



Indian Speech-Language & Hearing Association (ISHA)

Regd. Under the Karnataka Societies Registration Act, Karnataka Act No, 17 Registration No. 25/67-68

Dear Life Members,

The Indian Speech-Language & Hearing Association (ISHA) has prepared a draft national representation to be submitted to the Ministry of Social Justice and Empowerment regarding the proposed amendments to the Rights of Persons with Disabilities (RPwD) Rules, 2017, particularly the proposed *Assistive Products and Technology (Standards and Accessibility) Rules, 2026*.

The draft representation addresses important issues concerning Audiologists and Speech-Language Pathologists, including professional roles and clinical responsibilities, hearing aids and cochlear implant services, augmentative and alternative communication (AAC), product standards and certification, public procurement, affordability, repair and replacement, user safety, and accountability.

ISHA invites all Life Members to review the proposed comments and provide their valuable suggestions, additions or modifications. Your professional experience and regional perspectives will help ensure that the final representation is comprehensive, evidence-based and reflective of the concerns of our profession and the persons we serve.

Kindly send your comments and suggestions to the designated ISHA communication channel **on or before 20 October 2026**. Please identify the relevant section or recommendation and provide a brief rationale or supporting evidence wherever possible.

As the representation must be submitted to the Ministry within the prescribed consultation period, your timely response is essential. Comments received after the deadline may not be considered in the final submission.

Let us work together to ensure that ISHA's representation is strong, technically sound and adequately reflects the collective views of our members.

With regards,

N Alam

General Secretary

Indian Speech-Language & Hearing Association (ISHA)

To

Shri Ram Charan Meena
Under Secretary to the Government of India
Department of Empowerment of Persons with Disabilities (Divyangjan)
Ministry of Social Justice and Empowerment
Room No. 11A, 5th Floor, Pandit Deen Dayal Antyodaya Bhawan
CGO Complex, Lodhi Road, New Delhi – 110003
Email: rcmeena.79@gov.in

SUBJECT: ISHA's national representation and proposed amendments to the Draft Rights of Persons with Disabilities (Amendment) Rules, 2026 concerning Assistive Products and Technology (Standards and Accessibility)

REFERENCE: Draft notification concerning insertion of Assistive Products and Technology (Standards and Accessibility) under Rule 15 of the Rights of Persons with Disabilities Rules, 2017; Gazette reference CG-DL-E-03102026-276767 (to be verified against the official Gazette before dispatch).

Respected Sir,

The Indian Speech-Language & Hearing Association (ISHA), the national professional association representing Audiologists and Speech-Language Pathologists, respectfully submits this representation on the Draft Rights of Persons with Disabilities (Amendment) Rules, 2026, particularly the proposed framework for Assistive Products and Technology (Standards and Accessibility).

ISHA welcomes the Government of India's initiative to strengthen accessibility, product quality, certification, procurement, affordability, repair, replacement and accountability in assistive technology. A clear national framework can materially improve the independence, communication, participation and quality of life of persons with disabilities.

We submit, however, that assistive technology must be understood as more than the device alone. For hearing aids, cochlear implants and augmentative and alternative communication (AAC) systems, outcomes often depend on an integrated pathway that may include needs assessment, clinical evaluation, individualized selection, fitting or programming, verification, training, rehabilitation, follow-up, maintenance and accessible grievance redress. Product conformity and clinical suitability are related but distinct matters.

ISHA therefore requests targeted amendments that preserve the draft's accessibility objectives while clarifying professional roles, service standards, procurement safeguards, user protections and the respective legal responsibilities of DEPwD, the Rehabilitation Council of India (RCI), the Bureau of Indian Standards (BIS), the Central Drugs Standard Control Organization (CDSCO) and other competent authorities.

Key recommendations

- Distinguish product certification and supply from regulated clinical assessment, prescription, fitting, programming, rehabilitation and outcome evaluation.
- Require clinical services that fall within the RCI framework to be delivered by appropriately qualified and currently registered professionals, consistent with applicable law and scope of practice.

- Recognize Audiologists as key clinical professionals for hearing assessment and hearing-aid services, and Speech-Language Pathologists as key clinical professionals for communication assessment, AAC selection and language/communication intervention, with multidisciplinary participation where indicated.
- All aids and appliances for persons with speech language and hearing disorders as well as disabled should be prescribed by Registered ASLP holding valid RCI CRR no.
- Provision of any spare parts, or any upgradation of devices should be for a minimum duration of three years.
- All apps should have either monthly, quarterly, half year or annual subscription
- Build clinically appropriate fitting, verification, user training, rehabilitation, follow-up, repair and replacement into public procurement and service planning.
- Use transparent, objective and legally compliant procurement criteria; protect users from conflicts of interest, misleading claims, inaccessible complaint systems and avoidable loss of essential communication.
- Ensure privacy-by-design, informed consent, data minimization and accountability for connected or AI-enabled assistive technology.

The detailed clause-wise proposals, supporting scientific and legal considerations, clinical service standards and procurement safeguards are enclosed as Annexures II–V. The official draft notification is identified as Annexure I for reference; it should be attached as the original government document rather than reproduced as an ISHA-authored text.

We request that this representation be formally acknowledged, referred to the appropriate technical and legal authorities, and considered before the draft rules are finalised. We would welcome the opportunity to provide technical input during any consultation or expert committee process.

Yours faithfully,

For the Indian Speech-Language & Hearing Association (ISHA)

General Secretary
Indian Speech-Language & Hearing Association (ISHA)

Enclosures

- Annexure I – Copy of the Government’s draft notification (official copy to be attached).
- Annexure II – Proposed clause-wise amendments and reasons.
- Annexure III – Scientific, clinical and legal rationale.
- Annexure IV – Proposed national clinical service standards and implementation framework.
- Annexure V – Proposed public procurement, financial protection, safety and accountability safeguards.

Copy to:

Secretary, Department of Empowerment of Persons with Disabilities (Divyangjan), Ministry of Social Justice and Empowerment, Government of India, New Delhi.



भारत का राजपत्र The Gazette of India

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असाधारण
EXTRAORDINARY

भाग II—खण्ड 3—उप-खण्ड (ii)
PART II—Section 3—Sub-section (ii)

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सामाजिक न्याय और अधिकारिता मंत्रालय

(दिव्यांगजन सशक्तिकरण विभाग)

अधिसूचना

नई दिल्ली, 8 सितम्बर, 2026

का.आ. 5241(अ).— चूँकि दिव्यांगजन अधिकार नियम, 2017, दिव्यांगजन अधिकार अधिनियम, 2016 (2016 का 49) की धारा 100 की उप-धारा (1) और (2) द्वारा यथा अपेक्षित, प्रकाशित किया गया था, इसे एतद्वारा उक्त धारा की उप-धारा (1) द्वारा यथा अपेक्षित, उन सभी व्यक्तियों की जानकारी के लिए प्रकाशित किया जाता है जिनके इससे प्रभावित होने की संभावना है; और एतद्वारा यह सूचना दी जाती है कि उक्त प्रारूप नियमों पर उस तारीख से, जिस तारीख को राजपत्र की प्रतियां जिनमें यह अधिसूचना प्रकाशित की गई है, जनता को उपलब्ध करा दी जाती हैं, तीस दिनों की अवधि की समाप्ति के पश्चात विचार किया जाएगा;

आपत्तियां और सुझाव, यदि कोई हों, तो उन्हें श्री राम चरण मीना, अवर सचिव, भारत सरकार, दिव्यांगजन सशक्तिकरण विभाग, कमरा संख्या 11 ए, पांचवां तल, पंडित दीनदयाल अंत्योदय भवन, सीजीओ कॉम्प्लेक्स, लोधी रोड, नई दिल्ली, 110003 को या rcmeena.79@gov.in पर ईमेल द्वारा भेजा जा सकता है।

उक्त विनिर्दिष्ट अवधि के समाप्त होने से पहले किसी भी व्यक्ति से उक्त प्रारूप नियमों के संबंध में प्राप्त होने वाली आपत्तियों और सुझावों पर केंद्रीय सरकार द्वारा विचार किया जाएगा।

और चूंकि, सार्वजनिक सुविधाओं और सेवाओं के लिए सुगम्यता मानकों और दिशानिर्देशों को बाद में उक्त नियमों के नियम 15 में शामिल किया गया था;

और चूंकि, भारत के माननीय सर्वोच्च न्यायालय ने 2005 की रिट याचिका (सिविल) संख्या 243 और 2006 की 228 [राजीव रतूडी बनाम भारत संघ व अन्य] में दिनांक 8 नवंबर, 2024 के अपने निर्णय द्वारा, अन्य बातों के साथ-साथ, केंद्र सरकार को उक्त नियमों के नियम 15 (F) के तहत निर्धारित विस्तृत दिशानिर्देशों से गैर-परक्राम्यनियमों को अलग करके अधिनियम की धारा 40 की अपेक्षानुसार उन्हें स्पष्ट रूप से परिभाषित करने का निर्देश दिया था, तथा क्षेत्रवार मानकों में एकरूपता और स्पष्टता की आवश्यकता पर बल दिया था;

अतः, अब, अधिनियम की धारा 40 के साथ पठित धारा 100 की उप-धारा (1) और (2) द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए, केंद्र सरकार एतद्वारा दिव्यांगजन अधिकार नियम, 2017 में आगे संशोधन करने के लिए निम्नलिखित नियम बनाती है, अर्थात्:

प्रारूप नियम

1. संक्षिप्त नाम और प्रारंभ—

(1) इन नियमों को दिव्यांगजन अधिकार (संशोधन) नियम, 2026 कहा जाएगा।

(2) ये आधिकारिक राजपत्र में इनके प्रकाशन की तिथि से प्रवृत्त होंगे।

2. नियम 15 (1) के खंड (घ) का संशोधन—

दिव्यांगजन अधिकार नियम, 2017 में, नियम 15 के उप-नियम (1) के खंड (घ) को निम्नलिखित रूप में प्रतिस्थापित और संशोधित किया जाएगा:—

(घ). सहायक उत्पाद और प्रौद्योगिकी (मानक और सुगम्यता)

अध्याय I – प्रारंभिक

1. संक्षिप्त नाम और प्रारंभ—

(1) इन नियमों का नाम सहायक उत्पाद और प्रौद्योगिकी (मानक और सुगम्यता) नियम, 2025 है।

(2) ये राजपत्र में इनके प्रकाशन की तारीख को प्रवृत्त होंगे।

2. परिभाषाएँ—

इन नियमों में, जब तक कि संदर्भ से अन्यथा अपेक्षित न हो,

(क) “सहायक उत्पाद” से वह वास्तविक वस्तु या उपकरण अभिप्रेत है जिसका उपयोग दिव्यांगजन अपनी दैनिक गतिविधियों को अधिक स्वतंत्रता से करने के लिए करते हैं, चाहे वह व्हीलचेयर, श्रवण यंत्र, सफेद छड़ी, स्क्रीन रीडर, ब्रेल डिस्प्ले या संचार ऐप हो।

ऐसे उत्पादों को आगे इस प्रकार वर्गीकृत किया जा सकता है:

(i) “आवश्यक सहायक उत्पाद” से ऐसे सहायक उत्पाद अभिप्रेत हैं जिनकी आवश्यकता दिव्यांगजनों को अपनी दिनचर्या और दैनिक गतिविधियों को पूरा करने के लिए होती है, जैसे कि श्रवण यंत्र, गतिशीलता सहायक उपकरण, स्क्रीन रीडर, चश्मे और व्हीलचेयर;

(ii) “विशिष्ट सहायक उत्पाद” से दिव्यांगजनों के विशिष्ट समूहों के लिए अपेक्षित अधिक उन्नत सहायक उत्पाद अभिप्रेत हैं, जैसे कि संवर्धक और वैकल्पिक संचार उपकरण, कोक्लियर इम्प्लांट, और कृत्रिम अंग;

(iii) “उभरते सहायक उत्पाद” से नवीन और उन्नत प्रौद्योगिकियाँ अभिप्रेत हैं जो स्वतंत्रता और भागीदारी को बढ़ा सकती हैं, जैसे कि एआई-सक्षम संचार उपकरण, रोबोटिक्स, और ब्रेन-कंप्यूटर इंटरफेस प्रणालियाँ;

(ख) “सहायक प्रौद्योगिकी” वह सब कुछ है जो सहायक उत्पाद का उपयोग करने वाले व्यक्ति के लिए उसके अच्छी तरह से काम करने में सहायता करती है। इसमें यह आकलन करना शामिल है कि किस उत्पाद की आवश्यकता है, उसे फिट करना या अनुकूलित करना, व्यक्ति को उसका उपयोग करने का प्रशिक्षण देना, मरम्मत करना और निरंतर सहायता प्रदान करना तथा इस प्रकार यह सुनिश्चित करना कि सहायक उत्पाद का प्रभावी ढंग से और स्वतंत्र रूप से उपयोग किया जा सके;

(ग) गतिशीलता सहायक पासपोर्ट एक पोर्टेबल सूचना मार्गदर्शिका है जो व्हीलचेयर या अन्य संचालित गतिशीलता उपकरण के सटीक आयामों, वजन, बैटरी के प्रकार और उसे अलग करने के निर्देशों का विवरण देती है;

(घ) “सेवा प्रदाता” से सहायक प्रौद्योगिकी के आकलन, प्रिस्क्रिप्शन, फिटिंग, प्रशिक्षण, रखरखाव या मरम्मत में लगे किसी भी व्यक्ति या इकाई अभिप्रेत है। स्पष्टीकरण: *इन नियमों के प्रयोजनों के लिए, जवाबदेहता सुनिश्चित करने हेतु विनियामक प्रयोजनों के लिए यह परिभाषा अपनाई गई है।*

(ङ) “उपयोगकर्ता” से दिव्यांगजन अधिकार अधिनियम, 2016 (2016 का 49) के अधीन दिव्यांगजन अभिप्रेत है।

स्पष्टीकरण: ‘उपयोगकर्ता’ के अंतर्गत दिव्यांगजन अधिकार अधिनियम, 2016 के अधीन दिव्यांगजन शामिल हैं, और इसका विस्तार अस्थायी कार्यात्मक सीमाओं (जैसे कि फ्रैक्चर या शल्य-चिकित्सा पश्चात की स्थितियों) वाले व्यक्तियों तक हो सकता है।

अध्याय - II – सहायक उत्पादों का वर्गीकरण

3. सहायक उत्पादों की श्रेणियाँ.—

(1) सहायक उत्पादों को निम्नलिखित तीन श्रेणियों में वर्गीकृत किया जाएगा, —

(i) आवश्यक सहायक उत्पाद;

(ii) विशिष्ट सहायक उत्पाद; और उपयोगकर्ता-विशिष्ट कार्यात्मक आवश्यकताओं को पूरा करने के लिए उत्पादों की सभी श्रेणियों में सहायक प्रौद्योगिकी उपलब्ध होगी। प्रत्येक सूची के अंतर्गत अधिसूचित उत्पादों की सूची की समय-समय पर समीक्षा की जाएगी और ऐसे सहायक उत्पादों के निर्माण में हुई प्रगति के आधार पर किया जाएगा। उदाहरणस्वरूप, एक उभरते सहायक उत्पाद के रूप में सूचीबद्ध उत्पाद को एक बार इसके विनिर्देशों को मानकीकृत कर दिए जाने और निर्माण को सुव्यवस्थित कर दिए जाने के बाद आवश्यक या विशिष्ट सहायक उत्पाद के रूप में सूचीबद्ध किया जा सकता है।

(iii) उभरते सहायक उत्पाद।

अध्याय III – मानक और प्रमाणन

4. सहायक उत्पादों के मानक.—

(1) भारतीय मानक ब्यूरो या ऐसी अन्य प्राधिकारी जिसके पास अपेक्षित विशेषज्ञता है जिसे या तो ब्यूरो या केंद्रीय सरकार द्वारा नामित किया जाता है, आवश्यक और विशिष्ट सहायक उत्पादों के लिए मानक विहित करेगा।

- (2) यदि यह विनिर्देश चरणबद्ध तरीके से किया जाता है, तो ब्यूरो या अन्य नामित प्राधिकारी उन चरणों को अधिसूचित करेगा जिनमें मानक निर्धारण किया जा रहा है और इस कार्रवाई के तरीके को अपनाने के तकनीकी कारण बताएगा।
- (3) अपनी मानक निर्धारण अनुसूची तैयार करने में, ब्यूरो या अन्य नामित प्राधिकारी ऐसे सहायक उत्पादों या उपकरणों पर विशेष ध्यान देगा जो मानकीकरण के अभाव में दुर्घटनाओं या आपदाओं का कारण बने हैं।
- (4) केवल ब्यूरो या अन्य नामित प्राधिकारी द्वारा विनिर्दिष्ट मानकों के अनुसार निर्मित सहायक उत्पादों पर ही मानक चिह्न (स्टैंडर्ड मार्क) होगा।
- (5) किसी उत्पाद को मानक चिह्न के साथ जनता के उपयोग के लिए तभी उपलब्ध कराया जा सकता है जब वह भारतीय मानक ब्यूरो या अन्य नामित प्राधिकारी द्वारा विकसित विनिर्देशों के अनुसार बनाया गया हो।
- (6) भारतीय मानक ब्यूरो या अन्य नामित प्राधिकारी उस प्रक्रिया को विहित करेगा जिसके द्वारा सहायक उत्पादों या उपकरणों का निर्माता अपने उत्पाद पर बीआईएस चिह्न का उपयोग करने की अनुमति प्राप्त कर सकता है।

5. सिक्योरमेंट (सुरक्षात्मक) ब्रैकेट और गतिशीलता सहायक पासपोर्ट की अनिवार्य आवश्यकता

- (1) इस बात के पूर्वाग्रह के बिना कि बीआईएस या अन्य नामित प्राधिकारी सहायक उत्पादों के लिए क्या विनिर्देश विकसित कर सकते हैं, सभी मानक मैनुअल व्हीलचेयर और मोटराइज्ड व्हीलचेयर / पहिएदार गतिशीलता उपकरणों में ट्रांजिट-रेडी, टाई-डाउन सिक्योरमेंट ब्रैकेट लगाए जाएंगे।
- (2) संचालित (पावर्ड) व्हीलचेयर या अन्य गतिशीलता उपकरण के सभी निर्माताओं का यह विधिक कर्तव्य होगा कि वे ऐसे सहायक उत्पाद के साथ गतिशीलता सहायक पासपोर्ट प्रदान करें।

अध्याय IV – खरीद (अधिप्राप्ति) और वितरण

6. खरीद—

- (1) सहायक उत्पादों की सरकारी खरीद— जिसमें उपकरण, सॉफ्टवेयर और एकीकृत प्रणालियाँ शामिल हैं — एक पारदर्शी टेंडर प्रक्रिया के माध्यम से की जाएगी।
- (2) जबकि आवश्यक सहायक उत्पादों की खरीद स्व-प्रमाणित इकाइयों से की जा सकती है,
- (3) विशिष्ट सहायक उत्पादों की सोर्सिंग केवल प्रमाणित निर्माताओं से की जाएगी, जिसका अर्थ ऐसे निर्माता होंगे जिन्हें भारतीय मानक ब्यूरो या अन्य नामित प्राधिकारी द्वारा लाइसेंस दिया गया हो।

7. सहायक उत्पादों के लिए ऑनलाइन पोर्टल

- (1) सक्षम प्राधिकारी आवेदनों, प्रमाणन, खरीद, वितरण ट्रेकिंग और शिकायत निगरानी के लिए एक ऑनलाइन सहायक उत्पाद पोर्टल स्थापित करेगा।
- (2) उपभोक्ता मामले मंत्रालय के 'राइट टू रिपेयर' (मरम्मत का अधिकार) पोर्टल के साथ समन्वय में, यह पोर्टल मरम्मत के अधिकार का विस्तार सहायक उत्पादों तक करेगा।

अध्याय V – वित्तीय सहायता और वहनीयता

8. वित्तीय सहायता —

- (1) केंद्रीय सरकार और राज्य सरकारें पात्र उपयोगकर्ताओं को सहायक उत्पादों की अधिप्राप्ति (खरीद) के लिए वित्तीय सहायता प्रदान करने हेतु स्कीमें तैयार करेंगी। इन स्कीमों में सब्सिडी, प्रतिपूर्ति (रीइंबर्समेंट) और बीमा कवरेज के प्रावधान भी शामिल होंगे।

(2) सभी बीमा पॉलिसियाँ और सरकारी योजनाएं न केवल सहायक उत्पादों की प्रारंभिक लागत को कवर करेंगी, बल्कि जहाँ उपयोगकर्ताओं ने सीधे लागत वहन की है। वहां प्रतिस्थापन (रिप्लेसमेंट), मरम्मत और प्रतिपूर्ति को भी कवर करेंगी।

(3) शिकायत निवारण, बीमा कवरेज और प्रतिस्थापन के प्रावधान सहायक उत्पादों की आवश्यक श्रेणियों पर लागू होंगे।

9. मरम्मत और प्रतिस्थापन का अधिकार

(1) उपभोक्ता मामले मंत्रालय की 'मरम्मत का अधिकार' योजना का विस्तार आवश्यक और विशिष्ट सहायक उत्पादों तक किया जाएगा।

(2) आपदाओं या आपात स्थितियों की स्थिति में, राष्ट्रीय और राज्य आपदा प्रबंधन प्राधिकरण, राहत और पुनर्वास उपायों के एक भाग के रूप में प्रभावित उपयोगकर्ताओं को आवश्यक सहायक प्रौद्योगिकी की तत्काल प्रतिस्थापन या प्रावधान सुनिश्चित करेंगे।

अध्याय VI – नवाचार, जागरूकता और प्रवर्तन

10. राष्ट्रीय टोल-फ्री हेल्पलाइन —

उपयोगकर्ता की प्रतिक्रिया और शिकायतों के लिए एक राष्ट्रीय टोल-फ्री हेल्पलाइन स्थापित की जाएगी, जिसकी अनिवार्य समाधान समय-सीमा तीस दिन होगी।

सभी उपयोगकर्ताओं के लिए सुगम्यता सुनिश्चित करने के लिए टोल-फ्री हेल्पलाइन, शिकायत निवारण प्रणालियाँ और जन जागरूकता अभियान बहु-मॉडल (मल्टीमॉडल) होंगे, जिसमें वॉयस, टेक्स्ट-आधारित प्लेटफॉर्म और भारतीय सांकेतिक भाषा की व्याख्या शामिल होगी।

11. राष्ट्रीय सहायक उत्पाद दुर्घटना डेटाबेस

(1) यदि कोई सहायक उपकरण खराब हो जाता है और चोट या दुर्घटना का कारण बनता है, तो घटना की जाँच की जाएगी और जाँच के निष्कर्षों को विधिवत दर्ज किया जाएगा।

(2) सक्षम प्राधिकारी, सहायक प्रौद्योगिकी दुर्घटना डेटाबेस स्थापित करने और उसका रखरखाव करने के लिए, बीआईएस या किसी अन्य अधिसूचित निकाय को नामित करेगा।

(3) यह डेटाबेस नियम 4(2) में उल्लिखित सहायक उत्पादों के लिए मानक निर्धारण के चरणों का मार्गदर्शन करने और गैर-मानक सहायक उत्पादों के उपयोग को प्रतिबंधित करने पर साक्ष्य-आधारित निर्णय लेने के लिए मार्गदर्शक होगा।

[फा.सं. I-12012/2/2026-एआईसी]

गिरीश सी. होसूर, संयुक्त सचिव

MINISTRY OF SOCIAL JUSTICE AND EMPOWERMENT
[Department of Empowerment of Persons with Disabilities (Divyangjan)]
NOTIFICATION

New Delhi, the 8th September, 2026

S.O. 5241(E).— Whereas the Rights of Persons with Disabilities Rules, 2017 were published, as required by sub-sections (1) and (2) of section 100 of the Rights of Persons with Disabilities Act, 2016 (49 of 2016) is hereby published as required by sub-section (1) of the said section, for the information of all persons likely to be affected thereby; and notice is hereby given that the said draft rules shall be taken into consideration after the expiry of a period of thirty days from the date on which the copies of the Official Gazette in which this notification is published are made available to the public;

Objections and suggestions, if any, may be addressed to Shri Ram Charan Meena Under Secretary to the Government of India, Department of Empowerment of Persons with Disabilities (Divyangjan), Room No 11 A, 5th Floor, PanditDeenDayal Antyodaya Bhawan, CGO Complex, Lodhi Road, New Delhi, 110003 or by email at rcmeena.79@gov.in.

The objections and suggestions, which may be received from any person with respect to the said draft rules before the expiry of the period specified above, will be considered by the Central Government.

And whereas accessibility standards and guidelines for public facilities and services, were subsequently incorporated in rule 15 of the said Rules;

And whereas the Hon'ble Supreme Court of India, by judgment dated the 8th November, 2024 in Writ Petition (Civil) Nos. 243 of 2005 and 228 of 2006 [RajiveRaturi v. Union of India & Ors], inter alia, directed the Union Government to delineate non-negotiable rules as required by section 40 of the Act by segregating such non-negotiable rules from the expansive guidelines prescribed under rule 15(f) of the said Rules, and observed the need for uniformity and clarity across sectoral standards;

Now, therefore, in exercise of the powers conferred by sub-sections (1) and (2) of section 100 of the Act read with section 40 thereof, the Central Government hereby makes the following rules further to amend the Rights of Persons with Disabilities Rules, 2017, namely:

Draft Rules

1. Short title and commencement.—

(1) These rules may be called the Rights of Persons with Disabilities (Amendment) Rules, 2026.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. Insertion of clause (d) in rule 15 (1).—

In the Rights of Persons with Disabilities Rules, 2017, clause (d) in sub-rule (1) of rule 15 shall be inserted and amended as follows:—

(d). Assistive Products and Technology (Standards and Accessibility)

Chapter I – Preliminary

1.Short Title and Commencement.—

(1) These rules may be called the *Assistive Products and Technology (Standards and Accessibility) Rules, 2025*.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions.—

In these rules, unless the context otherwise requires,

(a) “Assistive product” is the actual thing or device that a person with disability uses. be it a wheelchair, hearing aid, white cane, screen reader, Braille display or a communication app. to carry out everyday activities more independently.

Such products may be further classified as:

(i) “Essential Assistive products” means such assistive products that persons with disabilities need to carry out their routine and everyday activities such as hearing aids, mobility aids, screen readers, spectacles, and wheelchairs;

(ii) “Specialised Assistive products” means more advanced assistive products required for specific groups of persons with disabilities, such as augmentative and alternative communication devices, cochlear implants, and prosthetics;

(iii) “Emerging Assistive products” means innovative and advanced technologies that may enhance independence and participation, such as AI-enabled communication devices, robotics, and brain-computer interface systems;

(b) “Assistive technology” is everything that helps the assistive product work well for the person using it. It includes assessing what product is needed, fitting or customising it, training the person to use it, carrying out repairs and providing ongoing support and thereby ensuring that the assistive product can be used effectively and independently

(c) Mobility Aid passport is a portable information guide that details the exact dimensions, weight, battery type and dissembling instructions of the wheelchair or other powered mobility device.

(d) “Service provider” means any person or entity engaged in the assessment, prescription, fitting, training, maintenance, or repair of assistive technology. *Explanation: For the purposes of these Rules, this definition is adopted for regulatory purposes, ensuring accountability.*

(e) “User” means a person with disability under the Rights of Persons with Disabilities Act, 2016 (49 of 2016).

Explanation: ‘User’ includes persons with disabilities under the RPwD Act, 2016, and may extend to those with temporary functional limitations (such as fractures or post-surgical conditions).

Chapter II – Classification of Assistive Products**3. Categories of Assistive Products.—**

(1) Assistive products shall be classified into the following three categories,—

(i) Essential Assistive products;

(ii) Specialised Assistive products; and Assistive technology shall be available across all categories of products to meet user-specific functional requirements. The list of products notified under each list shall be periodically reviewed and depending upon the progress made in the manufacture of such assistive products. Illustratively a product listed as an emerging assistive product could be listed as an essential or specialised assistive product once its specifications have been standardised and manufacture streamlined.

- (iii) Emerging Assistive products.

Chapter III – Standards and Certification

4. Standards of Assistive Products. —

- (1) The Bureau of Indian Standards or such other authority possessing the requisite expertise which either the Bureau or the central government designatesshall prescribe standards for essential and specialised assistive products
- (2) If this specification is undertaken in a phased manner, the Bureau or other designated authority shall notify the phases in which the standard setting is being undertaken and the technical reasons for adopting the course of action
- (3) In creating its standard setting schedule, the Bureau or Other designated Authority shall accord special attention to assistive products or devices which have resulted in accidents or mishaps due to absence of standardisation
- (4) Only Assistive products made in accordance with the standards specified by the Bureau or other designated Authority shall carry the standard mark.
- (5) A product can be made available for public use with the standard mark only if it has been made in accordance with the specifications developed by the Bureau of Indian Standards or other designated authority
- (6) The Bureau of Indian Standards or other designated authority shall prescribe the process by which a manufacturer of assistive products or devices can obtain permission to use the BIS mark on their product.

5. Mandatory Requirement of Securement Brackets and Mobility Aid Passport

- (1) Without prejudice to the specifications that BIS or other designated authority may develop for assistive products all standard manual wheelchairs and motorised wheelchairs / wheeled mobility devices will be fitted with transit -ready, tie down securement brackets.
- (2) All manufacturers of powered wheelchairs or other mobility device shall be under a legal duty to provide a mobility aid passport along with such assistive product.

Chapter IV – Procurement and Distribution

6. Procurement-

- (1) The Government procurement of assistive products — including devices, software, and integrated systems — shall be through a transparent tendering process.
- (2) Whilst essential assistive products could be procured from self-certified entities
- (3) Specialised assistive products shall be only sourced from certified manufacturers from certified manufacturers, which shall mean manufacturers either licensed by the Bureau of Indian Standards, or other designated authority.

7. Online Portal for Assistive Products

- (1) The Competent Authority shall establish an online Assistive Products Portal for applications, certification, procurement, distribution tracking, and grievance monitoring.
- (2) In coordination with the Right to Repair portal of the Ministry of Consumer Affairs this portal shall extend the right to repair to assistive products.

Chapter V – Financial Support and Affordability

8. Financial Support.—

- (1) The Central Government and State Governments shall frame schemes for providing financial support for procurement of assistive products to eligible users. The schemes shall also include provision for subsidies, reimbursements, and insurance coverage.
- (2) All insurance policies and government schemes shall cover not only the initial cost of assistive products but also replacement, repair, and reimbursement where users have borne costs directly.
- (3) The provisions of grievance redressal, insurance coverage, and replacement shall apply to essential categories of assistive products.

9. Right to Repair and Replacement

- (1) The Right to Repair Scheme of the Ministry of Consumer Affairs shall be extended to essential and specialised assistive products
- (2) In the event of disasters or emergencies, the national and state disaster management authorities, shall ensure immediate replacement or provision of essential assistive technology to affected users as part of relief and rehabilitation measures.

Chapter VI – Innovation, Awareness, and Enforcement

10. National Toll-Free Helpline.—

A national toll-free helpline shall be established for user feedback and complaints, with a mandatory resolution timeline of thirty days.

The toll-free helpline, grievance redressal systems, and public awareness campaigns shall be multimodal, including voice, text-based platforms, and Indian Sign Language interpretation, to ensure accessibility for all users.

11. National Assistive Products Accident Database

- 1) If any assistive device becomes dysfunctional and causes injury or accident, the incident shall be investigated and the findings of the investigation duly recorded.

- 2) The Competent Authority shall designate BIS or any other notified body, to establish and maintain an Assistive Technology Accidents Database.
- 3) This Database shall guide the phases of standard setting for assistive products mentioned in Rule 4(2) and to make an evidence-based decision on prohibiting the use of non-standard assistive products.

[F. No. I-12012/2/2026-AIC]

GIRISH C. HOSUR, Jt. Secy.

CLAUSE-WISE OBJECTIONS, PROPOSED INSERTIONS AND SCIENTIFIC–LEGAL JUSTIFICATIONS TO THE DRAFT RIGHTS OF PERSONS WITH DISABILITIES (AMENDMENT) RULES, 2026

Proposed submission by the Indian Speech-Language and Hearing Association (ISHA)

Consultation text: Gazette of India, CG-DL-E-03102026-276767, English text pp. 6–10

Purpose: This annexure accompanies the principal representation seeking clinically accountable, person-centred accessibility standards for hearing aids, cochlear implants, augmentative and alternative communication (AAC), and emerging communication technologies. Each recommendation identifies the corresponding provision in the actual draft. Proposed text is not current law. Final numbering and delegated-legislation compatibility require government/legal vetting.

Interpretive safeguards: Product conformity, professional clinical competence and public-financing entitlements are distinct regulatory questions. The proposed rules are framed under RPwD Act sections 40 and 100; matters that require independent authority under the RCI Act, medical-device laws, insurance legislation or government schemes should be implemented through coordinated instruments rather than asserted as automatically enforceable under this draft.

01. AMENDING RULE 2; PROPOSED INSERTION INTO RULE 15(1)(D) OF THE RPWD RULES, 2017

- **EXISTING DRAFT PROVISION / LOCATION:** The amending instrument proposes an Assistive Products and Technology (Standards and Accessibility) entry in rule 15(1), while the embedded schedule restarts numbering at rules 1–10.
- **DEFICIENCY / OBJECTION:** The relationship between the parent rule, embedded standards and independent commencement/enforcement is not expressed clearly; the English draft contains incomplete year/number fields.
- **PROPOSED INSERTION / SUBSTITUTION:** “The text inserted under rule 15(1)(d) shall constitute the notified non-negotiable accessibility standards for the assistive-technology sub-sector. Each obligation shall identify the responsible regulated entity, competent authority, compliance date, applicable conformity route and remedy. Clinical-service standards shall be implemented consistently with the RCI Act, 1992 and applicable health and medical-device legislation. The Central Government shall correct all numbering, dates and cross-references before final notification.”
- **JUSTIFICATION:** RPwD sections 40 and 100 require legal certainty; Rajive Raturi (8 November 2024) supports clear enforceable accessibility norms. A schedule that mixes product obligations and healthcare professional licensure without an express competence basis risks uncertainty and challenge.

02. CHAPTER I, RULE 2(A)(I)–(III): ESSENTIAL, SPECIALISED AND EMERGING PRODUCTS

- **EXISTING DRAFT PROVISION / LOCATION:** Hearing aids are essential; cochlear implants and AAC devices are specialised; AI-enabled communication devices are emerging.
- **DEFICIENCY / OBJECTION:** Technology-based labels can obscure clinical risk and exclude low-tech AAC, communication apps, implant external processors, remote microphones and other clinically necessary components.

- **PROPOSED INSERTION / SUBSTITUTION:** “The product categories shall be technology-neutral and shall include associated hardware, clinically necessary accessories, software and communication access systems. AAC includes unaided, low-tech and high-tech approaches; classification of a commercial product shall not restrict access to non-device communication methods. Implantable components shall remain subject to applicable medical-device regulation. Reclassification shall follow published risk, usability, clinical-function and stakeholder-review criteria.”
- **JUSTIFICATION:** WHO–UNICEF Global Report on Assistive Technology (2022) endorses integrated services and products. AAC is a multimodal intervention, not exclusively a speech-generating machine (ASHA AAC Practice Portal).

03. CHAPTER I, RULE 2(B): DEFINITION OF ASSISTIVE TECHNOLOGY

- **EXISTING DRAFT PROVISION / LOCATION:** Definition already includes assessment, fitting/customisation, training, repairs and ongoing support.
- **DEFICIENCY / OBJECTION:** The inclusive definition is positive but omits prescription accountability, objective verification, rehabilitation, outcome monitoring and informed user choice.
- **PROPOSED INSERTION / SUBSTITUTION:** “For clinically prescribed hearing and communication products, assistive technology services shall, as appropriate to individual need, include assessment, shared decision-making, documented clinical recommendation, fitting or programming, objective verification where indicated, functional validation, communication and auditory rehabilitation, user and communication-partner training, periodic review, repair, replacement and continuity planning. The user shall retain informed choice of communication modality.”
- **JUSTIFICATION:** WHO World Report on Hearing (2021) and AAA Pediatric Amplification Guidelines (2013) recognize care pathways and verification, rather than device delivery alone.

04. CHAPTER I, RULE 2(D): DEFINITION OF SERVICE PROVIDER

- **EXISTING DRAFT PROVISION / LOCATION:** Any person or entity undertaking assessment, prescription, fitting, training, maintenance or repair is included without stated qualification.
- **DEFICIENCY / OBJECTION:** A single unrestricted definition conflates licensed clinical acts with commercial dispensing and mechanical repairs. It could inadvertently appear to authorize unqualified clinical practice.
- **PROPOSED INSERTION / SUBSTITUTION:** “Service provider” means an accountable entity supplying assistive products or associated services. “Qualified clinical assistive-technology professional” means an individual holding a discipline-appropriate recognized qualification and valid registration where required by applicable law, and working within competence and lawful scope. Clinical audiological assessment, clinical hearing-aid selection, programming and verification shall be performed by an appropriately qualified audiologist; speech-language and individualized AAC assessment, language-system customization and communication intervention shall involve an appropriately qualified speech-language pathologist; implant surgery and medical decisions remain with authorized medical specialists. Technical maintenance and commercial logistics may be performed by competent non-clinical personnel without independently authorizing clinical practice.”
- **JUSTIFICATION:** RCI Act, 1992, particularly section 13, establishes a statutory registration framework for specified rehabilitation professions. The formulation respects existing scope limitations, team-based care and reasonable access rather than claiming unsupported universal exclusivity.

05. CHAPTER I, RULE 2(E): DEFINITION OF USER

- **EXISTING DRAFT PROVISION / LOCATION:** The draft covers persons with disabilities and suggests possible extension to temporary functional limitations.
- **DEFICIENCY / OBJECTION:** Undefined extension may generate uncertainty about eligibility and may leave acquired communication disorders and complex needs underserved.
- **PROPOSED INSERTION / SUBSTITUTION:** “User eligibility under the RPwD Act shall be interpreted consistently with that Act. Programmes may additionally support temporary or acquired functional limitations where authorized by applicable schemes. Eligibility for basic communication supports shall not be conditioned upon completion of complex clinical assessments or upon a particular speech modality.”
- **JUSTIFICATION:** RPwD sections 3, 25, 27 and 42 support non-discriminatory communication access. Disability status, scheme eligibility and clinical need should not be conflated.

06. CHAPTER II, RULE 3: CATEGORIES AND PERIODIC REVIEW

- **EXISTING DRAFT PROVISION / LOCATION:** Three categories are established, with periodic reassignment based largely on manufacturing standardisation.
- **DEFICIENCY / OBJECTION:** Manufacturing maturity alone does not measure safety, user need, clinical risk or actual communication benefit.
- **PROPOSED INSERTION / SUBSTITUTION:** “Periodic classification review shall consider clinical risk, intended use, user-reported functional outcomes, interoperability, affordability, service requirements, adverse incidents and accessibility in Indian languages. Consultation shall include persons with disabilities, RCI-recognized domain professionals, medical specialists where applicable, BIS/CDSCO and independent experts.”
- **JUSTIFICATION:** UNCRPD articles 4(3), 9, 21 and 26 favour participation and functional access; WHO–UNICEF (2022) recommends people-centred assistive technology systems.

07. CHAPTER III, RULE 4: STANDARDS AND CERTIFICATION

- **EXISTING DRAFT PROVISION / LOCATION:** BIS or a designated authority sets product standards; the standard mark is tied to manufacturing conformity.
- **DEFICIENCY / OBJECTION:** No distinction is made between product conformity and safe individual clinical application; coordination with CDSCO is unspecified.
- **PROPOSED INSERTION / SUBSTITUTION:** “Standards for hearing and communication technologies shall separately specify (a) product safety/performance and applicable statutory conformity; (b) accessible information, interoperability, repairability and cybersecurity; and (c) a linked clinical-service standard where fitting or prescription is required. BIS or another designated body shall consult RCI, relevant qualified audiologists and speech-language pathologists, persons with disabilities, ENT/implant specialists and CDSCO as applicable. No BIS mark shall be described as evidence of individualized clinical suitability.”
- **JUSTIFICATION:** The Medical Devices Rules, 2017 and applicable CDSCO requirements cannot be displaced by a general assistive-products mark. AAA (2013), BSA Real Ear Measurement guidance (2018), and WHO (2021) support individual fitting and verification.

08. CHAPTER III, RULE 4: PRIORITY-SETTING AND PHASED STANDARDS

- **EXISTING DRAFT PROVISION / LOCATION:** The draft prioritizes products associated with accidents and allows phased standard-setting.

- **DEFICIENCY / OBJECTION:** Injury-only triggers overlook language deprivation, prolonged inability to communicate, inappropriate amplification and failure to access implant rehabilitation.
- **PROPOSED INSERTION / SUBSTITUTION:** “Priority shall additionally be assigned to products whose failure, unsuitable configuration or absence of essential services presents foreseeable risk of serious functional harm, including prolonged loss of hearing or communication access. A published schedule shall identify hearing aids, cochlear implant external systems and AAC, with reasons and transition dates.”
- **JUSTIFICATION:** Communication exclusion may produce major participation harm without a reportable bodily injury. JCIH (2019) supports timely pediatric hearing care; Niparko et al. (2010) documents variability and developmental importance of cochlear implant pathways.

09. CHAPTER IV, RULE 6: TRANSPARENT TENDERING AND SELF-CERTIFICATION

- **EXISTING DRAFT PROVISION / LOCATION:** Government procurement must be transparent; essential products may come from self-certified entities; specialised products from certified manufacturers.
- **DEFICIENCY / OBJECTION:** Self-certification of hearing aids without a defined conformity route could be inadequate; the lowest device price alone cannot ensure appropriate fitting, maintenance or communication outcomes.
- **PROPOSED INSERTION / SUBSTITUTION:** “Public procurement shall require conformity with all applicable product and medical-device laws, documented technical eligibility, clinical suitability, lifecycle service costs, repair arrangements, interoperability and accessible warranties. Self-certification may be accepted only where permitted by the applicable conformity-assessment framework and subject to audit. Tenders for hearing technology shall obtain documented input from qualified audiologists; AAC tenders from qualified speech-language pathologists; cochlear implant tenders from the multidisciplinary implant team. Award criteria shall comply with applicable procurement rules and avoid sole reliance on initial device price where service quality is material.”
- **JUSTIFICATION:** Public procurement should optimize usable access and value over product lifespan. The General Financial Rules and applicable procurement manuals must govern tender design; clinical consultation does not imply unlawful single-vendor preference.

10. CHAPTER IV, RULE 6: ADD INDIVIDUAL CLINICAL DELIVERY SAFEGUARDS

- **EXISTING DRAFT PROVISION / LOCATION:** The draft addresses procurement but not clinical acceptance, fitting, activation, or validation after distribution.
- **DEFICIENCY / OBJECTION:** A certified device may be clinically inappropriate or remain unused after distribution.
- **PROPOSED INSERTION / SUBSTITUTION:** “For publicly funded clinically fitted hearing aids, the procuring agency shall provide access to audiological assessment, indicated verification and follow-up. For cochlear implants, a documented multidisciplinary pathway shall cover candidacy, surgery, activation/mapping, auditory and communication rehabilitation and review. For individualized AAC, assessment and implementation shall include communication access, language needs, user preferences and communication-partner training, without restricting low-tech or self-selected AAC.”
- **JUSTIFICATION:** WHO World Report on Hearing (2021); AAA (2013); JCIH (2019); ASHA AAC Practice Portal; Schlosser & Wendt (2008).

11. CHAPTER IV, RULE 7: ONLINE PORTAL

- **EXISTING DRAFT PROVISION / LOCATION:** A portal is proposed for applications, certification, procurement, distribution and grievances, linked to right to repair.
- **DEFICIENCY / OBJECTION:** No minimum clinical-service tracking, privacy protection, offline access or accessible communication pathway is specified.
- **PROPOSED INSERTION / SUBSTITUTION:** “The portal shall record product conformity, supplier accountability, warranty and repair status and, with proportionate consent-based safeguards, referral to clinical services and follow-up completion. Sensitive clinical records shall not be made publicly accessible. Accessible offline assistance, Indian-language interfaces, text, voice, AAC-compatible communication and Indian Sign Language options shall be provided. Data processing shall comply with applicable privacy and data-protection law.”
- **JUSTIFICATION:** RPwD section 42 supports accessible ICT; confidentiality and proportionality are especially important for speech, voice, hearing and health information.

12. CHAPTER V, RULE 8: FINANCIAL SUPPORT AND INSURANCE

- **EXISTING DRAFT PROVISION / LOCATION:** Governments are to frame financial-support schemes; text suggests insurance coverage and repair/replacement, but later wording focuses on essential products.
- **DEFICIENCY / OBJECTION:** The draft is internally inconsistent regarding specialised products and does not address clinically necessary services or the limits of delegated power over insurance contracts.
- **PROPOSED INSERTION / SUBSTITUTION:** “Subject to the governing statutes and eligibility rules of each scheme, financing frameworks shall consider the full clinically indicated pathway: assessment, fitting, earmoulds, batteries/chargers, processors, mapping, AAC software and access accessories, communication-partner training, rehabilitation, repairs, replacement and follow-up. Essential and specialised products shall both be addressed. Any binding insurance mandate shall be implemented through coordination with the competent insurance regulator and appropriate enabling instruments.”
- **JUSTIFICATION:** WHO–UNICEF (2022) identifies financing and service delivery as central to access. RPwD sections 24–27 support healthcare, social security and rehabilitation, but section 40 alone should not be assumed to rewrite all private insurance policies.

13. CHAPTER V, RULE 9: REPAIR, REPLACEMENT AND DISASTERS

- **EXISTING DRAFT PROVISION / LOCATION:** Right-to-repair extension and emergency replacement are proposed.
- **DEFICIENCY / OBJECTION:** No spare-part transparency, software access, continuity-of-communication arrangements or service levels are defined.
- **PROPOSED INSERTION / SUBSTITUTION:** “Manufacturers and funded suppliers shall disclose repair charges, warranty, spare-parts availability, expected service timelines, processor and software support and accessible escalation procedures. Schemes shall provide risk-proportionate temporary or loaner devices or alternative communication arrangements when essential hearing/communication access is interrupted. Disaster-response plans shall prioritize continuity for users dependent on AAC or hearing technology.”
- **JUSTIFICATION:** UNCRPD articles 9, 20 and 21 and WHO–UNICEF (2022) support continuing functional access, not merely first-time purchase.

14. CHAPTER VI, RULE 10: TOLL-FREE HELPLINE

- **EXISTING DRAFT PROVISION / LOCATION:** The draft specifies a 30-day resolution period and voice, text and Indian Sign Language access.
- **DEFICIENCY / OBJECTION:** Uniform 30-day resolution is unsuitable for urgent failure of an essential communication system; AAC-specific access and clinical escalation are missing.
- **PROPOSED INSERTION / SUBSTITUTION:** “Complaints shall be acknowledged promptly and triaged by severity. Immediate safety incidents and complete loss of essential communication access shall receive expedited interim support; routine complaints shall be resolved within the prescribed period or accompanied by a reasoned status and escalation route. Access channels shall include AAC-compatible interfaces, accessible text, Indian languages and Indian Sign Language. Clinical disputes shall be referred to independent domain-qualified reviewers.”
- **JUSTIFICATION:** RPwD sections 3 and 42 require effective accessibility. A uniform administrative clock cannot replace clinical risk triage.

15. CHAPTER VI, UNNUMBERED “NATIONAL ASSISTIVE PRODUCTS ACCIDENT DATABASE” AFTER RULE 10

- **EXISTING DRAFT PROVISION / LOCATION:** The draft requires investigation of device failure causing injury or accident and a BIS/notified-body database.
- **DEFICIENCY / OBJECTION:** The provision has no rule number; physical injury is too narrow; medical-device vigilance coordination and due process are unclear.
- **PROPOSED INSERTION / SUBSTITUTION:** “Insert a separately numbered rule: “Reportable assistive-technology incidents shall include serious injury, significant malfunction and prolonged critical loss of communication or hearing access. Reports shall be risk-classified, investigated proportionately and linked to applicable medical-device vigilance systems without duplicative or conflicting reporting. A qualified clinical reviewer shall be involved where the incident concerns fitting, programming, auditory access or communication function. Confidentiality, manufacturer response, corrective action and user notification shall be prescribed.”
- **JUSTIFICATION:** Clinical incidents can compromise communication and participation without an immediate physical accident. Existing medical-device vigilance responsibilities must remain intact.

16. NEW CROSS-CUTTING PROVISION AFTER RULE 10: GOVERNANCE, IMPLEMENTATION AND USER SAFEGUARDS

- **EXISTING DRAFT PROVISION / LOCATION:** No dedicated national domain-clinical advisory mechanism, explicit conflict-of-interest safeguard, phased compliance plan or outcome evaluation is stated.
- **DEFICIENCY / OBJECTION:** Without implementation ownership, standards may remain aspirational and clinical expertise may be excluded from technical decisions.
- **PROPOSED INSERTION / SUBSTITUTION:** “The Central Government shall establish a multidisciplinary advisory mechanism with persons with disabilities, RCI, BIS, competent medical-device authorities, qualified audiologists, speech-language pathologists, ENT/implant specialists and other relevant experts. It shall publish domain-specific service guidance, conflict-of-interest safeguards, implementation milestones and quality indicators. Indicators shall assess functional participation, follow-up and user satisfaction, and shall not be used to deny access solely because an individual does not achieve a standardized outcome.”
- **JUSTIFICATION:** UNCRPD articles 4(3) and 26, RPwD sections 3, 27, 40 and 42, and WHO Rehabilitation 2030 favour integrated, accountable and participatory systems.

PRIORITY REDLINES FOR THE MINISTRY

- **FIRST PRIORITY:** rule 2(d)—separate qualified clinical professionals from sellers, manufacturers and technicians.
- **SECOND PRIORITY:** rule 4—separate product certification from clinically appropriate fitting, verification and rehabilitation.
- **THIRD PRIORITY:** rule 6—embed domain-qualified ASLP consultation and lifecycle clinical-service criteria in public procurement.
- **FOURTH PRIORITY:** rules 8–9—fund continuing access, rehabilitation, repair and replacement for essential and specialised devices, subject to appropriate statutory instruments.
- **FIFTH PRIORITY:** rule 10 and the unnumbered accident database—provide urgent communication-access safeguards and clinical incident review.

LEGAL REFERENCES

1. Primary draft: Gazette of India, CG-DL-E-03102026-276767, English pp. 6–10. <https://cdnbbsr.s3waas.gov.in/s3e58aea67b01fa747687f038dfde066f6/uploads/2026/10/20261005916213315.pdf>
2. Rights of Persons with Disabilities Act, 2016: sections 3, 24–27, 40, 42 and 100.
3. Rehabilitation Council of India Act, 1992: section 13 (subject to statutory applicability and professional scope).
4. Rajive Raturi v Union of India, Supreme Court of India, judgment 8 November 2024 (enforceable accessibility standards).
5. Vikash Kumar v UPSC (2021) 5 SCC 370 (substantive equality and reasonable accommodation).
6. UN Convention on the Rights of Persons with Disabilities: articles 4(3), 9, 20, 21, 24–26.
7. WHO (2021). World Report on Hearing.
8. WHO & UNICEF (2022). Global Report on Assistive Technology.
9. American Academy of Audiology (2013). Clinical Practice Guidelines: Pediatric Amplification.
10. British Society of Audiology (2018). Practice Guidance: Using Real Ear Measurements to Verify the Fitting of Digital Signal Processing Hearing Aids.
11. Joint Committee on Infant Hearing (2019). Year 2019 Position Statement. Journal of Early Hearing Detection and Intervention 4(2), 1–44.
12. Niparko JK et al. (2010). Spoken language development in children following cochlear implantation. JAMA 303(15):1498–1506. doi:10.1001/jama.2010.451.
13. Schlosser RW & Wendt O (2008). Effects of AAC intervention on speech production in children with autism: systematic review. American Journal of Speech-Language Pathology 17(3):212–230. doi:10.1044/1058-0360(2008/021).
14. ASHA Practice Portal: Augmentative and Alternative Communication.
15. WHO Rehabilitation 2030: A Call for Action.
16. Medical Devices Rules, 2017; applicable BIS conformity requirements; General Financial Rules, 2017 and procurement guidance (as applicable).

Submission note: This document deliberately avoids presenting proposed Audiologist and Speech Language Pathologist only service rules as already operative Indian law. The Ministry should vet the final wording against RCI-recognized qualifications, existing health and device regulation, rule-making competence and accessible service provision before gazette notification.

Prepared for consideration by the Indian Speech-Language and Hearing Association (ISHA)

This annexure supplements the principal representation and Annexure II; it does not purport to state that the consultation draft is currently enforceable law.

1. PURPOSE AND EVIDENTIARY METHOD:

This dossier supports the requested amendment of the proposed Assistive Products and Technology (Standards and Accessibility) Rules. It distinguishes (i) authoritative empirical findings, (ii) clinical professional guidance, (iii) legal obligations already in force, and (iv) policy recommendations for prospective adoption. A professional association should not present proposed exclusive competencies as already mandated by the RPwD Act.

2. THE SCALE OF UNMET NEED: VERIFIABLE GLOBAL FIGURES

- **WHO World Report on Hearing (2021):** WHO estimated that more than 1.5 billion people live with some degree of hearing loss and approximately 430 million require rehabilitation; by 2050 nearly 2.5 billion may have hearing loss and at least 700 million may require rehabilitation. These are global estimates, not Indian prevalence figures.
- **WHO–UNICEF Global Report on Assistive Technology (2022):** More than 2.5 billion people need one or more assistive products, while nearly one billion lack access. The report recommends a people-centred system integrating products, trained personnel, financing, procurement, information and service provision.
- **India-specific data integrity:** The 2011 Census estimate of 2.68 crore persons with disabilities is dated and is not a direct estimate of persons needing hearing aids, cochlear implants or AAC. A new India-specific denominator should be developed using transparent definitions and current surveys.

3. WHY DEVICE CERTIFICATION IS NOT EQUIVALENT TO CLINICAL EFFECTIVENESS

Conformity assessment can test a device against defined technical characteristics. It does not establish whether amplification is safe and appropriately fitted to a specific ear, whether an implant recipient receives appropriate programming, or whether an AAC user can communicate meaningfully in everyday settings. These are different questions requiring clinical and functional evidence. A defensible regulatory model must specify the product, the qualified service pathway and measurable user-centred outcomes separately.

4. HEARING AIDS: SCIENTIFIC BASIS FOR AUDIOLOGIST-LED CLINICAL FITTING

Audiological care may involve validated behavioural or electrophysiological testing, differential assessment, device candidacy, prescription, electroacoustic testing, real-ear verification, pediatric prescriptive targets, aided validation, counselling and follow-up. The American Academy of Audiology pediatric amplification guideline (2013) and British Society of Audiology real-ear measurement guidance (2018) support individualized verification rather than relying solely on manufacturer first-fit settings. Verification should be required where clinically indicated and feasible, with documented alternative procedures where unavailable.

For infants, the Joint Committee on Infant Hearing (2019) endorses the 1–3–6 benchmark: screening by one month, diagnostic confirmation by three months, and enrollment in appropriate early intervention by six months. These are international programme targets, not currently binding Indian statutory deadlines. Policy implication: procurement should pay for clinically appropriate services and timely referrals, not merely units dispensed.

5. COCHLEAR IMPLANTS: MULTIDISCIPLINARY LONGITUDINAL CARE

Implant candidacy and follow-up require medical and surgical assessment, audiological testing, shared decision-making, activation, mapping, hearing rehabilitation and speech-language/communication

intervention as indicated. Niparko et al. (JAMA, 2010) documented spoken-language development after implantation in a longitudinal pediatric cohort, while also illustrating variability across children. This evidence supports early, sustained services but does not justify guaranteed speech outcomes or a single communication modality. Deaf culture, sign language, bilingual approaches and informed family choice must be respected.

6. AAC: COMMUNICATION INTERVENTION RATHER THAN HARDWARE ALONE

AAC includes gestures, symbols, low-tech boards, partner-assisted approaches, access devices and speech-generating technologies. Assessment should examine receptive and expressive language, pragmatic purposes, literacy, motor and sensory access, participation contexts, language preferences and partner capacity. ASHA AAC guidance supports a collaborative, person-centred assessment and intervention approach. Schlosser and Wendt (2008) reviewed AAC interventions for children with autism and found no evidence that AAC inhibits speech; conclusions should be read in light of study limitations and heterogeneous outcomes.

SLPs should be named as principal communication-clinical stakeholders, while occupational therapists, special educators, physiotherapists, psychologists, rehabilitation engineers and users contribute according to need. No rule should require professional authorization before a person may use ordinary gestures, communication boards or freely available basic AAC tools.

7. LEGAL ARCHITECTURE AND LIMITS OF DELEGATED RULE-MAKING

- **RPwD Act, 2016:** Sections 3, 16–17, 25–27 and 42 support substantive equality, inclusive education, health, rehabilitation and accessible information and communication. Sections 40 and 100 provide the relevant accessibility/rule-making framework. Specific financial entitlements, criminal sanctions or occupational monopolies must not be presumed to arise automatically from a generic accessibility rule.
- **RCI Act, 1992:** Section 13 and RCI guidance identify recognized qualifications and CRR registration as central to rehabilitation-professional practice. The draft should expressly preserve this statutory regime, define clinical versus non-clinical tasks, and require registration wherever legally applicable; it should not authorize unregistered sellers to perform regulated clinical acts.
- **Medical-device regulatory overlap:** The Drugs and Cosmetics Act and Medical Devices Rules, 2017, administered through the competent regulators, may govern relevant devices according to their legal classification and intended use. Product approval and professional competence are complementary, not interchangeable. Harmonization language should prevent duplicative or contradictory requirements.
- **Constitution and Supreme Court:** Articles 14 and 21, *Vikash Kumar v. UPSC* (2021) and *Rajive Raturi v. Union of India* (2024) provide strong principles of substantive equality, reasonable accommodation and enforceable accessibility. They do not themselves prescribe a particular audiologist/SLP staffing ratio or exclusive professional jurisdiction.
- **UNCRPD:** Articles 9, 20–21, 24–26 link accessibility, mobility, expression, education, health and habilitation/rehabilitation. Article 4(3) requires close consultation with persons with disabilities through their representative organizations. Professional governance must therefore be co-designed with users.

8. REGULATORY IMPACT AND PROPORTIONALITY

A proportionate framework distinguishes high-risk clinical fitting and implant programming from ordinary sale, low-tech AAC and repairs. Professional supervision may be onsite, telehealth-enabled or organized through district hub-and-spoke arrangements when clinically safe and permitted by law. Phased implementation should avoid excluding rural populations. Cost and feasibility impact assessments should accompany mandatory new service requirements.

9. EVIDENCE-TO-AMENDMENT CROSSWALK

- **Audiology verification:** Supports Annexure II provisions concerning definitions, professional competence, service standards, procurement and outcome measurement.
- **Cochlear implantation:** Supports multidisciplinary care, longitudinal mapping/rehabilitation, repair continuity and meaningful performance indicators.
- **AAC evidence:** Supports recognition of qualified SLPs, inclusive low-tech access, language customization, partner training and safeguards for AI-generated speech.
- **RCI and RPwD statutory framework:** Supports qualification safeguards and clear agency roles, subject to delegated legislative authority.
- **WHO–UNICEF procurement and financing:** Supports lifecycle costing, accessibility, service packages, repair, spare parts and user involvement.

Authorities and References:

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2. WHO & UNICEF (2022), Global Report on Assistive Technology — <https://www.who.int/publications/i/item/9789240049451>
3. RCI, Norms and Guidelines—CRR registration (effective 14 October 2025) — <https://rehabcouncil.nic.in/norms-guidelines/>
4. CDSCO, Medical Devices Rules, 2017 and amendments — <https://cdsco.gov.in/opencms/opencms/en/Acts-and-rules/Medical-Devices-Rules>
5. UNICEF, Assistive technologies—WHO/UNICEF procurement manual — <https://www.unicef.org/supply/assistive-technologies>
6. ASHA Practice Portal, Augmentative and Alternative Communication — <https://www.asha.org/practice-portal/professional-issues/augmentative-and-alternative-communication/>
7. JCIH (2019), Year 2019 Position Statement — https://www.jcih.org/JCIH_2019_Executive_Summary.pdf
8. Niparko et al. (2010), JAMA 303:1498–1506 — <https://doi.org/10.1001/jama.2010.451>
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11. Additional primary legal authorities: Constitution of India, arts. 14 and 21; Rights of Persons with Disabilities Act, 2016, ss. 3, 16–17, 24–27, 40, 42 and 100; Rehabilitation Council of India Act, 1992, especially s. 13; UN Convention on the Rights of Persons with Disabilities, arts. 4, 9, 20–21 and 24–26; Vikash Kumar v. UPSC (2021) 5 SCC 370; Rajive Raturi v. Union of India, Supreme Court judgment of 8 November 2024. Exact holdings and applicability must be checked by counsel before filing.

PROPOSED NATIONAL CLINICAL SERVICE STANDARDS, WORKFORCE AND IMPLEMENTATION FRAMEWORK

Prepared for consideration by the Indian Speech-Language and Hearing Association (ISHA)

This annexure supplements the principal representation and Annexure II; it does not purport to state that the consultation draft is currently enforceable law.

1. FOUNDATIONAL SERVICE STANDARD

Every publicly funded clinically prescribed hearing or communication assistive product should be supported by a proportionate, documented continuum of care: needs identification → informed choice → assessment → clinical selection → supply → fitting/programming → verification/validation → training/rehabilitation → follow-up → maintenance and replacement. This is a proposed standard, not a claim that all stages are presently legally mandated by the draft.

2. FUNCTIONAL RESPONSIBILITY AND ACCOUNTABILITY MATRIX

a) Hearing assessment and differential audiology:

- **Responsible personnel:** RCI-recognized, currently registered audiologist where applicable
- **Minimum accountability:** Appropriate validated testing; medical referral criteria; consent and report.

b) Hearing aid selection and programming

Responsible personnel: Qualified audiologist

Minimum accountability: Indication, device choice, individualized programming, objective verification where appropriate, functional validation.

c) Cochlear implant medical candidacy and surgery

- **Responsible personnel:** Qualified ENT/implant surgeon and multidisciplinary team
- **Minimum accountability:** Medical evaluation, surgical consent, risk counselling, perioperative safety.

d) Implant activation and mapping

- **Responsible personnel:** Appropriately qualified and specifically trained clinician under applicable law
- **Minimum accountability:** Documented programming, safety limits, aided measures, follow-up and escalation.

e) Speech-language and auditory rehabilitation

- **Responsible personnel:** Qualified SLP and/or audiologist within competence
- **Minimum accountability:** Individualized communication goals, participation outcomes, family support.

f) AAC communication assessment and language design

- **Responsible personnel:** Qualified SLP with relevant team
- **Minimum accountability:** Language, literacy, pragmatics, symbol systems, cultural and linguistic appropriateness.

g) AAC motor/sensory access and positioning

- **Responsible personnel:** Occupational therapist and other competent rehabilitation professionals as indicated
- **Minimum accountability:** Access method, posture, switch/eye-gaze suitability and fatigue.

h) Repair, technical service, logistics

- **Responsible personnel:** Authorized technical staff/manufacturer
- **Minimum accountability:** Traceability, safe repairs, replacement parts and user communication; no implied clinical license.

3. MINIMUM HEARING-AID PATHWAY

- Document hearing and communication needs, history, audiological findings and medically significant red flags.
- Record device selection rationale, user choice and financial disclosures.
- Undertake electroacoustic and real-ear/coupler verification as appropriate; document exceptions and alternative validation.
- Provide counselling on use, cleaning, feedback, batteries, safe listening and communication strategies.
- Schedule individual follow-up and reassessment after changes in hearing or communication need.

4. MINIMUM COCHLEAR IMPLANT PATHWAY

- Convene multidisciplinary candidacy review with transparent eligibility and communication options.
- Document medical and audiological assessment, expectations, informed consent and family preference.
- Provide documented activation, mapping and device-use education by appropriately competent personnel.
- Offer auditory and speech-language rehabilitation matched to individual goals, including access to sign language/AAC where desired.
- Monitor implant functionality, processor support, outcomes and long-term replacement needs.

5. MINIMUM AAC PATHWAY

- Complete a participation-based communication needs assessment, including user priorities and preferred language.
- Trial accessible options across no-tech, low-tech and high-tech systems without unjustified vendor lock-in.
- Assess vocabulary organization, language representation, motor/sensory access and interoperability.
- Train users and communication partners; integrate across home, school, employment and health services.
- Maintain backup communication and continuity plans for device failure; reassess as needs evolve.

6. QUALITY AND EQUITY SAFEGUARDS

Clinical documentation must be proportionate, accessible and privacy-protective. Outcomes should include functional communication, device usability, user-reported participation, repair turnaround and service continuity; no standardized speech score should become a blanket exclusion criterion. The right to refuse a particular device or choose sign language, AAC or multimodal communication should be respected.

7. WORKFORCE AND SERVICE-DELIVERY DESIGN

States should map RCI-registered ASLP availability and establish district referral networks, mobile audiology, tele-audiology and tele-AAC where clinically appropriate. Remote supervision must not be used to conceal an absence of qualified accountability. Short courses offered by manufacturers should not be treated as equivalent to recognized clinical qualifications. Implementation must be staged so that safety rules do not abruptly deprive rural users of services.

8. SUGGESTED IMPLEMENTATION PHASES (POLICY RECOMMENDATION)

- **0–6 months:** Create DEPwD–RCI–BIS–CDSCO–MoHFW coordination mechanism; include disabled persons' organizations and ASLP representatives; publish crosswalk of applicable product and clinical requirements.

- **6–18 months:** Pilot standard care pathways and procurement packages in diverse states; train clinicians and procurement officials; launch complaints and device-tracking functions with privacy safeguards.
- **18–36 months:** Expand service networks, audit equity and outcomes, revise financing packages, publish transparent annual reports and independent evaluation.

9. PROPOSED MEASURABLE INDICATORS AND SAFEGUARDS

- **Clinical access:** Percentage of eligible publicly funded users offered assessment and indicated follow-up; measure by district and disability group.
- **Verification and outcome:** Percentage of fittings with documented clinically appropriate verification or reasoned exception; user-centred functional outcomes, not raw device counts.
- **Repair continuity:** Median repair turnaround, percentage with temporary alternative access where essential, and frequency of unresolved failures.
- **AAC participation:** Proportion with individualized communication goals and partner training, where appropriate; participation across contexts.
- **Equity:** Rural–urban gaps, language access, age, gender, multiple disability and financial barriers; report aggregate data only.

10. GOVERNANCE AND INFORMED PARTICIPATION

A national advisory mechanism should include persons with disabilities and representative organizations, RCI, BIS, CDSCO, relevant ministries, audiologists, SLPs, implant teams, AAC specialists and procurement experts. Clinical committees should record conflict-of-interest declarations and publish de-identified quality reports. Recommendations must remain consistent with the RPwD Act, RCI Act, relevant medical-device law and professional scope.

Authorities and source documents

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11. Additional primary legal authorities: Constitution of India, arts. 14 and 21; Rights of Persons with Disabilities Act, 2016, ss. 3, 16–17, 24–27, 40, 42 and 100; Rehabilitation Council of India Act, 1992, especially s. 13; UN Convention on the Rights of Persons with Disabilities, arts. 4, 9, 20–21 and 24–26; Vikash Kumar v. UPSC (2021) 5 SCC 370; Rajive Raturi v. Union of India, Supreme Court judgment of 8 November 2024. Exact holdings and applicability must be checked by counsel before filing.

PROPOSE PUBLIC PROCUREMENT, FINANCIAL PROTECTION, SAFETY AND ACCOUNTABILITY SAFEGUARDS

Prepared for consideration by the Indian Speech-Language and Hearing Association (ISHA). **This annexure supplements the principal representation and Annexure II**; it does not purport to state that the consultation draft is currently enforceable law.

1. CORE PROCUREMENT PROPOSITION

The public purchaser should procure an accessible, clinically usable service package—not merely a boxed device. The draft’s procurement and repair provisions should be operationalized through transparent technical specifications, appropriate clinical input, competition, total cost of ownership and documented performance. No tender design should automatically exclude compliant small suppliers or undermine applicable procurement rules.

2. PRE-TENDER NEEDS ASSESSMENT

- Identify intended population, functional needs, age groups, languages, rural access and existing clinical capacity.
- Document applicable BIS and CDSCO requirements according to device classification; do not assume all AAC apps are regulated medical devices.
- Consult end users and disability organizations on accessibility and repair barriers.
- Obtain qualified audiology/SLP input on clinically relevant technical specifications, without granting a single commercial brand an advantage.

3. TENDER SCHEDULE: MANDATORY DISCLOSURES

- **Regulatory conformity:** Document applicable certification, licences, conformity evidence, device traceability and intended use.
- **Clinical interoperability:** Require compatibility with relevant fitting software, clinically indicated accessories, AAC vocabulary export/import, accessibility options and transparent proprietary limitations.
- **Service delivery:** Identify qualified clinical service providers, appointment availability, fitting/programming, counselling, training and follow-up commitments.
- **Warranty and spare parts:** Disclose warranty terms, battery/charger and processor support, software update period, parts availability, repair costs and escalation procedures.
- **Total cost of ownership:** Price devices and clinically necessary service components separately and transparently; include projected maintenance, consumables and replacement.
- **Data protection:** For connected/AI systems, require security controls, consent, data-minimization, user control, breach response and applicable Indian-law compliance.

4. EVALUATION MODEL AND LAWFUL COMPETITION

Use mandatory minimum technical/clinical qualification criteria followed by a procurement method permissible under the General Financial Rules and relevant procurement manuals. Where quality-and-cost evaluation is legally authorized, publish objective criteria and weightings in advance; where L1 applies, establish meaningful minimum performance and service requirements before price comparison. A categorical ban on L1 without legal authority should not be sought. Record independent professional technical input and conflict-of-interest disclosures.

5. MODEL CONTRACT CLAUSES

- **Clinical qualification:** Suggested contractual language- “The supplier shall not represent dealership authorization or manufacturer training as equivalent to an RCI-recognized rehabilitation qualification. Regulated clinical acts shall be undertaken only by legally competent professionals.”
- **Acceptance testing:** Suggested contractual language- “Delivery acceptance shall require inspection of device conformity, accessories, accessibility and software functionality; individual clinical acceptance shall be separately documented when fitting is indicated.”
- **Training and rehabilitation:** Suggested contractual language- “The contract shall specify user/caregiver training and referral or delivery arrangements for clinically indicated rehabilitation, with responsible providers and timelines.”
- **Repair and continuity:** Suggested contractual language- “The supplier shall publish repair turnaround targets, spare-part and warranty obligations and an escalation route. Public programmes shall consider backup access for users who depend on the product for essential communication.”
- **Incident escalation:** Suggested contractual language- “Safety events shall be triaged immediately, reported to competent medical-device authorities where required, and independently investigated as appropriate. Complaints shall not be closed solely because the supplier disputes them.”
- **Audit and payment:** Suggested contractual language- “Payments may be linked to verifiable deliverables such as supply, commissioning, documented training and service support, without conditioning payment on unrealistic speech or language outcomes.”
- **Data and user rights:** Suggested contractual language- “Users retain access to their records, communication content and accessible complaint mechanisms, subject to applicable law. Vendor lock-in should be disclosed and minimized where feasible.”

6. FINANCIAL COVERAGE: WHOLE-PATHWAY COSTING

Subject to scheme eligibility, budgetary authority and other applicable law, Government should consider assessment, fitting, verification, mapping, speech-language intervention, AAC configuration, training, earmoulds, accessories, batteries/chargers, software, repairs and replacement. These recommendations do not imply an existing universal legal entitlement to insurance reimbursement or all associated costs. Publish eligibility, co-payment and appeal rules clearly.

7. COMPLAINTS, GRIEVANCE REDRESS AND ADVERSE-EVENT HANDLING

A proposed 30-day ordinary complaint resolution period should not govern urgent safety or loss-of-essential-communication cases. Adopt risk-based triage: immediate safeguarding for injury/serious malfunction; expedited interim access for critical communication failures; ordinary complaints with clear acknowledgment, reasoned outcome and appeal. Route statutory medical-device vigilance matters to the competent regulator and avoid parallel conflicting findings.

8. TRANSPARENT NATIONAL PORTAL WITH PRIVACY-BY-DESIGN

The proposed portal should track certification status, procurement, distribution, repair tickets and complaints through role-based access. Public dashboards should display aggregated statistics; identifiable audiograms, medical histories, speech recordings, AAC vocabulary and sensitive communication content should not be publicly accessible. Retention, consent, access logs and data correction mechanisms must follow applicable Indian law.

9. ANTI-CORRUPTION AND CONFLICT-OF-INTEREST SAFEGUARDS

- Publish eligibility criteria and technical scoring before tender opening.
- Require declaration of manufacturer ties, commissions, referral arrangements and evaluator conflicts.
- Separate independent clinical recommendation from sales incentives wherever practicable.
- Provide accessible written product alternatives and reasons for selection.
- Conduct risk-based audit of duplicate distribution, unused devices, unsupported billing and unexplained repeat testing, while preserving procedural fairness.

10. RECOMMENDED NATIONAL AUDIT DASHBOARD

- **Procurement:** Unit price, total lifecycle cost, bidder eligibility, deviations, cancellations and supplier concentration.
- **Clinical quality:** Qualified-service coverage, documented fitting, training and follow-up completion.
- **Function and participation:** User-reported access and communication outcomes, with individualized benchmarks and no coercive speech-only target.
- **Continuity:** Repair and replacement delays, downtime, availability of backup equipment.
- **Safety and grievance:** Adverse events, severity, investigation status, closure and appeal outcomes.
- **Equity:** Disaggregated access by state, district, age, gender, rurality, disability and communication modality where privacy-safe.

11. REQUESTED DECISION AND PROPOSED ORDER

ISHA requests that DEPwD (i) formally consult qualified ASLPs and representative organizations of persons with disabilities; (ii) adopt a model procurement schedule and minimum clinical service standard; (iii) harmonize product certification with RCI professional qualifications and CDSCO requirements; (iv) require repair continuity and accessible grievances; and (v) publish phased implementation and monitoring guidance after statutory and financial review.

Authorities and source documents

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4. CDSCO, Medical Devices Rules, 2017 and amendments — <https://cdsco.gov.in/opencms/opencms/en/Acts-and-rules/Medical-Devices-Rules>
5. UNICEF, Assistive technologies—WHO/UNICEF procurement manual — <https://www.unicef.org/supply/assistive-technologies>
6. ASHA Practice Portal, Augmentative and Alternative Communication — <https://www.asha.org/practice-portal/professional-issues/augmentative-and-alternative-communication/>
7. JCIH (2019), Year 2019 Position Statement — https://www.jcih.org/JCIH_2019_Executive_Summary.pdf
8. Niparko et al. (2010), JAMA 303:1498–1506 — <https://doi.org/10.1001/jama.2010.451>
9. Schlosser & Wendt (2008), AJSLP 17:212–230 — [https://doi.org/10.1044/1058-0360\(2008/021\)](https://doi.org/10.1044/1058-0360(2008/021))
10. DEPwD consultation notice, 5 October 2026 — <https://depwd.gov.in/en/draft-rules-on-non-negotiable-accessibility-standards-for-assistive-technology-sub-sector/>
11. Additional primary legal authorities: Constitution of India, arts. 14 and 21; Rights of Persons with Disabilities Act, 2016, ss. 3, 16–17, 24–27, 40, 42 and 100; Rehabilitation Council of India Act, 1992, especially s. 13; UN Convention on the Rights of Persons with Disabilities, arts. 4, 9, 20–21 and 24–26; Vikash Kumar v. UPSC (2021) 5 SCC 370; Rajive Raturi v. Union of India, Supreme Court judgment of 8 November 2024. Exact holdings and applicability must be checked by counsel before filing.