

India's Disability Policy – Analysis of Core Concepts of Human Rights

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ABSTRACT

Purpose: To analyse India's National Policy for Persons with Disabilities (2006), using a Human Rights approach.

Method: A framework analysis was carried out using EquiFrame, which analyses policies for inclusion and quality of Core Concepts of Human Rights and inclusion of Vulnerable Groups.

Results: India's National Policy for Persons with Disabilities scored 67% for Core Concept Coverage, 24% for Core Concept Quality and 42% for Vulnerable Group Coverage. This gave the policy an overall ranking of Low quality.

Conclusions: The current policy for persons living with disabilities in India would benefit from being updated to encompass the Core Concepts of Human Rights.

Limitations: Further analysis of policies in areas such as health, education, social protection and transport would lead to a more in-depth analysis of the country's integration and streamlining of disability across all policies.

Key words: disability, India, policy, EquiFrame, Human Rights, health.

INTRODUCTION

India is one of the world's fastest growing economies and claims to be the largest democratic republic (Reddy et al, 2011). It has a population of 1.241 billion (World Bank, 2011), of which an estimated 2.13% have disabilities (Government of India, 2001). This constitutes over 21 million people who require support to ensure access and inclusion within society. During this period of Indian economic growth, policy support for human rights of persons with disabilities is essential, to ensure the equity gap is decreased and that the voices of these persons are heard.

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The recent United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2007) and the World Report on Disability (World Health Organisation and World Bank, 2011), both the first of their kind, have highlighted the needs of this group on a global stage. The UNCRPD promotes an equal society by recognising that persons with disabilities need to be guaranteed the same levels of dignity, respect and social inclusion as other members of society. The Convention, among other objectives, promotes the mainstreaming of disability issues as an integral part of development (UNCRPD, 2007). As a primary general obligation, the Convention (in Article 4) obliges signatory States “to take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes” (UNCRPD, 2007). India signed this convention on 30th March, 2007.

The Millennium Development Goals (MDGs) although leading to improvements in some specific areas such as HIV/AIDS, TB and Child Mortality, can be argued to have led to development deficits in other areas not mentioned (The Lancet, 2013). Disability was not mentioned in the MDG 2015 agenda. By ensuring access of persons with disabilities to appropriate services, it can provide a base for further development of inclusion through policies in other areas. It can also be argued that a policy which provides an equitable framework for persons with disabilities can be an indicator of the overall equity for the population (MacLachlan et al, 2011a).

It has been suggested that only 2% of persons with disabilities in a developing country have their needs met with rehabilitation and basic services (Durocher et al, 2012). It has also been estimated that only 2-3% of children with disabilities attend school in a developing country context, with many remaining illiterate (Durocher et al, 2012). It is important to note that many services have costs attached. An example of this is seen in India’s health system. This includes a large private sector which accounts for 78% of total healthcare spending, with many people experiencing catastrophic out-of-pocket payments (Kumar et al, 2011). Additionally, there is a reputation for informal payments (Cherecheş et al, 2013). Persons with disabilities are disproportionately affected by poverty (World Health Organisation & World Bank, 2011). Thus, there can be both physical and economical barriers to access and inclusion of services.

The aim of this research is to evaluate the extent to which India’s Disability Policy encompasses the Core Concepts of Human Rights of persons with disabilities.

METHOD

Identification of Policy

A review of the websites of the Government of India, Ministry of Health and Family Welfare and the Ministry for Social Justice and Empowerment, showed the following policies and legislation relating to health and disability to be in place:

- National Policy for Persons with Disabilities (2006)
- National Health Policy (2002)
- The National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act (1999)
- The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act (1995)
- The Rehabilitation Council of India Act (1992).

The following Draft Bill was available but was not yet signed into law:

- The Draft Rights of Persons with Disabilities Bill (2012).

The National Policy for Persons with Disabilities (2006) was chosen for analysis. Although it is not a legislative document, it is the most recent relevant policy and therefore indicative of the Indian Government's stance on this issue. Policy forms the framework from which legislative change occurs and therefore Disability policy is the key to guiding government decision-making (Aldersey and Turnbull, 2011).

EquiFrame Analysis

To evaluate this from a human rights perspective, the EquiFrame analytical framework was used (Mannan et al, 2011). This provides a standardised measurement tool for analysis of existing policies and for development of policies within a human rights framework (Eide et al, 2012; MacLachlan et al, 2012; Eide et al, 2013). This tool has been previously used to assess policy from a human rights perspective in relation to persons with disabilities (Mannan et al, 2012b; Mannan et al, 2012c; Van Rooy et al, 2012; Schneider et al, 2013).

Although the framework was developed in 2011, it has been used to examine the National Policy for Persons with Disabilities (2006), as the authors felt it was valid. Previous published studies have used the EquiFrame tool and analysed documents published before its inception (Aldersey & Turnbull, 2011; Amin et

al, 2011; MacLachlan et al, 2012). Additionally, analysis using this tool can be of assistance to policy-makers during future revisions of policy.

EquiFrame consists of 21 pre-defined Core Concepts of Human Rights (Table 1) as well as the inclusion of 12 identified Vulnerable Groups (Table 2). For further information, please refer to EquiFrame manual (Mannan et al, 2011).

Table 1: EquiFrame Core Concepts, Key Questions and Key Language (Mannan et al, 2011)

No.	Core Concept	Key Question	Key Language
1.	Non-discrimination	Does the Policy support the rights of vulnerable groups with equal opportunity in receiving health care?	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics (i.e. Living away from services; Persons with disabilities; Ethnic minority or Aged).
2.	Individualised services	Does the Policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Vulnerable groups receive appropriate, effective, and understandable services.
3.	Entitlement	Does the Policy indicate how vulnerable groups may qualify for specific benefits relevant to them?	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grant.
4.	Capability-based services	Does the Policy recognise the capabilities existing within vulnerable groups?	For instance, peer to peer support among women- headed households or shared cultural values among ethnic minorities.
5.	Participation	Does the Policy support the right of vulnerable groups to participate in the decisions that affect their lives and enhance their empowerment?	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.
6.	Coordination of services	Does the Policy support assistance of vulnerable groups in accessing services from within a single provider system (inter-agency) or more than one provider system (intra-agency) or more than one sector (inter-sectoral)?	Vulnerable groups know how services should interact where inter-agency, intra-agency, and inter-sectoral collaboration is required.

7.	Protection from harm	Vulnerable groups are protected from harm during their interaction with health and related systems	Vulnerable groups are protected from harm during their interaction with health and related systems
8.	Liberty	Does the Policy support the right of vulnerable groups to be free from unwarranted physical or other confinement?	Vulnerable groups are protected from unwarranted physical or other confinement while in the custody of the service system/provider.
9.	Autonomy	Does the Policy support the right of vulnerable groups to consent, refuse to consent, withdraw consent, or otherwise control or exercise choice or control over what happens to him or her?	Vulnerable groups can express “independence” or “self-determination”. For instance, person with an intellectual disability will have recourse to an independent third party regarding issues of consent and choice.
10.	Privacy	Does the Policy address the need for information regarding vulnerable groups to be kept private and confidential?	Information regarding vulnerable groups need not be shared among others.
11.	Integration	Does the Policy promote the use of mainstream services by vulnerable groups?	Vulnerable groups are not barred from participation in services that are provided for general population.
12.	Contribution	Does the Policy recognise that vulnerable groups can be productive contributors to society?	Vulnerable groups make a meaningful contribution to society.
13.	Family resource	Does the Policy recognise the value of the family members of vulnerable groups in addressing health needs?	The policy recognises the value of family members of vulnerable groups as a resource for addressing health needs.
14.	Family support	Does the Policy recognise that individual members of vulnerable groups may have an impact on the family members, requiring additional support from health services?	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support.
15.	Cultural responsiveness	Does the Policy ensure that services respond to the beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic, or linguistic aspects of the person?	i) Vulnerable groups are consulted on the acceptability of the service provided ii) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, i.e. respectful of the culture of vulnerable groups

16.	Accountability	Does the Policy specify to whom, and for what, services providers are accountable?	Vulnerable groups have access to internal and independent professional evaluation or procedural safeguard.
17.	Prevention	Does the Policy support vulnerable groups in seeking primary, secondary, and tertiary prevention of health conditions?	
18.	Capacity building	Does the Policy support the capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups?	
19.	Access	Does the Policy support vulnerable groups – physical, economic, and information access to health services?	Vulnerable groups have accessible health facilities (i.e., transportation; physical structure of the facilities; affordability and understandable information in appropriate format).
20.	Quality	Does the Policy support efficiency by providing a structured way of matching health system resources with service demands in addressing health needs of vulnerable groups?	Vulnerable groups are assured of the quality of the clinically appropriate services.
21.	Efficiency	Does the Policy support efficiency by providing a structured way of matching health system resources with service demands in addressing health needs of vulnerable groups?	

Table 2: Vulnerable Group Definitions and Coverage in National Policy for Persons with Disabilities, India (2006): using the EquiFrame tool (Mannan et al, 2011)

Vulnerable Groups	Definition	Coverage in Policy
Limited Resources	Referring to poor people or people living in poverty	Not mentioned
Increased risk for Morbidity; Ischaemic heart disease, LRTI, CVD, Perinatal conditions, COPD, Diarrhoeal Disease, TB, HIV/AIDS, RTA, Self-inflicted harm.	Referring to people with one of the top 10 illnesses, identified by WHO, as occurring within the relevant country	Not mentioned
Mother- Child Mortality	Referring to factors affecting maternal and child health (0-5 years)	Mentioned
Women-headed Households	Referring to households headed by a woman	Not mentioned
Children with Special Needs	Referring to children marginalised by special contexts, such as orphans or street children	Mentioned
Aged	Referring to older age	Not mentioned
Youth	Referring to younger age without identifying gender	Mentioned
Ethnic Minorities	Referring to non-majority groups in terms of culture, race or ethnic identity	Not mentioned
Displaced Populations	Referring to people who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence	Not mentioned
Living away from Services	Referring to people living far from health services, either in time or distance	Mentioned
Suffering from Chronic Illness	Referring to people who have an illness which requires continuing need for care	Not mentioned
Disabled	Referring to persons with disabilities, including physical, sensory, intellectual or mental health conditions, and including synonyms of disability	Mentioned

Scoring

If a Core Concept was mentioned, it received a score on a continuum from 1 to 4. This was a rating of the quality of commitment to the Core Concept within the policy document, based on the criteria below:

1 = Concept only mentioned.

2 = Concept mentioned and explained.

3 = Specific policy actions identified to address the concept.

4 = Intention to monitor concept was expressed.

If a Core Concept was not relevant to the document context, it was stated as not applicable.

Scoring was also given to each of the 12 Vulnerable Groups mentioned.

Summary Indices

The 4 summary indices of EquiFrame are outlined below (Mannan et al, 2011):

1) **Core Concept Coverage:** The policy was examined with respect to the number of Core Concepts mentioned from among the 21 Core Concepts identified; and this ratio was expressed as a rounded-up percentage. In addition, the actual terminologies used to explain the Core Concepts within each document were extracted to allow for future qualitative analysis and cross-checking between raters (Amin et al, 2011; MacLachlan et al, 2011a; Mannan et al, 2011; Eide et al, 2012; Mannan et al, 2012c; Van Rooy et al, 2012; Mannan et al, 2013).

2) **Vulnerable Group Coverage:** The policy was examined with respect to the number of Vulnerable Groups mentioned from among the 12 Vulnerable Groups identified; a score of 1 was given to each Vulnerable Group mentioned and a total out of the 12 groups was calculated. This ratio was expressed as a rounded-up percentage. The 'Disabled' category comprises, "Persons with disabilities, including physical, intellectual, or mental health conditions and including synonyms of disability" (Amin et al, 2011).

Although the study analysed a disability policy and not a human rights policy, the authors feel that inclusion of Vulnerable Groups was important to the analysis, as it has been noted in the World Report on Disability (WHO & World Bank, 2011) that disability disproportionately affects vulnerable groups such as women, the aged, and those suffering from chronic illness. They may run the

risk of multiple vulnerabilities and hence their inclusion in the policy analysis is deemed appropriate.

3) **Core Concept Quality:** The policy was examined with respect to the number of Core Concepts within it that were rated as 3 or 4 (as either stating a specific policy action to address a Concept or an intention to monitor a Concept) out of the 21 Core Concepts identified; and this ratio was expressed as a rounded-up percentage. When several references to a Core Concept were found to be present, the top quality score received was recorded as the final quality scoring for the respective Concept.

4) The document was given an **Overall Summary Ranking** in terms of it being of High, Moderate or Low standing according to the following criteria:

- (i) High = if the policy achieved $\geq 50\%$ on all of the three scores above.
- (ii) Moderate = if the policy achieved $\geq 50\%$ on two of the three scores above.
- (iii) Low = if the policy achieved $< 50\%$ on two or three of the three scores above.

The policy document was assessed by 2 independent raters. Qualitative data was extracted for each of the pre-defined Core Concepts and Vulnerable Groups mentioned, and this was analysed and compared to ensure inter-rater reliability.

RESULTS

The National Policy for Persons with Disabilities (2006) scored 42% for Vulnerable Groups Coverage, including "Mother and Child Mortality", "Children with Special Needs", "Youth", "Living Away from Services" and "Disabled". The Policy failed to refer to the other 7 vulnerable groupings (see Table 2).

Under Core Concept Coverage, the policy scored 67%, with 14 out of the 21 Core Concepts explicitly mentioned in relation to health. "Capacity Building" was mentioned 13 times and "Quality" was mentioned 10 times; "Accountability" was mentioned 7 times; "Prevention" and "Non-Discrimination" were mentioned 6 times each; "Family Resource" was mentioned 5 times; "Protection from Harm" was mentioned 4 times; "Entitlement" and "Access" were mentioned 3 times; "Contribution" and "Efficiency" were mentioned twice; and "Individualised Services", "Participation" and "Co-ordination of Services" were mentioned once (See Table 3).

Table 3: The Core Concepts Analysis of National Policy for Persons with Disabilities, India (2006): using EquiFrame (Mannan et al, 2011)

Core Concepts	Example of Key Language	Score	Times Mentioned
Non-discrimination	Article 13: Services extended to uncovered rural areas	3	6
Individualised services	Article 44: State-based specialised services and Community Based Rehabilitation (CBR) with a focus of caregivers and persons with disabilities involved in the process of rehabilitation	1	1
Entitlement	Article 34: Disability certificates awarded through government	2	3
Capability-based services	Not mentioned	-	-
Participation	Article 44: CBR and self-help groups encouraged with a focus of caregivers and persons with disabilities involved in the process of rehabilitation	1	1
Coordination of services	Article 37 – Directory of services; NGO, state-funded and advocacy groups to be made	1	1
Protection from harm	Article 36: Orphaned children with disabilities will be provided care through guardianship schemes and the National Trust for persons with autism, cerebral palsy, mental retardation and multiple disabilities	1	4
Liberty	Not mentioned	-	-
Autonomy	Not mentioned	-	-
Privacy	Not mentioned	-	-
Integration	Not mentioned	-	-
Contribution	Article 44: State-based specialised services and CBR/Self-help groups with a focus of caregivers and persons with disabilities involved in the process of rehabilitation	2	2
Family resource	Article 43: Disability specific manuals for families provided free of cost	1	5
Family support	Not mentioned	-	-
Cultural responsiveness	Not mentioned	-	-
Accountability	Article 13: Regulations for private providers of rehabilitative services	4	7

Prevention	Article 9: Emphasis on prevention of disabilities	3	6
Capacity building	Article 45: HR development in training of primary level workers in healthcare and community developments	3	13
Access	Article 32: Ensure inclusive and effective access to health services for children with disabilities	1	3
Quality	Article 11: Early detection and rehabilitation facilities development	3	10
Efficiency	Article 4: Development of rehabilitation infrastructure; Rehabilitation Facilities: 5 Composite Rehab Centres, 4 Regional Rehabilitation Centres, 120 District Disability Rehabilitation Centres (DDRCs)	2	2

Under Core Concept Quality the policy scored 24%. Out of the 14 Core Concepts mentioned, 5 scored “3” or more on the quality rating. “Non-discrimination”, “Prevention”, “Capacity Building” and “Quality” mentioned specific actions being taken and scored a “3”. “Accountability” mentioned an intention to monitor actions and scored a “4” (see Table 3).

Overall, the National Policy for Persons with Disabilities (2006) scored a summary ranking of Low Quality as 2 scores were under the 50% rating (Mannan et al, 2011).

DISCUSSION

From analysis of the Core Concepts of Human Rights and the inclusion of Vulnerable Groups in the Indian National Policy for Persons with Disabilities (2006) it can be debated that the human rights of this group are not being fully realised.

Core Concept Coverage

The Core Concept of “Capacity Building” is mentioned most often, with 13 references in the National Policy for Persons with Disabilities (2006). This includes training and development of more rehabilitative staff, along with the improvement of infrastructure to facilitate rehabilitative services throughout the country. The Policy also addresses the need to assess human resource requirements and to make a development plan. With the current Human Resources for Health crisis,

the evidence base for task-shifting to cadres with specific skills required for health programmes is growing and may be of benefit in the field of CBR (MacLachlan et al, 2011b; Reddy et al, 2011; Mannan et al, 2012a). There was no specific mention of a human resource plan to train a new cadre of CBR professionals. However, this may be due to the fact that the WHO CBR guidelines were formulated after this Policy was developed, following the CBR conference in Abuja in 2010, and the call for development of this cadre was made in order to address these guidelines (Mannan & MacLachlan, 2010; WHO, UNESCO, ILO, IDDC, 2010).

With respect to the Core Concepts of “Quality”, “Efficiency” and “Capacity Building”, the National Policy for Persons with Disabilities (2006) does not describe in detail the CBR process or express an intention to monitor its quality and efficiency. The WHO CBR guidelines (2010) provide a framework for CBR programmes, along with guidelines for monitoring and evaluation of CBR services. These encompass a large framework comprising a holistic model of care including empowerment, education, welfare and health, and in doing so they develop previous rehabilitative practice (MacLachlan et al, 2011b). Intention to monitor the quality and efficiency of CBR is crucial in providing a high quality CBR service in line with the WHO guidelines. It was mentioned previously that the complex nature of CBR is difficult to measure; however, the “Quality” and “Efficiency” will be difficult to address without assessment and benchmarking of CBR services.

Another point to note regarding the Core Concept of “Efficiency” is that India’s public health spending is set to increase from 0.9% to 3% of Gross Domestic Product(GDP) (Sen, 2011). In the field of healthcare it was found that the public health system framework may not be ready to manage this type of spending efficiently, with some government bodies returning allocated funds due to inability to spend them (Sen, 2011). This needs to be addressed across all sectors; for example, education, employment, social protection, and transport etc., to ensure that adequate frameworks are in place to manage the funding needed to provide services.

In relation to the Core Concept of “Entitlement”, the provision of aids and appliances was mentioned in the Policy. The WHO estimates that 0.5% of the world’s population requires prosthetics or orthotics, which would give an estimate of over 62 million people in India who may require assistive devices (World Health Organisation & the International Society for Prosthetics and Orthotics, 2005). Additionally, prosthetics and orthotics have an estimated lifespan of 3 years

and so need regular updating (Faber & Saggurthi, 2013). Capacity building is essential to ensure coverage of services to the vast population and to persons with disabilities living away from urban areas. In the year prior to the development of this Policy, guidelines that were published by the WHO and the International Society for Prosthetics and Orthotics (2005) discussed task shifting for specific areas of prosthetics, with shorter training courses for specific areas. The Core Concept of “Capacity Building” in relation to Orthotists and Prosthetists or a plan for development of mid-level cadres was not specifically mentioned when “Entitlement” to devices was discussed.

This Policy document mentions the Core Concept of “Protection from Harm” in the context of women and children. It does not explicitly mention protection for adult males with disabilities. It is important to note that many people with disabilities may suffer from abuse both at a household and/or institutional level (Hughes et al, 2012). Given the link between disability and poverty, adults with disabilities are also vulnerable to harm from economic deprivation (Mitra et al, 2013). Acknowledging this, monitoring this and ensuring both safety and justice, is essential in upholding this group’s right to “Protection from Harm”.

In relation to the Core Concept of “Access”, the Policy mentions access to services for children with disabilities. It also mentions a barrier-free physical environment to services. However, it does not mention the barrier of cost to access. It is important to note that this country has a reputation for informal payments (Cherecheş et al, 2013). As a result, the cost of the service and/or “unofficial” costs of these services may act as a barrier to many. India has more people living in poverty than all of Sub-Saharan Africa combined (Horton and Das, 2011). Additionally, it is widely accepted that persons with disabilities are more likely to suffer from poverty (Lang et al, 2011; World Health Organisation & World Bank, 2011; Mitra et al, 2013). Addressing the barrier of cost to “Access” of services is essential for equitable service provision.

In order to encompass the Core Concepts of “Entitlement” and “Access”, a clear idea of the number of persons with disabilities would assist in appropriate levels of service provision and funding allocation. It was mentioned earlier that of the 2.14 billion population in India, it was estimated that 2.13% (Government of India, 2001) have disabilities, affecting over 21 million people. However, the WHO has estimated that on an average 15% of the world’s population is living with disabilities (World Health Organisation & World Bank, 2011). This could indicate that the Indian disability rate is under-reported. It was noted in the

National Disability Policy (2006) that recording and monitoring of persons living with disability needed to be addressed; this 2.13% of the Indian population estimate may give a false representation of this group's needs and resource requirements. A structured monitoring system needs to be incorporated into the Policy to ensure accurate data are gathered. In 2013 a registration scheme was announced for people who have suffered a stroke, which may begin to provide some improved epidemiological data for this subset of the population (Biswas, 2013). The Washington Group has developed both an extended and short set of questions for assisting in consistent measurement of disability amongst UN Member States (Madans et al, 2011). Incorporating this into Indian census data collection could greatly aid accuracy in gathering disability statistics (Mitra, 2013), and in turn allow for accurate provision for "Access" and "Entitlement" to services.

The Core Concept of "Non-discrimination" scored highly in this analysis as on 6 occasions it mentioned the need for services in rural underserved areas, with specific policy actions to address this. However, as mentioned previously, it did not address the need for services for people living in poverty.

The Core Concept of "Integration" was not explicitly mentioned in this policy. The Core Concept of "Co-ordination of Services" was mentioned once, in relation to the development of a directory of services. With regard to "Integration" and "Co-ordination of Services", it is interesting to contrast the National Policy for Persons with Disabilities (2006) with policies across other sectors. For example, India's current National Health Policy (2002) does not appear to correlate with the National Policy for Persons with Disabilities (2006). The National Health Policy (2002) does make reference to persons with disability as a vulnerable group. This is understandable as the Disability Policy was written 4 years later, but the National Health Policy (2002) would benefit by being updated to encompass a more inclusive framework in the light of India signing and ratifying the UNCRPD (2007), and ensuring that the two policies promote the same messages. This will assist in ensuring "Integration" of Disability and improved "Co-ordination of Services" across sectors.

The Core Concept of "Family Resource" was mentioned 5 times. The Policy document acknowledged the need to strengthen the capacity of the family for rehabilitation and home-based education. However, the Core Concept of "Family Support" was not mentioned. In utilising family to care for persons with disabilities, it is important to acknowledge that the family members themselves may require support.

This Policy document does not mention the Core Concepts of “Liberty”, “Autonomy” and “Privacy”. These are all integral to providing individualised services, allowing for confidentiality and freedom of choice for persons with disabilities.

The Core Concepts of “Individualised Services”, “Contribution” and “Participation” were mentioned once in reference to the involvement of caregivers and persons with disabilities with the process of rehabilitation. However, it did not discuss these provisions in detail. The Core Concepts of “Cultural Responsiveness” and “Capability Based Services” were not explicitly mentioned. The World Report on Disability promotes moving towards a bio-psychosocial approach to disability, which involves a person-centred approach (World Health Organisation & World Bank, 2011). This Policy would benefit from updates to include a person-centred approach, incorporating the use of a person’s strengths and capabilities, in addition to addressing any needs, in an individualised way.

One of the strengths of this Policy is the explicit mention of the Core Concept of “Accountability”. This Core Concept was mentioned 7 times from the aspect of overall responsibility for the policy, with monitoring delegated to the Ministry for Social Justice and Empowerment; the Rehabilitation Council responsible for the drawing up of a human resources strategy; and the NGOs and private providers to be made responsible and accountable for services and actions. There was also reference in the Policy to the monitoring of these actions and plans.

Another of the strengths of this Policy is the mention of “Prevention” (6 times) in relation to the expansion of sanitation, immunisation, public health and nutrition programmes. It also mentioned screening programmes for at-risk children, awareness programmes aimed at women of reproductive age, and prevention of secondary health problems through health service delivery.

Core Concept Quality

Out of the Core Concepts mentioned, only 4 discussed specific policy actions regarding the Core Concept in “Accountability”, “Capacity Building”, “Quality” and “Non-Discrimination”. Only the Core Concept of “Accountability” discussed the responsibility of monitoring and evaluation of policy actions, and assigned the responsibility for monitoring the overall policy to the Ministry of Social Justice and Empowerment, in addition to making NGOs and private service providers responsible for monitoring their services.

Vulnerable Group Coverage

The World Report on Disability noted that disability disproportionately affects Vulnerable Groups, for example, women, the aged and those suffering from chronic illness (World Health Organisation & World Bank, 2011). Within India, research has shown vulnerable groups in society such as those living in poverty, in lower levels of the caste system or those living in certain geographical areas, for example, have worse health outcomes and may receive poorer quality of care (Narayan, 2011; Patelet al, 2011). Identifying and highlighting these vulnerabilities, and placing strategies around addressing their needs, is integral to achieving their human rights (Amin et al, 2011). The inclusion of Vulnerable Groups in this Policy document allows for their needs to be addressed, in addition to addressing the risk of multiple discriminations based on numerous vulnerabilities.

The Vulnerable Group of “Women-headed Households” was not mentioned. It was noted in the World Report on Disability (2011) that women and girls with disabilities can face multiple forms of discrimination. Women were mentioned in the context of maternal and child health. However, further inclusion of “Women-headed Households” in relation to women with disabilities or women caring for family members with disabilities to address the burdens that they may face, including social exclusion and increased risk of poverty, may assist in reducing additional levels of discrimination.

The Vulnerable Group of “Suffering from Chronic Illness” was omitted from the Policy. The Vulnerable Group of “Increased Relative Risk for Morbidity” was also not mentioned. Given the link between chronic illness and disability, access to services and healthcare by an inclusive policy that provides “Health for all” as promoted by the “Declaration of Alma-Ata” (World Health Organisation, 1978) is the key to achieving a more equitable society (Patel et al, 2011; Khoury et al, 2013). For example, Chronic Obstructive Pulmonary disease (COPD), a chronic illness and the fifth most common cause of morbidity in India (World Health Organisation, 2006), can lead to significant disability such as reduced mobility, shortness of breath, oxygen dependence and social isolation. Persons with pre-existing disabilities may also suffer from chronic illnesses or increased risk of morbidity, for example, acquiring COPD or HIV/AIDS. Awareness of the link between disability and chronic illness, and addressing of the rights of access to services should be accounted for in the policy (Groce et al, 2013).

The Vulnerable Groups of “Youth” and “Children with Special Needs” were mentioned and emphasised in this Policy document. However, the Vulnerable

Group of “The Aged” has been neglected in this document. Due to the ageing process, many people within this group suffer from disabilities, both physical and cognitive in nature. Additionally, without proper access to healthcare and rehabilitative facilities as required, the aged population is more likely to suffer worsening disability (Lunenfeld & Stratton, 2013).

The Vulnerable Group of “Limited Resources” was not mentioned. As discussed previously, there is a link between disability and poverty (World Health Organisation & World Bank, 2011). Costs for services may be a barrier to many. For example, India’s health system includes a large private sector, encompassing 78% of total healthcare spending, with many people experiencing catastrophic out-of-pocket payments (Kumar et al, 2011). India also has a reputation for informal payments (Cherecheş et al, 2013). Persons with disabilities may also have more costs associated with accessing services, such as costs of transport. Acknowledging the Vulnerable Group of “Limited Resources” and addressing barriers to their accessing of services is the key to achieving equity among service users.

The Vulnerable Groups of “Ethnic Minorities” and “Displaced Populations” were not expressly mentioned in this Policy document. India has a complex social structure and inclusion of all minorities in policy documents is required to ensure their needs are addressed.

The Vulnerable Group of those “Living Away From Services” was mentioned on numerous occasions. The Policy document discussed the needs of service users in rural and underserved areas.

Limitations

This study analysed India’s National Policy for Persons with Disabilities (2006). However, a further analysis across policies of Health, Education, Transport, and Social Protection, to ensure streamlining and integration of disability across sectors may provide a better context.

It is also notable that while extensive and participatory consultation has been conducted in the formulation of the listing of Vulnerable Groups incorporated by the EquiFrame methodology, additional Vulnerable Groups could be added in accordance with the requirements of a specific context. For example, many of the social groups identified by the Global Fund (2011) as underserved and most-at-risk populations are not included by EquiFrame, including men who have sex

with men; transgender persons; people who use drugs; sex workers and their clients; and prisoners. This point highlights the explicit and purposeful objective, function, and capacity of EquiFrame as a methodology for guidance on health policy content analysis, providing a variety of summary indices in accordance with equity and core concepts of health-related human rights, which may be modified according to context and purpose.

Implications for further research

Although this piece of research focussed on analysing India's National Disability Policy, there is still scope to analyse and assess the wider policies of the country, which may allow for further analysis of the Human Rights of persons with disabilities in India.

CONCLUSION

India ratified the UNCRPD (2007) on 1st October 2007. As a primary general obligation, the Convention (in Article 4) obliges signatory States "to take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes" (UNCRPD, 2007). The analysis conducted here has indicated that India's current disability policy is of low quality with regard to encompassing the Human Rights of persons with disabilities. However, it is notable that India's Ministry for Social Justice and Empowerment created a Department of Disability Affairs in May 2012. This Department is now responsible for addressing the needs of the disability community in India. This marks a significant step forward. By assigning responsibility, improved monitoring of current legislation and policy may be initiated, and advocacy for this group strengthened within the Government. Hopefully it may help to shape future services for persons with disabilities.

During this time of economic growth, more resources are available for investment in social services (Paul et al, 2011). Introduction and comprehensive explicit inclusion of Core Concepts of Human Rights and Vulnerable Groups is urgently required in India's National Policy for Persons with Disabilities (2006). It is imperative that inclusion of persons with disabilities is realised in order to ensure that they are afforded the same dignity, respect and social inclusion as others, and the equity gap is reduced.

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