Ms. Saadia Saeed**	Cooperative Teacher	SED
84.	**Mr. Noman Ahmed**	Chairman Architecture Dept.,	NED University of Engineering
85.	**Mrs. Qudsia Khan**	Principal	Ida Rieu School
86.	**Ms. Rukhsana Jaffer**	Member, Board of Governers	Ida Rieu
87.	**Dr. Munir Ahmed Lodhi**	Founder and Chairman	DEWA
88.	**Mr. N. Saquib Hameed**	Managing Trustee	LRBT
89.	**Mrs. Y. Rahman**	President and Founder Member	Al-Shifa Trust
90.	**Ms. Zia Akhtar**	President	Mafad-e-Niswan Trust
91.	**Mrs. Zeenat G. Muhammed**	Administrator	Ma Ayesha Center
92.	**Dr. Shiraz Hyder**	Medical Director	Ma Ayesha Center
93.	**Mr. Sohail Abbas Shah**	Administrator	PAB Vocational School for Blind
94.	**Ms. Kaniz Raza**	Principal	PAB Vocational School for Blind
95.	**Dr. Saleh Memon**	Secretary	Adult Blind Center Trust
	BALOCHISTAN		
96.	**Mr. Raheel Zia**	Deputy Secretary	Department of Social Welfare, Human Rights and Women Development
97.	**Mr. Abdul Ghaffar Nasir**	Director	Directorate of Social Welfare, Human Rights and Women Development
98.	**Mr. Naimatullah Baloch**	EDO Community Development	District Govt. Quetta
99.	**Mrs. Salma Qureshi**	Vice Principle	Federal Govt. VTCD Center
100.	**Mr. Manzoor Ali Mastoi**	Office Incharge	Federal Govt. SEC for PH
101.		All 4 head teachers of VH, PH, HI and MR Sections	Provincial Govt. Special Education Complex

Note: Names of parents and PWDs met have not been listed.

Annex III:

Existing Facilities For PWDs

(List as provided by different departments in Islamabad and provinces)

DGSE Centers

S. No	Name/Location
1.	National Special Education Center for Hearing Impaired, H-9 Islamabad
2.	National Special Education Center for Mentally Retarded, H-8/4 Islamabad
3.	National Special Education Center for Physically Handicapped, G-8/4 Islamabad
4.	National Special Education Center for Visually Handicapped, G-7/2 Islamabad
5.	National Institute of Special Education, G-7/2 Islamabad
6.	National Vocational Rehabilitation and Employment of Disabled Persons Center, H-8/4 Islamabad
7.	National Library and Resource Center, G=7/2 Islamabad
8.	National Mobility and Independent Training Center, G-7/2 Islamabad
9.	National Training Center for Special People
10.	National Braille Press, G-7/2 Islamabad
11.	SEC for PH, Rawalpindi
12.	SEC for PH, Abbottabad
13.	SEC for PH, Peshawar
14.	SEC for HI, Peshawar
15.	VTCDP, Peshawar
16.	SEC for HI, Swat
17.	SEC for VH, Kohat
18.	SEC for VH, Charsadda
19.	SEC for MR, Mardan
20.	SEC for MR, D.I. Khan
21.	SEC for PH, Muzaffarabad
22.	SEC for HI, Gilgit
23.	SEC for MR, Karachi
24.	SEC for VH, Karachi
25.	VTCD, Karachi
26.	SEC for MR, Hyderabad
27.	SEC for VH, Mirpurkhas
28.	SEC for PH, Nawab Shah
29.	SEC for PH, Larkana
30.	SEC for HI, Sukkur
31.	Institute for PH, Quetta
32.	SEC for MR, Sibi
33.	SEC for HI, Khuzdar
34.	VTCD, Quetta
35.	SEC for HI, Lahore
36.	VTCD, Lahore
37.	SEC for VH, Lahore
38.	Institute for PH, Lahore

39.	SEC for MR, Lahore
40.	SEC for HI, Jhang
41.	SEC for HI, Sargodha
42.	SEC for HI, Sheikhupura
43.	SEC for HI, Rahim Yar Khan
44.	SEC for MR, Gujranwala
45.	SEC for MR, Sahiwal
46.	SEC for MR, Multan
47.	SEC for MR, Bahawalpur
48.	SEC for PH, D. G. Khan
49.	SEC for PH, Faisalabad
50.	SEC for VH, Jhelum
51.	SEC for VH, Okara
52.	SEC for VH, Sialkot
53.	SEC for VH, Gujrat
54.	VREDP, Islamabad
55.	VREDP Service Center, Islamabad
56.	VREDP Service Center, Karachi
57.	VREDP Service Center, Gujrat

Source: Ministry of Women's Development, Social Welfare and Special Education, GOP, 2002, Pakistan's Special People, Opportunities and Challenges.

Islamabad – NGOs and Associations

1.	Hearing Impaired Centre DEWA
2.	Early Learning Centre
3.	CFSP
4.	STEPS
5.	Umeed-e-Noor
6.	

Source: information Collected by the team

NWFP – Provincial Government Centers

S. No	Name/Location
1	Government Institute for Blind, D.I Khan
2	Government Institute for Blind, Swat
3	Government Institute for Blind, Male, Peshawar
4	Government Institute for Blind, Female, Peshawar
5	Government Institute for Blind, Swabi
6	Government Institute for Blind, Mardan
7	Government Institute for Blind, Abbotabad
8	Government Institute for Deaf Children D.I Khan
9	Government Institute for Deaf Children Manshera
10	Government Institute for Deaf Children Dir
11	Government Institute for Deaf Children Kohat
12	Government Institute for Deaf Children Yakatoot, Peshawar
13	Government Institute for Deaf Children Gulbahar, Peshawar
14	Government Institute for Deaf Children Bannu
15	Government Institute for Deaf Children Abbotabad

16	Government Institute for Deaf Children Haripur
17	Government Center for physically handicapped and mentally retarded, Bannu
18	Government Center for physically handicapped and mentally retarded, Chitral
19	Government Center for physically handicapped and mentally retarded, Haripur
20	Government Center for physically handicapped and mentally retarded, Peshawar
21	Government Center for physically handicapped and mentally retarded, Mansehra

Source: Social Welfare Department, Government of NWFP, March 2004

NWFP – NGOs and Associations

7.	Pakistan Association Of Blind Center Abbotabad
8.	Al Huda Hearing Impaired and Rehabilitation Association, Abbotabad
9.	DROPS for orthopaedic care, Abbotabad
10.	Gul Zarif Khan Center for mentally retarded and physically handicapped, Bannu
11.	Umer Gul Nasir Center for mentally retarded and physically handicapped, Bannu
12.	Pakistan Association Of Handicapped Batagram
13.	Mohammad Afaq Khan Center for visually handicapped Charsadda
14.	Anjuman Naujawan for Disabled Charsadda
15.	Welfare Association for handicapped children, Chitral
16.	PTA for Blind D.I. Khan
17.	PTA for Deaf D.I. Khan
18.	PTA for Mentally Retarded D.I. Khan
19.	Handicapped Welfare Association D.I. Khan
20.	PTA for Deaf Lower Dir
21.	PAB School for Blind Haripur
22.	Society for Deaf and Dumb, Haripur
23.	Association for Rehabilitation of handicapped Karak
24.	Frontier Association for Mentally Handicapped Mardan
25.	PTA for Blind, Mardan
26.	Center for speech and hearing, Mardan
27.	PAB Center for Blind, Mardan
28.	PAB Center for Blind, Mardan
29.	Special Welfare Organization for physically handicapped, Mardan
30.	Ujala e Sahar Organization for physically handicapped, Mardan
31.	Society for Deaf and Dumb, Mansehra
32.	Association for rehabilitation and welfare of disabled children, Mansehra
33.	Institute for rehabilitation of disabled persons, Nowshera
34.	Association for Rehabilitation of Disabled Persons (ARDP), Swati Gate, Peshawar
35.	Al Umeed Society for deaf, Peshawar
36.	Deaf and Dumb Association, Peshawar
37.	PAB Center for Blind, Peshawar
38.	Disabled Citizens Welfare Association for physically handicapped, Peshawar
39.	Khushbo Social Welfare Society, Swat
40.	Community Development Council, Swat
41.	PTA Government Institute for Blind Swat
42.	PTA Government SE Center for hearing impaired, Swat
43.	PAB Center for blind, Swat
44.	Al Shifa School for speech and hearing, Swabi

45.	PAB Center for blind, Swabi
46.	Women Association For Welfare of physically handicapped, Swabi

Punjab – Provincial Government Centers

S. No	Name/Location
1	Government Primary School for Hearing Impaired Kasur
2	Government Primary School for Hearing Impaired Chiniot
3	Government Primary School for Hearing Impaired Mianwali
4	Government Primary School for Hearing Impaired Jhang
5	Government Primary School for Hearing Impaired Sialkot
6	Government Primary School for Hearing Impaired Khanewal
7	Government Primary School for Hearing Impaired Vehari
8	Government Primary School for Hearing Impaired Khanpur
9	Government Primary School for Hearing Impaired DG Khan
10	Government Primary School for Hearing Impaired Muzaffargarh
11	Government Primary School for Hearing Impaired Gujrat
12	Government Primary School for Hearing Impaired Attock
13	Government Primary School for Hearing Impaired Pakpattan
14	Government Primary School for Hearing Impaired Rajanpur
15	Government Primary School for Hearing Impaired Khushab
16	Government Middle School for Hearing Impaired Shaikhupura
17	Government Middle School for Hearing Impaired TT Singh
18	Government Middle School for Hearing Impaired Chakwal
19	Government Middle School for Hearing Impaired Gujranwala
20	Government Middle School for Hearing Impaired Sarghoda
21	Government Middle School for Hearing Impaired Rawalpindi
22	Government Middle School for Hearing Impaired Jhelum
23	Government Middle School for Hearing Impaired Bahawalpur
24	Government High School for Hearing Impaired for Girls Lahore
25	Government High School for Hearing Impaired for boys Lahore
26	Government High School for Hearing Impaired Central Lahore
27	Government High School for Hearing Impaired for boys Faisalabad
28	Government High School for Hearing Impaired for girls Faisalabad
29	Government High School for Hearing Impaired for boys Multan
30	Government High School for Hearing Impaired for girls Multan
31	Government High School for Hearing Impaired Sahiwal
32	Government High School for Hearing Impaired Okara
33	Government Intermediate College for Hearing Impaired
34	Government Primary School for Visually Handicapped DG Khan
35	Government Primary School for Visually Handicapped Multan
36	Government Middle Sunrise School for Visually Handicapped Lahore
37	Government Middle School for Visually Handicapped for girls Lahore
38	Government Middle School for Visually Handicapped Sarghoda
39	Government Middle School for Visually Handicapped Rawalpindi
40	Government Middle School for Visually Handicapped Gujranwala
41	Government Middle School for Visually Handicapped Faisalabad
42	Government High School for Visually Handicapped Lahore

43	Government High School for Visually Handicapped Rawalpindi
44	Government High School for Visually Handicapped Bahawalpur
45	Government Shadab School for Mentally Retarded Lahore
46	Government Shadab School for Mentally Retarded Multan
47	Government Shadab School for Mentally Retarded Sarghoda
48	Government Middle School for Physically Handicapped Multan
49	Government Middle School for Physically Handicapped Lahore

Source: Department of Special Education, Government of Punjab, March 2004

Punjab – NGOs and Associations

S. No	Name/Location
1	Nigheban Welfare Society Bahawalpur
2	Pakistan Association of Blind (PAB) Bahawalpur
3	Welfare Society for Physically Handicapped, Bahawalpur
4	Pakistan Association of Blind (PAB) Bahawalnagar
5	Jamia Abbasia Welfare Society Bahawalnagar
6	Anjuman Falah e Mazooran, Rahim Yar Khan
7	Sir Syed Deaf Association Rahim Yar Khan
8	Crescent Education Welfare Association Rahim Yar Khan
9	Parents Teachers Association (PTA) Rahim Yar Khan
10	Al Khidmat Rahim Yar Khan
11	Madina Deaf and Dumb Association Khanpur
12	Faisal Deaf Welfare and Sports Association Faisalabad
13	Friends Welfare Society Faisalabad
14	Sir Syed PTA Faisalabad
15	Pakistan Deaf and Disabled Welfare Association Faisalabad
16	Tanzeem Ul Lisan Faisalabad
17	Pakistan Alliance of the Blind Faisalabad
18	Pakistan Association of Blind (PAB) Faisalabad
19	Mian Mohammad Trust Faisalabad
20	Alliance of Physically Disabled Persons Faisalabad
21	Insan Dost Tehrik Faisalabad
23	PTA Government SE School Faisalabad
24	Faisalabad Society For for the welfare of mentally retarded children Faisalabad
25	Pakistan Anjuman Nabina Jhang
26	Psychological Society Jhang
27	Sir Syed PTA TT Singh
28	Pakistan Association of Blind (PAB) Sarghoda
29	Ibne Rushd PTA Sarghoda
30	Deaf and Dumb Welfare Society Sarghoda
31	National Association of Blind Sarghoda
32	DARUL ISLAM Social Welfare Society Khushab
33	Pakistan Association of Blind (PAB) Mianwali
34	Association for the Welfare and Rehabilitation of Disabled (ARDP) Mianwali
35	Qadir Foundation Bakhar
36	Deaf and Dumb Association Gujranwala
37	National Council for Education and Welfare of Mentally Retarded Children Gujranwala

38	Association of the Deaf Gujranwala
39	Noman Hearing Impaired Society Mandi Bahauddin
40	Allama Iqbal Deaf and Dumb Social Welfare Association Sialkot
41	Parents teacher Association Sialkot
42	Anjuman Falah e Behbood Muzaffargarh
43	AL ASAR Development Organization DG Khan
44	Pakistan Association of Blind (PAB) DG Khan
45	PTA SE School DG Khan
46	AL ANAM Welfare association Lahore
47	Disabled Welfare Society Lahore
48	Idara Behbood E Khawateen Mazooran Lahore
49	Al Khazami/PTA for PH and MR Children Lahore
50	Anjuman Behbood E Maashara Lahore
51	Cancer research Foundation Lahore
52	Council For Welfare Training and Rehabilitation of Disabled Women Lahore
53	Deaf and Dumb Welfare Society Lahore
54	Islahi Committee Lahore
55	Islahi Behbood Committee Lahore
56	Lahore Mental Health Association (Fountain House) Lahore
57	Lahore Public Welfare Society Lahore
58	Manavan Welfare Society Lahore
59	National Eye Bank Society Lahore
60	Pakistan Society for the blind Lahore
61	Pakistan Deaf and Dumb Training Association Lahore
62	Pakistan Blind Children Society Lahore
63	Pakistan Society for prevention and cure of blindness Lahore
64	Pakistan Uplift Society for the blind Lahore
65	PTA of SE School for Hearing Impaired Lahore
66	Pakistan Society for the Rehabilitation of Disabled Persons (PSRDP) Lahore
67	Santnagar Social Welfare Society Lahore
68	Society for drug abuse prevention Lahore
69	Welfare Association for Deaf and Dumb Lahore
70	Women Voluntary Services Lahore
71	The Layton Rehmatullah Benevolent Trust (LRBT) Lahore
72	Blind Welfare Association Lahore
73	National Centre for mentally challenged children Psychology department, Mayo Hospital Lahore
74	Pakistan Academy for Disabled Lahore
75	Technical Services Association for Disabled Lahore
76	Shahdab Welfare Society Lahore
77	Women Social Services organization Wah Cantt
78	Education Welfare Society for Disabled Children Rawalpindi
79	Al Noor Welfare Society Rawalpindi
80	Social Welfare Society for mentally retarded persons Rawalpindi
81	Fatima Jinnah Women Educational/Vocational Society Rawalpindi
82	Arshad Centre for Special Education Rawalpindi
83	Society for Mentally Handicapped Children Rawalpindi

84	Anjuman Behbood e Mazooran Rawalpindi
85	Parents Teachers Association Satellite Town Rawalpindi
86	St. Joseph's Hospice Association
87	PAF Base PTA for Handicapped Rawalpindi
88	HIMAT Welfare Society Attock
89	Rothas Welfare Society Jhelum
90	Social Welfare Council For Mentally retarded Children Jhelum
91	Deaf and Dumb Welfare Society Jhelum
92	Anjuman Falah e Behbood Deaf and Dumb and Blind Chakwal
93	Pakistan Association of Blind (PAB) Multan
94	Mohammad Bin Qasim Welfare Organization Multan
95	Idara E Tahafaz e Binai Multan

Source: Social Welfare Department (SWD) Government of Punjab, March 2004

Sindh – Provincial Government Centers

S. No	**Name/Location**
	Rehabilitation Center for PH, Qasimabad, Hyderabad
	Rehabilitation Center for Multiple Handicapped Children, Near Civil Hospital Badin
	Rehabilitation Center for Multiple Handicapped Children, Bhut Mohallah Dadu
	Rehabilitation Center for Multiple Handicapped Children, Ward No. 3 Thatta
	Rehabilitation Center for PH, Khipro Mirpur Khas
	Rehabilitation Center for Multiple Handicapped Children, Near Batul Nasir Hotel Sanghar
	Rehabilitation Center for Multiple Handicapped Children, Ghalib Nagar Larkana
	Rehabilitation Center for Multiple Handicapped Children, Shikarpur
	Rehabilitation Center for Multiple Handicapped Children, Jacobabad
	Rehabilitation Center for Multiple Handicapped ChildrenBander Road Sukkur
	Rehabilitation Center for Multiple Handicapped Children, Damrah Road Nawab Shah
	Rehabilitation Center for PH, Station Road Khiarpur
	Rehabilitation Center for PH, Korangi No. 5 Karachi
	Rehabilitation Center for Multiple Handicapped Children, Al Noor Society Karachi
	Rehabilitation Center for Multiple Handicapped Children, Liyari Karachi
	Rehabilitation Center for Multiple Handicapped Children, Asif Abad Old Pak Coloney Police Station Karachi

Source: Ministry of Women's Development, Social Welfare and Special Education, GOP, 2002, Pakistan's Special People, Opportunities and Challenges.

Sindh – NGOs and Associations

S. No	**Name/Location**
1.	Pakistan Association of Blind (PAB) School for Girls North Karachi, Karachi
2.	Pakistan Association of Blind (PAB) Nazimabad No. 3 Karachi
3.	Pakistan Association of Blind (PAB) Nazimabad No.6 Karachi
4.	Pakistan Association of Blind (PAB) Lea Market Karachi
5.	Pakistan Association of Blind (PAB) Landhi No 1, Karachi
6.	Pakistan Association of Blind (PAB) Khuldabad Landhi, Karachi
7.	Al Maktoom Braille Society Jacob Lines Karachi
8.	Adult Blind Centre, Garden East Karachi
9.	Ida Rieu Centre, MA Jinnah Road Karachi

10.	Special Children Educational Institute DHA Karachi
11.	SCINOSA Day Home, North Nazimabad Karachi
12.	Sahara, Gulshan-e-Iqbal Karachi
13.	Darul Khushnood Staff line Fatima Jinnah Road Karachi
14.	Rahatkadah Gulshan e Iqbal Karachi
15.	Danish Ghar, Clifton Karachi
16.	Darul Sukoon P.E.C.H.S. Karachi
17.	Darul Khidmat, Qayyumabad Karachi
18.	Institute of behavioral psychology DHA Karachi
19.	ACELP Rafique Shaheed Road Karachi
20.	Karachi Vocational Training Center DHA Karachi
21.	Child Guide School Azizabad Karachi
22.	Markaz e Umeed F B Area, Karachi
23.	PAFWA MASHAL School, PAF base Shahrae Faisal Karachi
24.	PNS Special Children School, Karsaz Kaarchi
25.	AL SHIFA TRUST Airport Karachi
26.	Umeed Special Academy UCD Landhi Karachi
27.	Pakistan Association for Mental Health, Clifton Karachi
28.	Ujala Center, DHA, Karachi
29.	Society For Rehabilitation of Crippled Children, Nizami Road off MA Jinnah Road Karachi
30.	Ma Aysha Memorial Center, KUCHS Karachi
31.	Ida Rieu Welfare Association, MA Jinnah Road Karachi
32.	AURA Day Care Center for Cerebral Palsy, PECHS Karachi
33.	Baitul Tabasum Baldia Town Karachi
34.	Al-Faizan Center, Wahaj Memorial Hospital, FB area, Karachi
35.	Society For Care of Handicapped Children, KMC Staff Clinic Guru Mandir Karachi
36.	Bait Ul Shafquat Azam Town Karachi
37.	Daraul Rehmat Eissa Nagari, Karachi
38.	Darul Mussarat Baldia Town, Karachi
39.	Blessing Home PECHS Karachi
40.	Association of Physically Handicapped Adult (APHA), Gulistan-e-Johar, Karachi
41.	Rehabilitation Center for Physically Handicapped (RCPH), Karachi
42.	ABSA School for Deaf, DHA Karachi
43.	DEWA Academy for Deaf Gulshan-e-Iqbal, Karachi
44.	AIMS (Speech and Language Therapy Center, Rajput Hospita, Gulshan-e-Iqbal, Karachi
45.	Speech and Hearing Center, PECHS, Karachi
46.	England Speech and Hearing Center, DHA, Karachi
47.	Sindh Mary School for Deaf, Baldia Karachi
48.	St. Mary School for Deaf, Ittihad Town Karachi
49.	Special Children Day Care Center, North Karachi
50.	Day Break School for Special Children, Maripur, Karachi
51.	Special Education School PNAD, Hub River Road, Karachi
52.	Saiban Academy for Special Children, Gulshan-e-Hadeed, Karachi
53.	PREWA, North Nazimabad Karachi
54.	Manzil Special Education Center, PECHS, Karachi
55.	READ, DHA, Karachi
56.	Rahat Ghar (Umeed-e-Naw), Gulshan-e-Iqbal, Karachi

57.	CARE, Bath Island Karachi
58.	Al-Saiban Rehabilitation Association, Gulshan-e-Iqbal Karachi
59.	New Hope Foundation, North Karachi
60.	Country Angles, Shah Faisal Colony Karachi
61.	International School of Studies, Tipu Sultan Road, Karachi
62.	Institute of Educational Development, Agha Khan University, Karachi
63.	SPE_ED, PECHS Karachi
64.	Aziz Beghum Memorial Center, Garden East, Karachi
65.	Rhab Foundation for the Disabled, North Karachi
66.	Interline, Main Abdul Hassan Isphaine Road, Karachi
67.	Spell Bound, Clifton, Karachi
68.	Al Umeed Rehabilitation Center (AURA), Gulistan-e-Johar, Karachi

Source: Social Welfare Department (SWD) Government of Sindh, March 2004 and Directory provided by Department of Special Education, University of Karachi, May 2004

Balochistan - Government

S. No	Name/Location
	Government Special Education Complex with separate sections for VH, MR, PH, HI, Quetta

Balochistan – NGOs and Associations

S. No	Name/Location
	Anjuman-e-Bahalie Mazooran, Quetta
	Association for Hearing Impaired, Quetta
	Institute for Special Children, Quetta

Annex IV:

List of Medical Rehabilitation Centers in Pakistan

Provincial Headquarter	District Headquarter	Town/Tehsil
.KING EDWARD MEDICAL COLLEGE, University of the Punjab, Lahore It has a number of attached hospitals including the Mayo Hospital, Lady Willingdon and Lahore General Hospitals	Ayub Medical College, University of Peshawar, Abbottabad .	KUNRI CHRISTIAN HOSPITAL, Kunri, Umerkot, Sindh
ALLAMA IQBAL MEDICAL COLLEGE, Lahore University of the Punjab The Medical School: uses the Jinnah Hospital as its main teaching hospital	Quaid-e-Azam Medical College, Islamia University, Bahawalpur	BACH CHRISTIAN HOSPITAL, Qulandarabad, Hazara,
FATIMA JUNNAH MEDICAL COLLEGE FOR WOMEN, University of the Punjab, Lahore. It is for women only.	Punjab Medical College, Faisalabad.	TANK CHRISTIAN HOSPITAL, Tank, near Dera Ismail Khan, NWFP,
THE SERVICES HOSPITAL, Lahore	Nishtar Medical College, Bahuddin Zakaria University, Multan	MEMORIAL CHRISTIAN HOSPITAL, Sialkot
SHEIKH ZAYED HOSPITAL, Lahore	Liaquat Medical College, University of Sind, Jamshoro	SHILOKH MISSION HOSPITAL, Jalapur Jattan, Gujrat
C.M.H. Lahore P.W.R., Cairns Hospital, Lahore United Christian Hospital, Lahore Society of Rehabilitation of Disabled, Lahore Data Darbar Hospital, Lahore Gulab Devi Hospital for Chest Diseases, Lahore Fatima Memorial Hospital, Lahore Shalamar Hospital Trust, Lahore	Chandka Medical College, University of Sindh, Larkana	Faisal Shaheed Memorial Hospital Trust, Gujranwala

Ittefaque Hospital, Lahore Shaikh Zayed Hospital, Lahore		
MARGALLA INSTITUTE OF HEALTH SCIENCES, Islamabad. Cantonment General Hospital, Rawalpindi	Nawabshah Medical College for Girls, University of Sindh, Nawabshah	
QUAID-I-AZAM POSTGRAGUATE MEDICAL COLLEGE, PAKISTAN INSTITUTE OF MEDICAL SCIENCES, Islamabad	Punjab: District Headquarters Hospital, Sargodha, Sialkot, Jhelum Rahim Yar Khan, Sahiwal	
RAWALPINDI MEDICAL COLLEGE, University of the Punjab, Rawalpindi	Sindh: District Headquarters Hospital, Sukkur	
Federal Government Services Hospital, Islamabad	NWFP: District Headquarters Hospital, D.I. Khan, Mardan	
CHILDREN'S HOSPITAL, PAKISTAN INSTITUTE OF MEDICAL SCIENCES, Islamabad	C.M.H. Multan C.M.H. Sialkot C.M.H. Kharian P.O.F. Hospital, Wah Cantt P.A.F. Base Hospital, Sargodah C.M.H. Okara C.M.H. Gujranwala C.M.H. Jhelum	
AGA KHAN UNIVERSITY Hospital /MEDICAL COLLEGE Karachi	C.M.H. Abbottabad	
DOW MEDICAL COLLEGE, University of Karachi, Karachi.	C.M.H. Muzaffarabad	
SINDH MEDICAL COLLEGE AND JINNAH POSTGRADUATE MEDICAL CENTRE, University of Karachi, Karachi	Saidu Group Hospitals, Swat	
LIAQUAT NATIONAL HOSPITAL, Karachi		
AL SHIFA EYE HOSPITAL, Rawalpindi.		
Bolan Medical College,		

University of Baluchistan, Quetta.		
Marhaba Hospital, Peshawar Health Care Medical Centre, Peshawar		
Khyber Medical College, University of Peshawar, Peshawar		
P.A.F. Hospital, Mauripur, Karachi P.N.S. Shifa, Karachi Naval Surgery, Karachi		
Abbasi Shaheed Hospital, Karachi K.V. Site Hospital, Karachi S.R.S. Hospital, Karachi Social Security Hospital, Landhi, Karachi Baqai Hospital, Karachi Spencer Eye Hospital, Karachi National Institute of Child Health, Karachi L.R.B.T. Hospital, Karachi Akhter Eye Hospital, Karachi Sind Government Hospital, Liaquatabad,Karachi		
C.M.H. Quetta		
C.M.H. Peshawar		

Source: Adapted from Pakistan Medical and Dental Council's list of institutions approved for medical education and house job.

Annex V:

List of manufacturers of Orthotics and Prosthesis [82]

.Al-Hameed Industries Sargodha Road Gujrat Tel: 4906 Produce: Braille presses, arithmetic braille slates.	Al-Shifa Trust Eye Hospital Low Vision Aids Clinic Jhelum Road Rawalpindi Produce: Braille presses.	Artificial Limb Centre Quaid-e-Azam Medical College Bahawalpur Produce: Orthoses and prostheses.
Asian Blind Union/PAB V-E, 20/13 Meher Manzil Nazimabad, Karachi Produce: White canes, braille slates, other devices for blind people.	DEWA Academy Gulshan-e-Iqbal Karachi Produce: Braille presses.	Fauji Foundation Medical Centre Rawalpindi Cantt. Tel: 66095-8 Produce: Orthoses and prostheses.
Government Printing Press c/o Government Institute for the Blind Model Town Bahawalpur	Hayat Shaheeed Hospital Artificial Limb Centre Peshawar Produce: Orthoses and prostheses.	Jinnah Post-Graduate Medical Centre Radiqui Shaheed Road Karachi Produce: Orthoses and prostheses.
National Book Foundation Liaquat Memorial Library Stadium Road Karachi Produce: Braille presses.	National Federation for the Welfare of the Blind 36/3, Love Lane Inside Iqbal Market Garden East, Soldier Bazar No. 2 Karachi Tel: 710891 Produce: Braille presses.	National Institute of Electronics (NIE) H. No. 17, Sector H-9 Islamabad Produce: Hearing aids and moulds.
Optical Palace M.A. Jinnah Road Opp. KMC G.P.O. Box 1249 Karachi Produce: Hearing aids and moulds.	Pakistan Society for the Rehabilitation of the Disabled 111, Ferozpur Road Lahore Produce: Orthoses and prostheses.	PETCOT University Post Box No. 751 Peshawar Produce: Prostheses and orthoses.
Raees Enterprises Chamun Building Chowk dal gran Nishter Road Lahore Produce: Braille presses.	Shah Faisal Center for Hearing Impaired Children Plot No. 27 Sector H-9 Islamabad Produce: Hearing aids and moulds.	Technology Links (Pvt.) Ltd. House No. 10 Street No. 36 Islamabad. Produce: Hearing aids and moulds.
UNHCR Afghan Refugee Artificial Limb Center Peshawar Produce: Orthoses and prostheses.		

[82] Economics and Social Commission for Asia and the Pacific (ESCAP), *Production and distribution of assistive devices for people with disabilities*: *Supplement1 - Chapter 10-13 - ST/ESCAP/1774,* UNITED NATIONS PUBLICATION, 1997, ISBN: 92-1-119775-9

Annex VI:

Measures Approved by Federal Cabinet for Improving Physical Access of PWDs

1. Ramp in building, at entry to building, parks/public places and at split level change in flours.
2. Lifts, Wide enough to accommodate wheel chairs and multi story buildings with recorded vocal announcement of the flour reached and tactile information.
3. Railing besides the ramps and corridors with engraving braille, giving direction.
4. Metal bar in corridors for the visually handicapped allowing continues sliding of hands, along it without obstruction.
5. Well-lit building to facilitate persons with low vision.
6. Tactile maps (braille) on both sides of entrance for easy location.
7. Wide doors for people on wheel chairs and frames.
8. At least one toilet at each flour for disabled with grab bars, W.H.B. with lever handles, mixture and access for wheel chair.
9. Yellow color one square foot dotted flouring.
10. Space reserved in parking for disabled near the entrance.
11. Recreational facilities in parks and public places for disabled with necessary safety measures.
12. Emergency bells in lift and bath rooms.
13. Switches and Security lights to be easily accessible for the disabled.
14. Grills for safety of the disabled at required places.