POLICY BRIEF

Closing the Last Mile

Health Access, Food Security and Disability Accessibility in Andhra Pradesh: An Action Agenda for Legislators

Prepared for Members of the Legislative Assembly, Andhra Pradesh

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Contents

Annexures A through C are designed to be photocopied and used independently of the main text.

Executive Summary

This brief asks for something specific: that Members of the Legislative Assembly in Andhra Pradesh use the tools already in their hands — Assembly questions, constituency development funds, district review committees, and their standing with district administration — to close three gaps that keep showing up together in the same households: poor access to basic healthcare, unreliable access to food entitlements, and physical environments that people with disabilities cannot use.

None of these gaps needs a new law. India already has strong statutes on the books. The National Food Security Act, 2013 makes subsidised foodgrain a legal entitlement, not a favour. The Rights of Persons with Disabilities Act, 2016 requires public buildings, transport and services to be accessible, and set deadlines that have already passed. The National Health Mission funds primary care infrastructure in every district. The problem is the last mile: the fair price shop with a step no wheelchair can climb, the anganwadi centre a child with cerebral palsy has never entered, the pension that stops because a biometric scanner cannot read worn fingerprints.

The numbers behind this are not obscure. Per the NFHS-5 survey (2019–21), roughly 31 per cent of children under five in Andhra Pradesh are stunted and about 59 per cent of women aged 15–49 are anaemic. Census 2011 counted 2.68 crore persons with disabilities in India — 2.21 per cent of the population — while the WHO estimates that about one in six people worldwide live with significant disability, which suggests our official count misses most of them. People who are missing from the count are also missing from ration lists, pension rolls and hospital planning.

Members of the Legislative Assembly sit at the exact point where these systems can be fixed. An MLA can compel answers from departments on the floor of the House, direct constituency development funds to ramps and accessible toilets, convene certification camps so residents actually get the UDID cards that unlock entitlements, and insist in district review meetings that accessibility compliance be reported the same way road-works progress is reported.

What this brief recommends, in brief

- **Audit first.** Commission a constituency-level accessibility audit of every primary health centre, fair price shop, anganwadi centre, government school and bus stand against the checklist in Annexure B. Most fixes cost thousands of rupees, not lakhs.
- **Fund the fixes locally.** Direct constituency development funds to the audit's findings: ramps, handrails, accessible toilets, signage and counter heights. Central SIPDA funds and 15th Finance Commission grants to local bodies can carry the larger works.
- **Bring certification to people.** Hold one UDID and disability-certification camp per mandal per year, jointly with the medical and revenue departments, so entitlements stop depending on a family's ability to travel to a district hospital.

- **Fix the ration last mile.** Push for doorstep delivery of PDS rations for cardholders with severe disabilities and for a working fallback when biometric authentication fails, so no one loses a legal entitlement to a machine error.
- **Ask questions on the record.** Table the model Assembly questions in Annexure A on accessibility deadlines under the RPWD Act, anganwadi infrastructure, and anaemia programme coverage. Written answers create data; data creates accountability.
- **Report annually.** Ask the government to place an annual accessibility and disability-inclusion statement before the Assembly, so progress is measured in public rather than assumed.

The rest of this document sets out the evidence, the legal obligations, and a costed, sequenced plan. It is written to be used: the annexures contain ready-to-table questions, an audit checklist that a small team can complete in a week, and a one-page reference to the schemes constituents ask about most.

1. Introduction: Why This Brief, and Who We Are

1.1 Purpose

This is a working document for legislators, prepared for Members of the Legislative Assembly in Andhra Pradesh. It covers three subjects that are usually handled by three different departments — health access, food access, and accessibility for persons with disabilities — and argues that at the constituency level they are one subject. The family that cannot get a disability certificate is often the same family skipping meals at the end of the month and postponing a hospital visit because the bus stand has no ramp and the fare is a day's wages.

The brief has three aims. First, to put the relevant facts and legal obligations in one place, so that a busy legislator or their staff can find the operative provision without wading through bare acts. Second, to translate those obligations into actions that are actually within an MLA's power — not what the Union government should do, not what an ideal state budget would fund, but what can be started in a single constituency this quarter. Third, to provide ready-made instruments: draft Assembly questions, an audit checklist, and a scheme reference table.

1.2 About ScholarSupport

ScholarSupport is a student-founded initiative working on education access and health literacy. Working with partner organisations, including KSNV, we have run health literacy workshops and outreach that has reached more than 1,000 people affected by health disparities. Our work in classrooms and community settings kept surfacing the same pattern: the barriers people described were rarely about ignorance and usually about access — a clinic too far, a document too hard to get, a building with stairs and no other way in.

We are not a think tank and do not claim to be one. What we bring is proximity to the people these systems are supposed to serve, and the willingness to do the unglamorous work — audits, camps, follow-up — that turns entitlements on paper into entitlements in hand. This brief draws on published government data, statute, and what we have seen and heard in our own outreach.

1.3 Scope and method

The brief focuses on Andhra Pradesh, with its 175 Assembly constituencies and 26 districts, though most recommendations would transfer to any Indian state. Quantitative claims rest on public sources: the National Family Health Survey (NFHS-5, 2019–21) state factsheet, Census 2011, budget documents, and the texts of the National Food Security Act, 2013 and the Rights of Persons with Disabilities Act, 2016. Where a figure is approximate, we say so. Where we could not verify something, we have left it out rather than dressed up a guess.

A note on language. We use “persons with disabilities” as the RPWD Act does. Where government schemes use other terms, we keep the scheme's official name so that readers can find it in departmental records.

1.4 How to read this document

Sections 2 through 6 are the evidence base: the legal floor, and the state of play in health, food and accessibility. A reader short on time can go straight to Section 7 (what an MLA can do), Section 8 (recommendations, sequenced by timeline), and the annexures. Each recommendation names the department responsible, the funding source, and the first concrete step.

2. The Legal and Policy Floor

Everything this brief asks for is already required by law or announced policy. That matters politically: an MLA pressing on these subjects is not asking the government for new generosity, but asking it to keep commitments the Parliament of India and the state's own government have made. This section sets out the floor beneath the three subjects of the brief.

2.1 Constitutional provisions

The Constitution does not use the word “accessibility”, but the Supreme Court has read the right to life under Article 21 to include the right to health and to live with dignity. Among the Directive Principles, Article 39(a) directs the State to secure adequate means of livelihood, Article 41 speaks to the right to public assistance in cases of disablement, and Article 47 makes raising the level of nutrition and public health a primary duty of the State. These are the constitutional pegs on which the statutes below hang. Public health, sanitation, hospitals and dispensaries sit in the State List — which is precisely why a state legislator's attention matters more here than in most policy fields.

2.2 The National Food Security Act, 2013

The NFSA converted food assistance from a scheme into a statutory entitlement. Its key provisions for constituency work:

- Priority households are entitled to 5 kg of foodgrain per person per month; Antyodaya Anna Yojana households to 35 kg per household. Since January 2023, foodgrain under the Act has been supplied free of cost, an arrangement the Union government extended for five years from January 2024.
- Children aged six months to six years are entitled to an age-appropriate meal through the anganwadi; children in government and aided schools to a hot cooked mid-day meal. These are entitlements under Sections 4 to 6 of the Act, not discretionary welfare.
- Pregnant and lactating mothers are entitled to maternity benefit of not less than ₹6,000, delivered through the Pradhan Mantri Matru Vandana Yojana.
- The Act mandates grievance redressal: a District Grievance Redressal Officer and a State Food Commission. Both exist on paper in every state; how often they are used in practice is a fair subject for an Assembly question.

Nothing in the Act conditions these entitlements on biometric authentication succeeding. Departmental circulars require exception-handling when Aadhaar authentication fails; a cardholder turned away because a scanner cannot read their fingerprints is being denied a statutory right.

2.3 The Rights of Persons with Disabilities Act, 2016

The RPWD Act replaced the 1995 law and is considerably more demanding. Points most relevant to an MLA:

- It recognises 21 categories of disability, including cerebral palsy, autism spectrum disorder, intellectual disability, blood disorders such as

thalassaemia and sickle cell disease, and acid attack survivors. A person with at least 40 per cent of a specified disability ("benchmark disability") qualifies for reservations and several schemes.

- Section 25 obliges governments to provide free healthcare, priority in attendance and treatment, and barrier-free access in all parts of government and aided hospitals.
- Sections 40 to 46 cover accessibility. The Rules of 2017 required existing public buildings to be made accessible within five years — a deadline that fell in June 2022 — and service providers to make services accessible within two years. These deadlines are law, and they have passed.
- Section 31 guarantees free education for children with benchmark disabilities between ages 6 and 18; Sections 16 and 17 oblige schools to be inclusive, with accessible buildings and appropriate teaching support.
- Reservation: not less than 4 per cent of government posts and 5 per cent of seats in government and aided higher education institutions.
- Institutions: a State Commissioner for Persons with Disabilities (Section 79) with the power to inquire into deprivation of rights, and a State Advisory Board (Section 66) that includes members of the State Legislature. District-level committees are also mandated.

The Act's enforcement machinery is only as strong as the questions put to it. The State Commissioner's annual report, and whether the State Advisory Board has met as required, are both matters an MLA can raise on the floor of the House.

2.4 National missions and central schemes

- **National Health Mission.** Funds primary health centres, community health centres, ambulance networks (108) and mobile medical units (104 services in Andhra Pradesh), plus programmes such as Anaemia Mukt Bharat and the Rashtriya Bal Swasthya Karyakram (RBSK), which screens schoolchildren for disease, deficiency and disability.
- **Ayushman Bharat – PM-JAY.** Cashless hospitalisation cover for eligible families, operating in Andhra Pradesh alongside the state health insurance scheme (NTR Vaidya Seva, previously Dr. YSR Aarogyasri).
- **Accessible India Campaign (Sugamya Bharat Abhiyan).** Launched in December 2015 to make buildings, transport and information systems accessible. Its citizen app allows anyone to report an inaccessible public building — a tool constituency offices can use systematically.
- **SIPDA.** The Scheme for Implementation of the RPWD Act provides central funds for accessibility works, skill training and early-intervention centres. States must propose projects to draw the money; an under-used pipeline is a choice, not a constraint.
- **Poshan Abhiyan / Saksham Anganwadi.** The national nutrition mission, working through anganwadi centres — which makes the physical accessibility of those centres a nutrition issue as much as a disability issue.

2.5 State schemes in Andhra Pradesh

Scheme names in Andhra Pradesh change with governments; entitlements mostly persist under new labels. As of this writing, the schemes an MLA's constituents will most often invoke are these:

Scheme	What it provides	Notes for constituency work
NTR Bharosa pensions	Monthly social pension; persons with disabilities receive an enhanced amount (₹6,000 per month as of the July 2024 revision, higher for certain severe conditions)	Most common grievances: certification thresholds, biometric failures, deletions during verification drives
Rice card / PDS	Free foodgrain under NFSA through fair price shops	Check shop accessibility, doorstep delivery for severe disability, nominee facility
NTR Vaidya Seva	Cashless treatment in empanelled hospitals for eligible families	Awareness is low for newer procedure lists; help desks at area hospitals help
Anna canteens	Subsidised cooked meals at ₹5 in urban centres	Siting near bus stands and hospitals, and accessible counters, determine who can use them
Mid-day meal (PM POSHAN, state-branded)	Hot cooked meal for schoolchildren	Include children with disabilities in home-based education in delivery planning
Anganwadi services (ICDS)	Supplementary nutrition, pre-school, growth monitoring for under-6s and mothers	Physical access and inclusion of children with disabilities are the weak points

The table is deliberately short. Annexure C carries a fuller version designed to be photocopied for constituency office staff.

> **The point of Section 2**
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> Every recommendation in this brief enforces an existing obligation. The deadlines in the RPWD Rules have passed; the NFSA entitlements are statutory; the state schemes are funded and announced. The question an MLA is entitled to press, in the House and in district meetings, is simply: where does compliance stand, and what is the plan to close the gap?

3. Health Access: Where the System Loses People

3.1 The shape of the problem

Andhra Pradesh is, by most all-India comparisons, a middling-to-good performer on health. It has a functioning ambulance network, a long-running state health insurance scheme, village-level health facilities under the Family Doctor programme, and health indicators generally better than the national average. That is exactly why this brief does not ask for a new hospital programme. The gap in the state is not the absence of a system; it is the number of people the existing system quietly loses.

People fall out of the system at predictable points. They do not know an entitlement exists. They know it exists but cannot complete the paperwork. They have the paperwork but cannot physically reach or enter the facility. They reach the facility but are turned away by queue, cost of the day's lost wages, or the absence of the one specialist they came for. Each of these steps loses a percentage of people, and the losses compound. A programme that is 90 per cent effective at each of five steps reaches barely half the people it was designed for.

Our own workshop experience matches this. When we ask attendees why a family member did not get treated, the answers are concrete and logistical: the bus, the queue, the second visit that was required, the document that was in the wrong name. Almost nobody says they did not believe in treatment. Health literacy work matters — it is much of what we do — but it works only when the system on the other side of that literacy is reachable.

3.2 What the data says

- NFHS-5 (2019–21) found that in Andhra Pradesh about 59 per cent of women aged 15–49 are anaemic, as are roughly 63 per cent of children aged 6–59 months. Anaemia at this scale is not a clinical footnote; it depresses school performance, work capacity and maternal outcomes across the whole population.
- Around 31 per cent of children under five are stunted and about 30 per cent underweight: better than many states, still nearly one child in three.
- Out-of-pocket expenditure remains a major driver of rural distress and debt nationally, which is why awareness and actual usability of NTR Vaidya Seva and PM-JAY, rather than their nominal coverage, is the operative question.
- Rural specialist vacancies at community health centres are a chronic all-India problem, and Andhra Pradesh is not exempt. A sanctioned post that has been vacant for three years is, for the patient, the same as no post.

Two cautions about data. First, the NFHS figures predate the most recent state programmes, so current performance may be better; the way to know is to ask, on the record, for district-wise updates. Second, almost none of the routinely published health data is disaggregated by disability. The state cannot say, today, what share of persons with disabilities are enrolled in its own health insurance scheme. That silence is itself a finding.

3.3 The access barriers that repeat

Distance and transport

Primary health centres serve populations spread over many villages. For a daily-wage household, a clinic visit costs the fare plus a lost day of income, twice if a follow-up is required. For a person using a wheelchair, the question is more basic: whether any bus on the route can be boarded at all. Telemedicine and mobile medical units blunt this barrier where they actually operate on schedule — worth verifying, not assuming.

Paperwork and proof

Insurance schemes, disability pensions and free-treatment categories all run on documents: ration card, Aadhaar, income certificate, disability certificate. Each document has its own office, queue and failure mode. Families at the margins — migrant workers, women separated from their husbands, elderly people with worn fingerprints — are precisely the families most likely to fail a document check and least equipped to appeal one.

The facility itself

Section 25 of the RPWD Act requires barrier-free access in government hospitals. In practice, many primary health centres have steps at the entrance, no accessible toilet, examination tables that cannot be lowered, and no staff member who knows sign language. A deaf patient describing symptoms through an untrained intermediary is receiving a lower standard of care, whatever the prescription says.

Information

Scheme awareness is uneven and skews toward those already connected: the literate, the networked, those near a town. Health literacy programmes like ours reach some of the rest, but the state's own last-mile machinery (ASHAs, anganwadi workers, village volunteers) is the only channel with universal reach. Whether that machinery has been briefed on disability entitlements is another question worth asking in writing.

3.4 What good looks like at constituency level

- Every PHC and CHC entrance passable by wheelchair, with one accessible toilet and priority queuing for persons with disabilities and pregnant women actually enforced — not a wall poster.
- A published weekly schedule for mobile medical units and specialist visits, displayed at panchayat offices, so that a family can plan a visit instead of gambling on one.
- RBSK school screening feeding into actual referrals: a child flagged for a developmental delay gets an appointment at the District Early Intervention Centre, and someone follows up when the family does not reach it.
- Anaemia testing and supplementation drives that report coverage by habitation, not by average, because averages hide exactly the hamlets being missed.

- A functioning help desk at the area hospital for NTR Vaidya Seva and PM-JAY, staffed by someone whose job is to say yes.

An honest constraint

An MLA cannot fill specialist vacancies or redesign the insurance scheme. But an MLA can make the losses visible: how many RBSK referrals were completed, how many biometric authentication failures occurred at pension disbursal, how many PHCs meet the accessibility standard. Departments manage what legislators measure.

4. Food Access and Nutrition: Entitlement versus Delivery

4.1 The paradox to hold in mind

Andhra Pradesh is a rice-surplus state with one of the country's older and denser public distribution networks, and it still records child stunting near 31 per cent and anaemia in a majority of its women. That pairing — plenty in the godown, deficiency in the body — tells you the problem is not production. It is a delivery problem, a diversity problem (calories without protein and micronutrients), and an inclusion problem: the households missing from the lists are the ones that needed the lists most.

4.2 The Public Distribution System, up close

The PDS in the state works well by national standards: rice cards cover most of the population, foodgrain is free under the NFSA arrangement in force since January 2023, and doorstep delivery models have been piloted through mobile dispensing units. The failure points are at the margins, and they are specific:

- **Biometric failure.** Manual labourers, the elderly, and people with certain disabilities (leprosy-cured persons, people with cerebral palsy, amputees) fail fingerprint authentication at rates far above average. Departmental rules provide for exceptions and nominees; shop-level practice frequently does not. Every month of failed authentication is a month of a statutory entitlement denied.
- **The shop itself.** Fair price shops are ordinary rented rooms, often up a step or two, with no seating and long waits. For a bedridden cardholder or a wheelchair user, the shop may as well be in another district unless the nominee system or doorstep delivery actually functions for them.
- **Exclusion from lists.** New households, migrant families, and adults with disabilities living apart from their parents routinely struggle to get cards issued or split. The application is digital-first, which helps the connected and strands the rest.
- **Quality and quantity disputes.** Underweighing and quality complaints persist wherever weighment is not displayed and grievance routes are unknown. The NFSA's District Grievance Redressal Officer exists for exactly this; almost no cardholder we have met has heard of the office.

4.3 Children: anganwadis and school meals

For children, food access runs through two institutions. The anganwadi delivers supplementary nutrition and growth monitoring for under-sixes; the school delivers the mid-day meal. Both are entitlements under the NFSA. Both have an inclusion gap with respect to disability.

A child with a disability who does not attend the anganwadi (because the building is inaccessible, or the worker feels unequipped, or the family anticipates rejection) silently loses the nutrition entitlement along with the pre-school one. The same happens at school age: children enrolled under home-based education

provisions of the RPWD Act are legally entitled to support, but a hot meal delivered at school does not reach a child who is never at school. Districts that have solved this did it simply, by attaching take-home rations or doorstep delivery to the home-based education roll. It is an administrative decision, not a budget line.

Growth monitoring deserves one more sentence: anganwadi weighing and screening is where developmental delays are often first noticed. An anganwadi worker trained to refer a child to the District Early Intervention Centre is the cheapest disability-detection infrastructure the state owns.

4.4 Anaemia as a legislative subject

Anaemia is worth an MLA's specific attention because it is common, measurable, cheap to treat, and moves within a single electoral term. The interventions — iron and folic acid supplementation, deworming, fortified rice through PDS and school meals, testing at scale — are all funded under existing programmes (Anaemia Mukt Bharat, Poshan Abhiyan). What is usually missing is coverage reporting at a level fine enough to act on. A district average of 59 per cent anaemia is a headline; a mandal-wise table is a work plan. Asking for the mandal-wise table, twice a year, in writing, is a perfectly good use of an unstarred Assembly question.

4.5 Community kitchens and the ₹5 meal

The revived Anna canteens serve subsidised cooked meals at ₹5 in urban locations. For daily-wage workers, the elderly poor, patients' families camped outside hospitals, and homeless persons with psychosocial disabilities, a reliable cooked meal is the difference between a manageable day and a desperate one. Three constituency-level variables decide whether canteens serve the people who need them most: siting (near bus stands, hospitals, labour addas), hours (matching shift work, not office hours), and the physical counter (reachable from a wheelchair, with staff briefed to serve patrons who cannot queue). All three are locally negotiable; none requires Amaravati's permission.

> **What Section 4 adds up to**
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> Food security in the state is no longer mainly a question of whether grain reaches the shop. It is whether the last hundred metres work for the least mobile cardholder, whether children outside institutions keep their entitlements, and whether nutrition quality — not just calorie delivery — is anyone's named responsibility. All three are visible from, and fixable at, the constituency level.

5. Disability and Accessibility: The Widest Gap

5.1 How many people are we talking about?

Census 2011 counted 2.68 crore persons with disabilities in India, 2.21 per cent of the population. The WHO's global estimate is that about one in six people live with significant disability. The gap between those figures is not a technicality. India's census question undercounts psychosocial, intellectual and multiple disabilities, and undercounts women with disabilities most of all. Applied to a typical Assembly constituency of a few lakh people, the honest range runs from several thousand officially counted persons with disabilities to several tens of thousands by international prevalence — most of them uncertified, and therefore invisible to every scheme that keys off a certificate.

This is the single most useful fact in this section: in most constituencies, the majority of persons with disabilities are not in the system at all. Every downstream entitlement — pension, reservation, travel concession, assistive devices, insurance priority — depends on a disability certificate and, increasingly, a UDID card. Certification is the gate, and the gate is far away.

5.2 Certification and the UDID bottleneck

Getting certified typically means travelling to a district or area hospital, often more than once, for assessment by a medical board that sits on certain days, subject to the availability of the relevant specialist. For a rural family supporting a member with a severe disability, each attempt costs transport for two people and lost wages. Families give up; the paperwork defeats them before the medicine does. The 21-category framework of the RPWD Act made more people eligible, but assessment capacity for the newer categories — autism, learning disabilities, blood disorders — is concentrated in a handful of facilities.

The proven fix is to move the board, not the family: periodic certification camps at mandal level, with the medical board, UDID enrolment, and pension processing at one venue on one day. Districts across the country have run such camps for years. The binding constraint is administrative will and coordination between the medical, revenue and welfare departments — which is exactly the coordination an MLA convenes better than anyone else in the district.

5.3 The built environment

The RPWD Rules set a five-year deadline, expiring June 2022, for making existing public buildings accessible. Walk any constituency headquarters town today and audit the government buildings against the harmonised accessibility guidelines: entrance ramps of usable slope, doors a wheelchair can pass, an accessible toilet that is not locked or used for storage, signage, a reachable counter. Most buildings fail, and fail cheaply — the missing ramp is a few thousand rupees of masonry; the locked toilet is a management order, not a work order.

Three categories of building matter most, because they gate everything else:

- **Health facilities** (PHCs, CHCs, area hospitals): inaccessibility here compounds every health gap in Section 3.

- **Entitlement points** (fair price shops, panchayat and tahsildar offices, banks and post offices where pensions land): inaccessibility here converts legal entitlements into other people's favours, because the cardholder must depend on an intermediary.
- **Schools and anganwadis:** inaccessibility here decides whether inclusive education under Sections 16–17 of the RPWD Act is real. A school with a ramp, an accessible toilet and one trained resource teacher retains children with disabilities; a school with none quietly sheds them, and the dropout is recorded as the family's choice.

Transport belongs in the same paragraph as buildings. Bus travel is the accessibility question for rural Andhra Pradesh: whether APSRTC's fleet on ordinary district routes includes any boarding-accessible buses, whether conductors hold the reserved seats, whether bus stands have ramps and audible announcements. Rail and air matter less to daily life than the 20-kilometre bus ride to the mandal headquarters.

5.4 Education and early intervention

The earlier a disability is identified and supported, the smaller its lifelong cost, to the person and to the exchequer. The machinery exists on paper: RBSK screening in schools and anganwadis, District Early Intervention Centres for children under six, resource teachers under Samagra Shiksha, and the Section 31 guarantee of free education for ages 6 to 18. The constituency-level questions are about throughput, and they are askable: How many children were flagged by RBSK screening last year, and how many completed referral? Does the DEIC have its sanctioned therapists? How many schools in the constituency have a resource teacher within reach? Vague answers to precise questions are themselves informative, and they are on the record.

5.5 Livelihood, pensions and dignity

The disability pension (₹6,000 monthly under NTR Bharosa as of the July 2024 revision, higher for certain severe conditions) is, for many households, the most tangible thing the state does. Grievances cluster in three places: people wrongly assessed below the 40 per cent benchmark; deletions during verification drives that the affected family learns about only when the money stops; and the recurring biometric problem at disbursal. Each cluster is legible to a constituency office that keeps a simple register of pension complaints, and each has an escalation route — the medical board, the collectorate, the State Commissioner for Persons with Disabilities under Section 79.

Beyond pensions, the 4 per cent reservation in government posts is under-filled nearly everywhere, mostly through vacancy-identification exercises that never happened rather than through hostile intent. A written Assembly question asking which departments have completed identification of posts under Section 33, and what the current shortfall is, tends to produce movement, because the legal position is unambiguous and no minister wants to defend a blank.

5.6 Attitudes, and why hardware is still the right first ask

Everyone who works in this field knows that attitudes, whether of officials, employers, teachers or sometimes families, are the deepest barrier. But attitudes shift slowly and resist legislation, while ramps, camps and registers move now and create the daily contact that shifts attitudes over time. A person with a disability who can enter the panchayat office, collect their own ration and sit in the front row of the gram sabha is the most effective sensitisation programme a constituency can run. This brief therefore leads with hardware and process, in the confident expectation that culture follows contact.

6. Where the Three Gaps Meet

Treating health, food and disability as separate files misses what our outreach sees plainly: they concentrate in the same households and multiply each other. Four intersections deserve explicit attention in constituency planning.

6.1 Disability and nutrition

Children with disabilities are at sharply higher risk of malnutrition: feeding difficulties, exclusion from anganwadi services, and family poverty deepened by care costs all pull the same direction. Malnutrition, in turn, causes and worsens disability: iodine and folate deficiencies, untreated anaemia in pregnancy, and early-childhood stunting all feed the developmental-delay caseload. A nutrition programme that cannot count how many of its beneficiaries have disabilities is not neutral; it is missing the children who need it most. The fix is boring and effective: one column in the anganwadi register, one line in the review meeting.

6.2 Disability and healthcare cost

Households with a member with a disability spend more on health, earn less on average, and travel further for services; the WHO's global work and Indian studies agree on the direction. Insurance helps only where enrolment, empanelment and the physical hospital all work for the family. Priority enrolment of certified persons with disabilities in NTR Vaidya Seva and PM-JAY, and a disability column in the schemes' own dashboards, would cost almost nothing and reveal a great deal.

6.3 Food schemes as the state's contact surface

The ration shop, the anganwadi and the school meal are the state's most frequent points of contact with poor households, monthly or daily against a hospital's yearly. Whatever the state wants to find (uncertified disabilities, anaemic mothers, out-of-school children) it will find fastest at these contact points, if the staff there are asked and trained to look. Constituency-level convergence — one mandal-level review that puts the food, health and welfare functionaries at one table — costs a morning per quarter.

6.4 The certification key

Almost every intersection above is unlocked by the same key: certification and UDID coverage. It is the single intervention with the widest downstream effect, which is why the certification camp is this brief's first-ranked recommendation. A constituency that gets certification coverage right will find every other programme working better within a year, because its beneficiary lists finally resemble its population.

7. What an MLA Can Actually Do

This section is the hinge of the brief. It lists the instruments available to a sitting MLA in Andhra Pradesh, in rough order of effort, with the use we are proposing for each. None requires a ministerial berth; several work as well from the opposition benches as from the treasury.

7.1 Questions in the Assembly

Starred and unstarred questions remain the cheapest accountability instrument in Indian politics. A written answer from a department is citable, comparable year over year, and collectable across MLAs. The strategic use is not the dramatic starred question but the patient unstarred one that extracts a table: district-wise accessibility compliance, mandal-wise anaemia coverage, pending UDID applications by district. Annexure A supplies fifteen drafted questions; a member tabling three per session would, within two years, have assembled a public dataset on these subjects that currently does not exist.

7.2 Constituency Development Programme funds

Andhra Pradesh's Assembly Constituency Development Programme gives each MLA an annual works allocation whose size varies by budget year. Accessibility works are almost ideally suited to it: small, visible, quick to execute through existing panchayat and municipal machinery, and spread across the constituency rather than concentrated in one village. A single year's allocation, directed by an audit, can plausibly retrofit every PHC and a large share of fair price shops and anganwadis in a constituency with ramps, handrails and accessible toilets. Few uses of the fund produce more benefit per rupee or per photograph.

7.3 Convening power in the district

An MLA's letter gets a meeting that a citizen's letter does not. The proposals in this brief that involve multiple departments — certification camps (medical, revenue, welfare), doorstep PDS delivery (civil supplies, panchayat raj), school accessibility (education, engineering) — stall precisely at inter-departmental seams. A quarterly convergence meeting at the constituency or mandal level, chaired by the MLA with the tahsildar, medical officer, CDPO, MEO and civil supplies deputy at the table, is where the seams get sewn. District-level review bodies, including the committees that track central scheme implementation, offer the same reach at a higher altitude for members who sit on them.

7.4 The floor of the House beyond questions

- Calling-attention notices and short-discussion motions can put a lapsed statutory deadline, such as the June 2022 accessibility deadline under the RPWD Rules, onto the day's record and the minister's desk.
- Private members' resolutions, though rarely passed, set markers. A resolution seeking an annual disability-inclusion statement before the House costs nothing and invites cross-party signatures, since disability is one of the few subjects with no natural party alignment.

- Committee membership: petitions, assurances and estimates committees can each be steered toward these subjects; the assurances committee, in particular, can chase the follow-through on every answer a department gives to the Annexure A questions.

7.5 The constituency office as infrastructure

Most of what reaches an MLA's camp office is individual grievance: a stopped pension, a rejected card, a denied admission. Handled one by one, these consume staff time and vanish. Logged in a simple register — date, mandal, scheme, failure type — they become the constituency's best dataset. Three months of honest logging will identify the failing fair price shops, the pension deletion clusters, and the schools turning away children with disabilities, with more precision than any survey. We are prepared to help design and maintain such a register; the format fits on one page.

7.6 Statutory levers most members never pull

- A reference to the State Commissioner for Persons with Disabilities under Section 79 of the RPWD Act, asking for an inquiry into a specific pattern of deprivation (for instance, inaccessible fair price shops in a named mandal), obliges a formal response.
- The State Advisory Board on disability, which includes legislators, is required to meet and advise; asking when it last met is itself a productive embarrassment.
- The District Grievance Redressal Officer under the NFSA exists in every district. An MLA who routes ration grievances through the DGRO in writing builds a paper trail that a phone call to the dealer never creates.
- Under the Sugamya Bharat app, complaints about inaccessible public buildings are geotagged and tracked centrally; a constituency office that files fifty in a month creates a dataset the district cannot ignore.

> **The one-sentence version of Section 7**
>
> An MLA who tables the questions, points the development fund at the audit, convenes the quarterly table, and keeps the register will move these three subjects further in one term than a decade of well-meaning appeals to Amaravati or Delhi.

8. Recommendations

Twelve recommendations follow, sequenced into three horizons. Each names the lead actor, the funding source, and the first step. The sequencing is deliberate: the first horizon builds the information base and delivers visible wins; the second institutionalises; the third legislates.

8.1 Horizon one: the first twelve months

1. **Commission the constituency accessibility audit.** Cover every PHC, CHC, fair price shop, anganwadi, government school, panchayat office and bus stand against the Annexure B checklist. A team of four — we would volunteer for this — can audit a mandal in a week. Lead: MLA's office with volunteers. Cost: near zero. First step: pick the first mandal and fix a date.
2. **Fund the fixes from the Constituency Development Programme.** Rank audit findings by usage of the building and cheapness of the fix; ramps, handrails, signage and toilet retrofits first. Lead: MLA; execution through panchayat raj engineering. Funding: ACDP, topped up by 15th Finance Commission grants to local bodies. First step: a works list from the first audited mandal.
3. **Run one certification and UDID camp per mandal per year.** Medical board, UDID enrolment, pension application and assistive-device assessment at one venue on one day; ASHA and anganwadi workers mobilise attendance from a pre-list. Lead: District Medical & Health Officer, convened by the MLA. Funding: existing departmental budgets; SIPDA for assistive devices. First step: a letter to the Collector proposing the calendar.
4. **Fix the PDS last mile for the least mobile.** Doorstep delivery or a working nominee arrangement for every cardholder with a severe disability or bedridden status; an exception register at every fair price shop for biometric failures, inspected monthly. Lead: civil supplies department. Cost: administrative. First step: an unstarred question (Annexure A, Q6–Q7) establishing the current rules, followed by a constituency pilot.
5. **Table the Annexure A questions.** Three per session, rotating across the three subjects. Lead: MLA. Cost: nil. First step: hand Annexure A to the member's legislative assistant this week.
6. **Start the grievance register.** One page, five columns, filled in for every scheme grievance the camp office receives. Reviewed monthly; clusters escalated to the DGRO or State Commissioner in writing. Lead: constituency office staff. Cost: nil. First step: print the register.

8.2 Horizon two: years one to three

7. **Make every anganwadi accessible and inclusive.** Ramps and toilet access from ACDP and ICDS maintenance funds; one training cycle for anganwadi workers on disability inclusion and DEIC referral; a disability column in the anganwadi register. Lead: ICDS project officer. First step: include anganwadis in audit horizon one.

8. **Close the RBSK referral loop.** Quarterly reporting, to the MLA's convergence meeting, of children screened, referred and actually seen at the DEIC, with reasons for non-completion. Lead: DM&HO. First step: ask for the current numbers — the gap between screened and seen will justify everything else.
9. **Get boarding-accessible buses onto district routes.** Press APSRTC, through the House and the district transport committee, for a published plan: accessible buses on the highest-footfall constituency routes, bus stand ramps, enforced reserved seating. Lead: APSRTC regional manager. First step: Annexure A, Q12.
10. **Attach nutrition delivery to home-based education rolls.** Every child registered for home-based education under the RPWD Act receives take-home rations or delivered meals equivalent to the school entitlement. Lead: education and ICDS jointly. First step: obtain the constituency's home-based education roll — its probable smallness is the point.

8.3 Horizon three: the state level

11. **An annual disability-inclusion and accessibility statement before the Assembly.** Department-wise compliance with RPWD accessibility deadlines, reservation fill rates under Section 33, SIPDA utilisation, and UDID coverage against estimated prevalence. Sought first by resolution; adopted, it becomes the state's standing scorecard. Lead: welfare department, on the House's direction.
12. **No occupancy certificate without accessibility compliance.** Amend building-permission workflow so that new public buildings are verified against the harmonised accessibility guidelines before occupancy — enforcement at the one moment when the state holds every card and retrofit cost is zero. Lead: municipal administration department. First step: a private member's resolution, paired with quiet work on the responsible minister.

A note on what is deliberately absent. This brief does not ask for new cash transfer schemes, new institutions, or demands whose fiscal size makes them easy to decline. Every item above is either administrative, fundable from allocations that already exist, or — in the case of the two state-level items — a reporting and process change. The design principle is that nothing here should be refusable on cost.

9. What It Costs and Where the Money Is

Orders of magnitude, not estimates; actual costs will come from the audit. The purpose of this section is to show that money is not the binding constraint.

Item	Typical unit cost	Funding source
Masonry ramp with handrail, single entrance	₹15,000–60,000 depending on rise and length	ACDP / panchayat funds / 15th FC grants
Accessible toilet retrofit in existing building	₹40,000–1,50,000	ACDP / Swachh Bharat convergence / SIPDA
Signage and counter modification, per facility	₹5,000–20,000	Departmental maintenance budgets
Certification camp, per mandal (logistics)	₹25,000–75,000	Departmental budgets; camp model already standard
Assistive devices (per beneficiary average)	₹3,000–15,000	ADIP scheme / SIPDA / CSR
Grievance register and audit programme	Effectively nil	Volunteer time; we offer ours

9.1 Sources worth knowing in detail

- **SIPDA** (Scheme for Implementation of the RPWD Act): central funds for accessibility works, early-intervention centres and skill training. Drawdown requires state proposals; under-utilisation is common and reversible. An Assembly question on the state's SIPDA utilisation over the last three years (Annexure A, Q10) will establish the headroom.
- **15th Finance Commission grants** flow directly to panchayats and urban local bodies, with untied components usable for exactly the small works this brief lists. Panchayat-level resolutions steer them; an MLA's suggestion at the gram sabha usually suffices.
- **CSR.** Disability, health and nutrition all sit in Schedule VII of the Companies Act. Industrial units in and near the constituency can fund devices, camp logistics and school retrofits. A one-page proposal from the MLA's office, with the audit as evidence, is the instrument.
- **Convergence,** the least glamorous source: Swachh Bharat for toilets, Samagra Shiksha for school ramps and resource teachers, NHM flexipool for camp logistics, MGNREGS for approach paths. Each exists; the quarterly convergence meeting (Section 7.3) is where they are actually combined.

10. Monitoring: A Scorecard That Fits on One Page

Programmes drift when nobody owns a number. We propose ten indicators, reviewed twice a year: once at a constituency meeting, once via Assembly question. Baselines come from the first audit and the first round of departmental answers.

#	Indicator	Source	Direction
1	Public buildings in constituency meeting basic accessibility checklist (%)	Constituency audit (Annexure B)	Up
2	UDID cards issued in constituency vs. Census-based estimate	District welfare office	Up
3	Certification camps held per year; applicants cleared same-day (%)	DM&HO	Up
4	PDS cardholders with severe disability receiving doorstep/nominee delivery	Civil supplies	Up
5	Biometric exception register entries resolved within one month (%)	Civil supplies	Up
6	RBSK referrals completed at DEIC (%)	DM&HO	Up
7	Anaemia among women 15–49, mandal-wise where testable	Health department / NFHS rounds	Down
8	Children on home-based education rolls receiving meal-equivalent rations (%)	Education + ICDS	Up
9	Schools with functional ramp, accessible toilet and assigned resource teacher (%)	Education department	Up
10	Pension grievances pending beyond 60 days	Constituency register	Down

Two rules keep a scorecard honest. Publish it; a laminated sheet at the camp office and a post on the MLA's social channels twice a year is enough. And never let an indicator be reported as an average when a distribution is available; averages are where failures hide.

We commit, for our part, to supporting the audit rounds, maintaining the register template, and returning annually with an updated version of this brief reflecting what the answers to the Annexure A questions reveal.

Annexure A: Fifteen Model Assembly Questions

Drafted for tabling as unstarred questions unless noted; a legislative assistant should adapt form to the current rules of procedure. Grouped by subject.

On disability and accessibility

Q1. Will the Government state the number of government and government-aided public buildings in the State that have been certified as compliant with the accessibility standards notified under the Rights of Persons with Disabilities Rules, 2017; the number yet to be made compliant; and the time-bound plan, district-wise, for achieving compliance, given that the five-year period prescribed under the Rules expired in June 2022?

Q2. Will the Government furnish district-wise figures of (a) Unique Disability ID cards issued to date, (b) applications pending and their average pendency, and (c) the estimated population of persons with disabilities per Census 2011, together with the steps proposed to close the gap between (a) and (c)?

Q3. Will the Government state the schedule of medical boards for disability certification in each district; whether certification camps at mandal level are proposed; and the specialist availability for assessment of the 21 categories recognised under the RPWD Act, 2016, in particular autism spectrum disorder, intellectual disability and blood disorders?

Q4. Will the Government state, department-wise, the number of posts identified for reservation under Section 33 of the RPWD Act, 2016, the current fill rate against the 4 per cent requirement, and the backlog vacancies proposed to be filled in the current year?

Q5. Will the Government state when the State Advisory Board on Disability last met, the recommendations it made, and the action taken thereon; and whether the annual report of the State Commissioner for Persons with Disabilities has been laid before the House as required?

On food access

Q6. Will the Government state the current provisions for doorstep delivery of foodgrains to ration cardholders who are bedridden or have severe disabilities; the number of beneficiaries availing such delivery, district-wise; and whether the Government proposes to notify a uniform entitlement to such delivery?

Q7. Will the Government state the number of biometric authentication failures recorded at fair price shops in the last twelve months; the exception-handling procedure prescribed where authentication fails; and the mechanism by which a cardholder denied grain due to authentication failure may obtain the entitlement in the same month?

Q8. Will the Government furnish mandal-wise data on coverage of iron and folic acid supplementation and anaemia testing under Anaemia Mukt Bharat for the last year, together with the prevalence estimates the Department currently uses for planning?

Q9. Will the Government state the number of children registered under home-based education pursuant to the RPWD Act, 2016, district-wise, and the arrangements by which such children receive the nutrition entitlements available to school-attending children under the National Food Security Act, 2013?

On health access

Q10. Will the Government state the funds sought and received by the State under the Scheme for Implementation of the Rights of Persons with Disabilities Act (SIPDA) in each of the last three years, the projects sanctioned, and the utilisation certificates furnished?

Q11. Will the Government state the number of primary health centres and community health centres that provide barrier-free access as required by Section 25 of the RPWD Act, 2016, including ramp access and at least one accessible toilet, and the plan for the remainder?

Q12. Will the Government state the number of boarding-accessible buses in the APSRTC fleet, the routes on which they operate, and the corporation's plan for accessible services on district and mandal routes; and the number of bus stations with ramp access and audible announcements?

Q13. Will the Government furnish, district-wise, the number of children screened under the Rashtriya Bal Swasthya Karyakram in the last academic year, the number referred to District Early Intervention Centres, and the number whose referrals were completed, with the sanctioned and filled strength of therapists at each DEIC?

Q14. Will the Government state the enrolment of persons with disabilities under NTR Vaidya Seva and PM-JAY, and whether the Government proposes to report scheme utilisation disaggregated by disability status?

Q15. Will the Government state the number of complaints received through the Sugamya Bharat portal and other channels regarding inaccessible public buildings in the State, and the disposal thereof?

Annexure B: Constituency Accessibility Audit Checklist

One page per facility. Mark each item Yes / No / Partial, photograph failures, and note the estimated fix. Derived from the Harmonised Guidelines and Standards for Universal Accessibility in India (2021); simplified for lay auditors. A two-person team needs about forty minutes per facility.

#	Check	Standard to apply
1	Step-free entrance, or ramp available	Slope not steeper than 1:12; firm surface; no loose mats
2	Ramp handrails	Both sides, 760–900 mm height, extending beyond top and bottom
3	Main door width	Clear opening at least 900 mm; wheelchair passes without lifting
4	Level internal circulation	No internal steps on the route to the service counter/consultation room
5	Accessible toilet	Present, unlocked, not used for storage; grab bars; 900 mm door; space to turn
6	Service counter height	A section at 750–800 mm usable from seated position
7	Seating in waiting area	Some seats with armrests; space for a wheelchair beside seating
8	Signage	Room/service signs readable, with symbols; at PHCs, key signs in Telugu
9	Tactile indicators	Warning strip at ramp edges and steps (larger facilities)
10	Drinking water point	Tap or dispenser reachable from seated position
11	Lighting	Entrance, corridors and toilet adequately lit after dusk
12	Emergency egress	Exit route usable by a wheelchair user; staff aware of assistance duty
13	Parking / drop-off	Space near entrance where a vehicle can stop for boarding (larger facilities)
14	Staff awareness	Staff can state the priority-service rule and whom to call for assistance
15	Complaint route displayed	Name and phone of grievance officer visible at entrance

Scoring and use

- Score each facility out of 15. Anything below 8 goes on the priority works list; items 1, 3, 5 and 6 are disqualifying failures at health facilities and fair price shops regardless of total score.
- Photographs matter more than scores: a works order attaches to a photograph, and a before/after pair is the MLA's proof of delivery.
- Repeat annually. The second audit is the accountability instrument: it converts last year's promises into this year's percentages.

Annexure C: Scheme Quick Reference for Constituency Offices

For camp-office staff answering walk-in queries. Verify current amounts each budget year; names change more often than entitlements.

Need at the counter	Scheme / provision	Where to apply or escalate
Disability certificate & UDID	RPWD Act certification; UDID portal	Medical board at district/area hospital; camps when scheduled; escalate to DM&HO
Disability pension	NTR Bharosa (₹6,000/month as of July 2024 revision; higher for certain conditions)	Village/ward secretariat; escalate to MPDO / municipal commissioner
Ration card issues (new, split, correction)	NFSA / rice card	Village/ward secretariat; escalate to tahsildar, then District Grievance Redressal Officer
Grain denied at shop (biometric or stock)	NFSA entitlement (free foodgrain)	Insist on exception register entry; complain to DGRO; note dealer and date
Hospital treatment costs	NTR Vaidya Seva / PM-JAY	Aarogyamithra desk at empanelled hospital; scheme helpline
Child (0–6) nutrition & preschool	ICDS / anganwadi services	Local anganwadi; escalate to CDPO
School meal / school access for child with disability	PM POSHAN; RPWD Act ss. 16–17, 31	Headmaster; MEO; district education officer
Assistive devices (wheelchair, hearing aid, etc.)	ADIP scheme / SIPDA camps	District welfare office; ALIMCO camps when scheduled
Maternity benefit	PMMVY (₹6,000 minimum under NFSA)	Anganwadi worker / ASHA registers the claim
Subsidised cooked meal	Anna canteen (₹5)	Nearest canteen; timings from municipal office
Inaccessible public building	RPWD Act ss. 40–46	Sugamya Bharat app; State Commissioner for PwDs; copy to MLA office register
Job reservation grievance	RPWD Act s. 33–34 (4% in government posts)	Appointing authority; State Commissioner for PwDs

Annexure D: Sources and Further Reading

- National Family Health Survey (NFHS-5), 2019–21: India and Andhra Pradesh state factsheets, Ministry of Health and Family Welfare / IIPS.
- Census of India 2011, tables on disabled population (C-series).
- The Rights of Persons with Disabilities Act, 2016, and the Rights of Persons with Disabilities Rules, 2017.
- The National Food Security Act, 2013.
- Harmonised Guidelines and Standards for Universal Accessibility in India, 2021, Ministry of Housing and Urban Affairs / CPWD.
- WHO, Global Report on Health Equity for Persons with Disabilities, 2022.
- Accessible India Campaign (Sugamya Bharat Abhiyan) documentation, Department of Empowerment of Persons with Disabilities, Government of India.
- Scheme guidelines: SIPDA; ADIP; Anaemia Mukt Bharat; Rashtriya Bal Swasthya Karyakram; PM POSHAN; Poshan Abhiyan; Pradhan Mantri Matru Vandana Yojana.
- Government of Andhra Pradesh: budget documents and scheme government orders for NTR Bharosa, NTR Vaidya Seva, Anna canteens, and the public distribution system, various years.
- State of play figures for Andhra Pradesh schemes reflect public announcements as of mid-2026; amounts and names should be re-verified against current government orders before citation in the House.

Prepared by ScholarSupport. Correspondence: reachscholarsuport@gmail.com. We welcome corrections; a brief that is wrong somewhere should be fixed, not defended.