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Disability Rights Perspectives

Council for Social Development

edited by
Kalpana Kannabiran and Asha Hans

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For

Sri. B.N. Yugandhar

In deep appreciation of his abiding commitment to the rights of persons with disabilities in India

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Abbreviations

AL	agricultural labour
ADL	activities of daily living
AISHE	All India Survey on Higher Education
BSUP	Basic Services to the Urban Poor
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CL	casual labour
CPC	Criminal Procedure Code
CRC	Child Rights Convention
DSSS	Disabled Shram Shakti Sangh
DALYs	Disability-Adjusted Life Years
ECT	electro-convulsive therapy
EFA	Education for All
ICF	International Classification of Functioning, Disability, and Health
HHI	household industries
IHDS	India Human Development Survey
LAA	Land Acquisition Act
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
NCPEDP	National Centre for Promotion of Employment of Disabled People
NEP	National Education Policy
NFHS	National Family Health Survey
NREGA	National Rural Employment Guarantee Act
NSS	National Sample Survey
NWOD	non-worker owing to disability
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PSDP	psycho-socially disabled person
PTSD	post-traumatic stress disorder
PWD	person with disability
RPWD	Rights of Persons with Disabilities
RTE	Right to Education
SCC	Supreme Court Cases
SDI	social development indices
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNESCO	United Nations Educational, Scientific and Cultural Organization
WRD	World Report on Disability

Introduction

Asha Hans and Kalpana Kannabiran

The *Social Development Report* (*SDR*) 2016 presents new research in the areas of disability studies, housing rights, labour, displacement and financial inclusion, besides providing a social development index that is cumulative across the different editions of the *SDR*. As with the previous volumes, this volume of the *SDR* is organized into three parts: Part I presents eleven essays organized around a thematic focus—disability; Part II presents six essays on critical areas in social development that have not so far received adequate focus—areas that are relevant for a general understanding of social development; Part III presents the social development index. The thematic focus of the *SDR* 2016 is disability, a little researched and poorly understood area in the social sciences and humanities in India, as also in development discourse.

Disability and Social Development

The context for the thematic focus of this volume, Part I, is set by the deliberations around the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and its ratification by India on 1 October 2007. The UNCRPD was adopted,

> recognizing the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty.

The introduction of the UNCRPD in 2008 signalled the recognition of disability as a human rights concern. Research in different countries has demonstrated disability as a development issue by mapping its bidirectional link to poverty. The World Health Organization's World Report on Disability (*WRD*), prepared in response to a request of the World Health Assembly attempts to fill the knowledge and information gap on disability. The consequent deliberations around a thorough redrafting of the disability law in India now await enactment. The participation of persons with disabilities, collectives of persons with disabilities, and advocates of disability rights in these deliberations at every level has resulted in a new common sense on the issue of disability rights, and in new measures of capabilities, human diversity, and full participation. Disability researchers and advocates welcomed the UNCRPD as a working document that would bring about change in the quality of life of persons with disabilities. Today, a decade after its adoption, the prevalent opinion is that the expected transformation did not take place. In order to evaluate the underlying causes for the obstruction of rights and their non-realization for persons with disabilities, it is important to initiate critical scholarly and public debate on the subject grounded in their lifeworlds.

Since its adoption in 1950, the Indian Constitution has provided the opportunity for an expansive enunciation of basic rights. It has moved to an interpretive tradition that upholds the spirit of the fundamental rights to life, liberty, and equality with dignity, among others. There is little doubt that it has provided the framework for an assertion of fundamental rights against not only the state, but also importantly against private actors. This is especially critical where the latter is found to perpetrate stigmatized identities that diminish the dignity of persons and oppress them in untold ways–as with persons with disabilities.

On December 27, 2015, Prime Minister Narendra Modi spoke for one and a half minutes about disability on 'Mann Ki Baat':

> Those in whom Paramatma has created a deficiency in the body, those for whom some part of the body does not work properly, we call them 'viklaang'…But sometimes, when we get to know them, we realise that although there is the deficiency that we see with our eyes, Ishwar has given them some extra power, there is a different kind of shakti that Paramatma has created within them which we cannot perceive with our eyes. But when we see … their capability, we are taken aback, 'Arre wah? How does he manage to do this?' Then, I had a thought: 'From our eyes we feel that he is "viklaang", but from experience we find that he has some extra power, atirikt shakti'. Then I had another thought: 'Why don't we, in our country, replace the word "viklaang" with the word "divyaang"?' These are those people who possess divinity—divyata—in one or more parts of their body; whose bodies are possessed by divine power (divya shakti), which those of us with normal bodies (saamaanya shareer) do not have. I really like this word. Compatriots, can we adopt 'divyaang' instead of 'viklaang' in common usage?[1]

Five months later, in May 2016, the Government of India incorporated this term officially, the department rechristened 'Department of Empowerment of Persons with Disabilities (Divyaangjan), Ministry of Social Justice and Empowerment'. It is our view that this assertion that disability as a divine gift is a grave misreading of the place of rights in realizing human dignity, and the role of the state in ensuring protection against discrimination. Very simply put, that which is divinely ordained shall not be questioned. 'Deficiency' and 'divyashakti' are Siamese twins that constitute the disability stereotype. It is our endeavour in putting this collection of essays together to understand afresh that the disproportionate disadvantage, exclusion, and stigmatization suffered by persons with disabilities is a result of discrimination against them, and are caused by cultural, social, and physical barriers that obstruct their effective participation in social and political life.

Within this larger context of the increasing significance of disability as a measure of diversity and its recognition as a ground of discrimination, the *SDR 2016* presents new research in this area, attempting to break the impasse created by the paucity of primary research, analysis, and even information on disability in India. The report attempts to (a) recapture the original rights paradigm envisaged a decade ago, which had so very clearly marked the injustices in the system and built a convention that promoted a just regime; and (b) build on that well-laid foundation with an exploration of disability-based deprivations, thereby mapping the specificities of positive measures that are mandated at every level in order to bring social relations within the ambit of this conceptual framework.

We attempt to investigate the many ways in which, severally and cumulatively, persons with disabilities have suffered disability-specific negative effects of the system that have contributed to the persistence of barriers that the UNCRPD and other related laws sought to remove. We hope, in the process, to open discussion on some of the important issues that need engagement with the system, on the comprehensive implementation of the UNCRPD (United Nations, 2006). Through an exploration of the obstacles, the contributors attempt to broaden and deepen the current discourse on disability demonstrating in the process why the welfare of the world's vulnerable peoples requires exceptional and necessary change in both state and society.

Through a consideration of the most essential aspects of disability rights the research provides both challenging and promising perspectives on the most severe threats to disability communities. The essays are constructed within a comprehensive framework derived from policy, empirical data, and the experience of persons with disabilities. Each chapter addresses the fundamental elements of rights, illuminating that persons with disabilities in all their heterogeneity ought to access those elements in their entirety.

The first two chapters in Part 1 provide a theoretical foundation, focusing on the conceptualization of a disability-responsive framework and outlining a comprehensive analytic lens for reflection on a range of concerns that follow. The next two chapters look at the specific situation of children—through a close look at girls with disabilities and schooling for children with disabilities. Chapters five through nine focus on higher education, work, labour, and livelihood underscoring the criticality of realizing the full potential of independent living for persons with disabilities. The last two chapters in this section probe into the most difficult issue of psycho-social disability (also looking specifically at women and girls, importantly) providing actions and strategies to roll back the violence within the system, working within the constraints of the present system yet seeking to transform it.

Definition, Measurement, and Incidence

The lack of a standard measure of disability across countries makes definition, comparisons, and statistical estimates of the incidence a challenging task. Combining

the 2010 population estimates and the 2004 disability prevalence estimates of the World Health Survey and Global Burden of Disease, the *WRD* estimates that there are over a billion people, that is, 15 per cent of the world's population (including children), living with disability (*WRD*, 2011: 29). The National Disability Policy of India estimated in 2006 that the disabled constitute 2.13 per cent of the country's population. Low- and middle-income countries are found to have lower prevalence rates than high-income countries (Eide, Loebe, and Mont, 2008). This may be partly explained by the fact that 'new approaches to disability measurement based on the bio-psychosocial model have largely been developed and implemented but have not yet been taken up in low- and middle-income countries' (Cappa, Petrowski, and Njelesani, 2015: 319).[2]

Poor data collection is also often 'clouded by extraneous factors that are difficult to quantify, such as the feminization of poverty, cultural concepts of sexual and reproductive rights, violence, abuse and other types of exploitation' (WHO and the World Bank, 2011). Then there are other indicators that are not in any data sets such as taking part in the life of the community, which are not quantified, and as Amartya Sen argues this is not only a loss in itself but also to our interpretation of whatever further deprivations it may generate (Sen, 2000: 13).

Although research and advocacy has indicated the need for data, very little has been achieved in India, so the *SDR* assigns a distinctive approach to fill the spaces left out in interpretative inquiries. Ashwini Deshpande presents a statistical overview drawing on different data sets—the Census, NSSO, IHDS, NFHS—and extant studies, in an attempt to address the gap in data and information on disability. With the statistics on disability in India focusing primarily on bodily impairments, and ambiguities with regard to the conceptual definition of disability, there is an underestimation of the incidence of disability. Yet a combined reading of different data sets provides us with a broad picture of the state of disability in India. Very simply the scale is evident when the 2 per cent disability prevalence rate of India which looks so minimal, suddenly overwhelms us with size when it is compared with and detected to be 'more than the population of Australia', or when our understanding of numbers in states change from whole population to proportions. Going beyond the disability-gender-age-type matrix, the disability-Scheduled Caste correlation in her chapter demonstrates the other disadvantages and exclusions which multiply with further intersection. The deprivations associated with a binary data of Disability-Scheduled Caste are highlighted and reflect the changes we will require in policy in order to fully comprehend disability deprivations.

Valid data is important not only for evidence-building for monitoring of policies but also for the provision of reasonable accommodation. The collection of data based on impairments and its confinement within the medical model makes this an important aspect to be challenged. The Bombay High Court set a precedent when ruling against the order of the Labour Court with regard to the refusal to pay compensation to a person with disability (PWD) (below 12 per cent) injured at the workplace. The Court quoted UNCRPD Articles 1, 4, 5, and 27 and observed that they were binding on the legal system—as reasoned by the Supreme Court in the Suchita Srivastava case[3]—interpreting disability to be broader than the medical model and linking it to the social model and to reasonable accommodation.[4]

Outside the data inconsistencies a major vantage point that influences the analysis and the arguments in the *SDR* is the human rights perspective related to disability. The fundamental assumption of this framework is that barriers produce inequities and obstacles to the realization of rights, and for that reason the present system, which is highly discriminatory is incompatible with the protection of human rights of the disability community and their basic needs. To counter the unwelcome effects of the discriminatory process that affect persons with disabilities such as poverty, social location (notably caste, tribe, minority status, gender), low literacy, patriarchy, stigmatization, and exclusion, new avenues are being explored to check the disenfranchisement through the intersectional inter-reading of the UNCRPD, the Constitution of India, and case law. This new and emerging legal framework moreover is being strengthened through intersectional interpretations with other Conventions such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Child Rights Convention (CRC). While CEDAW and CRC strengthen the framework, the UNCRPD, it must be emphasized, remains the inspiration—unlike the other international covenants it provides a holistic vision by integrating civil, political, as well as social, economic, and cultural rights.

Commencing with the international and national frameworks that have developed over the past decade in recognition and affirmation of the rights of persons with disabilities (RPWD), Asha Hans provides a broad overview of the major debates around the UNCRPD and

the intersection between concerns of the UNCRPD and CEDAW. State signatories to both the Conventions have obligations including adoption of legislation and other appropriate administrative measures, and modification or repeal of law, customs, or practices which are discriminatory (WHO, 2014). The UNCRPD and CEDAW are legally binding instruments and together can infuse the dynamism in the system which it sometimes lacks. Underscoring the specific experience of exclusion of women with disabilities she urges us to examine disability and gender as intersecting grounds, drawing on a wide range of consultations at a national level that were part of the UN alternative reporting processes under CEDAW as well as on her ongoing research with domestic violence survivors.

Although UNCRPD has a specific provision for children (Article 7) and one for women (Article 6), the Convention on the Rights of the Child is increasingly being made use of from a disability perspective. Nandini Ghosh and Supurna Banerjee, exploring the lived experiences of girls with disabilities in three states—Jharkhand, Odisha, and West Bengal—across four primary areas provide an extensive recognition of the barriers they face in accessing education. The primary focus of the chapter, which has otherwise remained neglected in research, includes access to rehabilitation facilities and care and support from parents and other caregivers. The importance of these aspects is underscored by Article 26 of the UNCRPD on Habilitation and Rehabilitation, which recognizes the restoration or improvement of better functioning (importantly, promoting independent living and inclusion in communities) and prevention of secondary disability as an important contributor to the quality of life of girls that will enable them to access education. This is not an easy task. The recent abuse of children in the Asha Kiran institutions in New Delhi where children among other deprivations were found to have not received basic rehabilitation services resulting in severe health-related risks is but one example. Having not been provided physiotherapy or occupational therapy nor taught activities of daily living (ADL), it was found that of the two hundred inmates in a complex of institutions, about 50 per cent were not toilet trained and 55 per cent were not taught to manage menstruation (Alkazi, 2016). As Ghosh and Banerjee's empirical data illustrate, the hostile environment of the local health system exacerbates the effects of impairment. It is argued therefore that the detection and treatment of impairments should not be taken as a separate area of medicine but should be considered as an integral aspect of public health (UNICEF, 2013: 27).

Caring is an important component of any health service system and is not just a need of the person or family of the disabled. The caring, or palliative aspect, tends to get lost as the emphasis in mainstream discourse on disability is on the medical perception of the body. Caring is accorded a low priority in India as it remains within the family and usually the responsibility of the mother. Although NGOs attempt to bridge the gaps in state services and go a long way in making girls with disabilities independent/minimally dependent, they cannot entirely replace the state in outreach.

Barriers in Education

The 'meritocratic gaze' that characterizes school education in India, Jha argued in his study of special education and inclusive education in India (2008), shifts the focus of attention from the pedagogy and curriculum in schools to the child's disability, individualizing disability and locating it within a psycho-medical perspective. His study of schools in Delhi conducted around 2003–2004 found that '[a] "rights discourse" was completely missing from all three schools' (Jha, 2008: 147). The situation is largely unaltered even in the present time. The rights framework has in a large measure to deal with poverty and a patriarchal environment, which has intersected to keep girls out of schools. We furthermore have to take note of the dialectic encounters of stigma and discrimination and the inequities and subjugations girls may suffer. Patriarchal gender regimes, older than democracy, are entrenched in the social system and difficult to challenge, especially as they are still not identified as major barriers in the life of girls and women with disabilities. Girls with disabilities remaining out of schools are near universal phenomena due to lack of toilets, safe and accessible transportation, and enabling learning environments. This is compounded by the digital divide based on elements such as 'girls cannot do maths, science and technology (STEM)'. The lack of role models and mentors at grassroots level and low networking keep girls out not only of schools but also vocational training and deny them a robust education and the right to work.

The exposure of children to multiple risks, compounded by children screening positive for a high risk of disability being denied access to adequate childcare and nutrition, foregrounds the criticality of the family in providing care to children who are disabled and those facing increased risk. A 2005 study by UNICEF estimated 150 million children with disabilities were at risk. Data from specific countries also suggest a higher risk in children belonging to ethnic minorities (*WRD*, 2011: 36). There is a sizeable

enrolment gap between children with and without disabilities, with figures across Asia, Europe, Africa, and South America showing higher enrolment rates for non-disabled children across age groups (*WRD*, 2011: 208). School problems, the report found, revolved around curriculum, pedagogy, inadequate training of teachers, physical barriers, labelling, violence, bullying, and abuse (*WRD*, 2011: 209). The denial of equality, dignity, and autonomy to persons with disabilities lies at the core of disability rights as human rights. An important finding of the *WRD*, 2011 and one that confirms our experience in India, is that persons with disabilities are at a greater risk of being targeted by violence. In the United States, the risk is 4–10 times more. The Asha Kiran experience shows it could be 9 on a scale of 10. A support measure that can be taken account of in India is the Convention on the Rights of the Child, which is globally being read with the UNCRPD. The integrated use of different human rights instruments can enable girls with disabilities enjoy freedom from exclusion and discrimination.

Barriers in schools and institutions of learning demonstrate to us the far-reaching consequences of barriers and denial of full and equal access to children/learners with disabilities. Jo Chopra McGowan examines schooling and the constitutional right to education through the experience of children with disabilities, pointing to the ways in which disability challenges commonplace ideas of comfort, capacity, and hierarchy in the classroom—the teacher at once a learner, having to learn to read and understand the languages of disability; and the inclusive classroom a space where vulnerabilities can no longer be masked, hidden, or invisibilized. The absence of support services required for inclusive education in real terms results in entire generations of children with disabilities missing out on the right to education.

This experience of a negative and hostile environment in school continues in higher education, as the study conducted by Kalpana Kannabiran and Soumya Vinayan demonstrates. This study, spread over 23 universities (state and central), generated data from across the country and a few colleges and found that while curricular neglect of disability as a measure of diversity and a ground of discrimination was rampant, the ranking of physical accessibility on a scale of 1–10 did not cross 4.8, pointing to chronic neglect of the basic needs of scholars with disabilities in institutions of higher learning in India today. In efforts to promote education, it has been argued, the provision of adequate and sustainable resources, an accessible learning including an environment of non-discriminatory attitudes by school personnel, students, and parents will generate an enabling atmosphere and overcome challenges. Not forgetting that in education a positive self-image and self-worth are critical to dignity, the recognition of cultural identity, for instance, deaf and autistic culture and mad pride[5] would provide holistic reasonable accommodation, especially for students of higher education. From job applications to modifications needed, it is often assumed that reasonable accommodation will prove expensive but then again all these cases call for a strategy that sees reasonable accommodation as an enabling factor capable of eliminating deep-rooted prejudice and improving the quality of life in society at large, not just for persons with disabilities.

It is now widely understood that environment determines a person's experience of disability—either as a facilitator or a barrier. But what do we mean by 'environment'? The International Classification of Functioning, Disability and Health (ICF), which the *WRD* draws on, maps environmental factors ranging from technological and built environment to emotional and psycho-social environments that influence active participation. Importantly, this classification makes a distinction between capacity and actual performance, the gap between which could be indicative of the environmental barriers that need to be eliminated. Accessibility is a concern that cuts across different domains of environment and must reach persons across disabilities. While it is widely acknowledged that accessibility standards are indispensable to inclusion and non-discrimination on grounds of disabilities, these have largely been left to the goodwill of the institutions—state and private. The *WRD* observes, 'Laws with mandatory access standards are the most effective way to achieve accessibility' (*WRD*, 2011: 175).

Accessibility is an important indicator of educational realization and States Parties have to ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education, and lifelong learning without discrimination and on an equal basis with others (Article 24.5). It is estimated that of the 75 million children of primary school age who are out of school, one-third are children with disabilities. UNESCO notes that ninety per cent of children with disabilities in developing countries do not attend school (UNESCO, 2010: 189). So, while enrolment remains the basic indicator for literacy the children who are missing from schools post enrolment prompt us to look for other variables. To this end, States Parties need to ensure that reasonable accommodation

is provided to persons with disabilities—even the provision of minimum support such as assistive devices and transportation for instance, while not sufficient in itself, will go a long way. The new draft National Education Policy (NEP) has recognized the need to include children with disabilities who constitute a significant proportion of out-of-school children as they are both socially and educationally disadvantaged.[6] It specifies the needs of educational needs of 'differently abled children and children with learning disabilities' who are facing multiple problems of social neglect; absence of support systems in the home; and inadequate and lack of appropriate facilities assistive devices, particularly in schools located in smaller towns and villages. However, it does not specifically provide for what had been demanded in the consultations by disability groups, for instance, open schooling, alternative response modes, and changes in inclusive staff policies.[7]

(1) The proposed pre-school education set-up should aim at early identification of disability to facilitate early rehabilitation and inclusion in collaboration with ASHAs and *Anganwadi* workers.
(2) Gender and disability disaggregated data should be collected not only on enrolment but on attendance at all levels of education. This data should be mandatorily displayed under proactive disclosures as mentioned under section 4 (b) of the Right to Information Act along with 17 other points mentioned under it.
(3) To improve quality of education, teacher trainings courses, in-service teacher trainings, and education curriculums should focus on value-based education system to invoke a lifestyle of conscious living–sincerity, commitment, compassion, mutual respect, tolerance, wisdom, integrity, and humility.
(4) Social and access audits should be conducted in all schools to help modify infrastructure and institutional mechanisms to ensure greater accountability.
(5) Special provisions should be created after proper assessment to accommodate intersectionality—caste, class, religious ethnicity, gender, disability and diversity in the curriculum of teachers as well as that for students.
(6) Incorporation of languages like sign language and Braille should be made compulsory for all teachers and students for promoting inclusion of disability.[8]

As the right to education includes everyone and is no longer only a State subject the budgetary provisions will be allocated only if the National Education Policy or NEP (2016) provides for it specifically. The basic problem still remains that Education comes under the Ministry of Human Resource and Development but disability has its own ministry (Social Justice and Empowerment) and both do not intersect.

Disability, Labour, and Work: Drawing on Experiences

The productive capacities of persons with disabilities have been poorly understood—they have been cast as weak, incompetent, and without legal capacity. This not only denies them the right to work and livelihood, but together with the meagre provision of assistance through welfare/ charity which encompasses Indian society, this trend in thinking and planning has exacerbated discriminatory behaviour towards persons with disabilities. Self-employment is increasingly important in rural areas but again a journey to implementing positive measures would need to define new pathways. Disabled men's work is feminized and many are kept out of the labour market. In this case the use of reasonable accommodation as per Article 27(i) needs augmentation to ensure equal and secure working conditions.

Research on disability has rarely been linked to the type of rural transformations underway and consequently, there has been no concerted attempt to map what is required to make such transformations more inclusive. In the research we are confronted with numerous questions—are persons with disability allowed to participate in the labour market? What opportunities does the rural–urban labour market provide for men and women with disabilities? J. Jeyaranjan and Padmini Swaminathan attempt to capture this diversity and the experience of barriers in the life worlds of persons with disabilities, by examining macro data for the state of Tamil Nadu, alongside the actual experience of disability in different rural locales in the state through a detailed study of five villages, presenting rich data from the field. As employment conditions in the state are very diverse, survey data from some diverse locations are used to profile the rural employment and work of the disabled in the state in an attempt to capture some of this diversity. Besides the well-known data on low accessibility to disability identification cards, education etc., this chapter throws up new information such as exclusion due to shifting of work from traditional methods to machines linked with new modes of transport not accessible to workers with disabilities. The new formation of work agreements based on contracts and gangs in general find persons with disabilities on the periphery. The increasing nucleation of families deprives the rural population of support and benefits of the development process.

Similarly in the urban context whether economic growth is ushering in opportunities for women to participate in remunerative activities is a key issue. Soumya Vinayan looks at urban employment in six towns in Telangana state in an attempt to capture diversity and barriers in the context of work in an urban setting. Taking forward the examination of rural landscapes and disability in the context of employment, it has to be considered that reasonable accommodation through positive measures could provide employment however weak the system. These 'threshold conditions' are of relevance for all fields of disability. Persons with disabilities face greater barriers–attitudinal and physical/environmental, and hence increased vulnerability, which restrict them from enjoying full citizenship. Reasonable accommodation is based on the right to equal and fair wages for which supported employment linked to independent living is essential and just.

A measure suggested at the Rio+20 meet by the Trade Unions Major group was to recognize and strengthen social protection systems as a key to build resilience (Major Group Position Paper, 2014).

Satish Agnihotri and Shruti Singh, going further, examine the ways in which the National Rural Employment Guarantee Act (NREGA), which is based on the principal of self-selection, and breaks new ground for the re-visioning of capabilities in the context of disability. Kalpana Kannabiran sets out the theoretical ground for re-ordering the labourscape through a cursory look at employment jursiprudence in India and the way out of the circle of mis-recognition through a close look at the NREGA in Andhra Pradesh. The creation of the category of 'worker with disabilities' is a major achievement of the NREGA, replacing the culture of charity, where persons with disabilities were ordinarily consigned to the omnibus category of 'non-labouring poor' within the framework of labour economics and labour studies. The NREGA enables a re-conceptualization of the definition of worker, marking a shift away from disabling discourses that presume a narrowly defined concept of ability and capacity that divests the disabled worker of the right to work.

We need policy measures to secure long-term economic ends, which can be achieved by the establishment of an environment where individuals can achieve their inherent potential. Poverty undermines the very foundation of human rights and development and its eradication cannot be achieved through stopgap measures.

Contextualizing work, Article 27 of the UNCRPD may not have been as productive as envisaged but it does provide a framework for thinking through independent living. Viewing it within the framework of reasonable accommodation and substantive equality will take it beyond welfarism and enrich the realizable potential of human rights.

Coercive Environments

Disability was considered to be a medical issue outside the discourse on identity or social status, till the UNCRPD changed the configuration. Although it has not provided any new rights, the Convention by combining socio-economic and civil-political rights portrays human rights as indivisible and universal for all persons–including people with disabilities. The distinction between disability and well-being is an important one as many disability researchers assert. The *WRD* cites an Australian National Health Survey in which 40 per cent of people with severe or profound disability rated their health as good, very good, or excellent (*WRD*, 2011: 8). Yet, unarguably, ensuring the prevention of health conditions that lead to disability is a development concern. The World Health Survey cited in the *WRD* draws attention to attitudinal, physical, and systemic barriers that impede the access of the disabled to health care, drawing on the findings of research in Uttar Pradesh and Tamil Nadu that pointed to cost, lack of local services, and transportation as being the top three obstacles to using health facilities (*WRD*, 2011: 62–3). The financing of health care, making it affordable and making medical equipment accessible to the disabled remains an urgent concern. The failure of service providers to communicate in appropriate formats or with sensitivity to the needs of the disabled care seekers might result, as it did in Zimbabwe, in the exclusion of the disabled from routine screening and counselling services (*WRD*, 2011: 72).

Disability audits of public and health care services, of existing and proposed policy and of institutions and organizations have pointed to the practices of exclusion and indirect discrimination resulting from a lack of sensitivity to the needs of persons with disabilities. A global survey in 2005 showed that of 114 countries, 37 had no training in place for rehabilitation professionals and 56 had not updated medical knowledge of health care providers on disability (*WRD*: 110). Aggravating these barriers in the structural and systemic environment are mental barriers—negative stereotypes and stigmatization—that question the right to choice, family life, adoption and such for persons with disabilities (*WRD*, 2011: 6). While there is a general tendency to homogenize disability and flatten out the diversity of condition and capability, disability

is, in fact, stunningly diverse and encompasses the child with learning disabilities, the injured soldier, and the elderly man with severely impaired mobility, not to speak of survivors of violence and those with psycho-social disabilities.

The heterogeneity of disability is linked to the diversity of issues where excluded groups are confronted with an uncaring society, non-recognition, and lack of reasonable accommodation required to transform the system. Despite India's full approval of Article 12 (Right to equal recognition before the law) the government's poor/non-implementation has drawn criticism.

The Persistence of Informal Power

Legal capacity, which consists of two elements: recognition as a legal entity and flowing from it the right to act. However, the legal construct from which these rights are realized and protected (Articles 12 and 25) have been both ignored and contravened. The Indian legal framework is insensitive and intensifies the discriminatory process by continuing to use words such as 'unsound mind/idiots' within the existing laws for persons with psycho-social (mental illness) disability. This links it to the determination of 'incapacity' for persons with psycho-social disability as embodied in the curtailing of their political right and economic rights to property, financial control, and custody of children. This also results in unlawful incarceration and remains a major barrier in the access to rights (Human Rights Watch, 2014). The non-consensual use of treatment such as Electro-Convulsive Therapy (ECT) and clinical trials against persons with psycho-social disabilities contravenes all human rights standards (Davar and Ravindran, 2015). Questions have been raised powerfully in widespread public articulations, which have come in response to the two fresh legislations the Mental Health Act and the Right to Persons with Disabilities Bill. With inequities and subjugations, women with disabilities specifically may suffer despite new laws—supposedly based on the UNCRPD—but still persisting with the old pathways of forced treatment. What is required is radical change in law and use of Article 12 of the UNCRPD which would create that change as it places an obligation on governments to put in place adequate mechanisms for effective, supported decision-making. Drawing on the reasonable accommodation and full legal capacity clauses can strengthen critical consciousness of basic ethics of human relationships in the context of Article 12 immeasurably.

We observe the harm by non use of legal capacity as Kriti Sharma maps the experience and treatment of disability in custody (prison and other state institutional facilities) through a detailed look at reports, case law, and field visits to Kashmir and Bihar, drawing important linkages between social violence, conflict, psycho-social health, and its treatment in aggravated contexts. The major contradiction that has emerged in India is that despite its resolution to move from a medical to a social model the viewing of psycho-social disability through a medical lens by using guardianship instead of supported decision-making reverses the UNCRPD regulatory process.

One change, though still weak, has been the establishment of community care for persons with psycho-social disability at the district level. Lack of budgets and personnel remain a major barrier in their implementation. The *WRD* finds large gaps in meeting support needs across the world—China, for instance, reported a shortage of personnel; and 30 countries (including Iraq, Madagascar, Mexico, Sudan, Thailand, and the United Republic of Tanzania) reported having fewer than 20 sign language interpreters (*WRD*, 2011: 140).

The CEDAW Concluding Remarks (58th session, 2014) to the Government of India recommended protection of girls and women from 'involuntary hospitalization and forced institutionalization' (United Nations, 2014) and provide the way forward. In this regard we can learn from other countries—the Italian experience for instance, of de-institutionalizing the mentally ill and equipping general hospitals to care for mentally ill patients, thus integrating mental health care with general health care, merits special mention. Although the coverage is far from adequate, the enactment of legislation and the drawing up of concrete plans of action supported by *budgetary allocations and inter-sectoral professional services show the way forward* (*WRD*, 2011: 106). This trend towards de-institutionalizing has also been followed in some countries in eastern Europe, notably Romania.

Among the various forms of violence, sexual violence, especially against girls and women with intellectual disabilities who are in institutional care, is a major concern. It has been noted that girls with disabilities are at particular risk of forced and coerced sterilizations performed by medical practitioners at the behest of parents or institutional heads without the consent of girls (WWD India Network, 2014: 185–8; Human Rights Watch, 2011). This violation of rights is not only abuse of their bodies but a form of social control. It keeps them away from school education and forces them to stay within the four walls of the house where the violence does not stop but is invisiblized. The Chandigarh Administration case is an example where a young girl in an institution was sexually assaulted and

was being forced to abort her child on the plea that she would not be able to take care of the child.[9] Mahima Nayar and Nilika Mehrotra highlight the issues faced by women with intellectual and psycho-social disabilities and the failure of institutional apparatuses to recognize the specific life situation of persons with intellectual and psycho-social disabilities. For women, violence remains a major concern, exacerbated by the chronic violence perpetrated on them by a range of actors—state and private. The continuing 'structural marginalization' through denial of legal capacity by the courts, the State and society have violated the UNCRPD but absence of data makes it difficult to highlight the issue. The emphasis on discriminations, unattended despite ratification of the UNCRPD, and growing voices of the disability community would help us locate spaces linking theory to policy and field implementation.

Judicial Custody and Prisoners with Disabilities

We have a slew of cases around prisoners' rights that emphasize their right to dignity and their right against cruel and degrading punishment, which have been understood to violate the right to life, guaranteed by Article 21 of the Indian Constitution.[10] In complying with the standards set out in constitutional jurisprudence on this matter, the offence for which the person has been apprehended or convicted is immaterial. The standard is clear. No person shall be subjected to degrading, inhuman, or cruel punishment that is violative of human dignity; the duty of care to be exercised in this matter during pre-trial custody is of a much higher order. These are standards applicable to all custodial situations and to all persons, irrespective of caste, sex, race, religion, or place of birth.

The Veena Sethi case[11] in the early 1980s brought to light the treatment of prisoners with mental illnesses and their prolonged incarceration for periods ranging from 16 to 30 years in custody. This is far in excess of sentences given to them in most of these cases. The judgement released them from illegal custody, but provided paltry and transport and food expenses till they reached home by way of compensation. That was long before there was a consciousness or political articulation of the RPWD, which, importantly today, includes civil and political rights for prisoners with disabilities.

We have, in the past two years, seen reports on the arrest of Dr G.N. Saibaba and the conditions under which he is being held in custody. This case raises concerns that are immediately relevant to our present discussion: As a person with disabilities who requires constant assistance and support, what are the standard minimum rules that must temper the decision to take him into custody, in order that the treatment meted out to him is not construed as cruel, degrading, and inhuman?

Article 4(d) of the UNCRPD enjoins States Parties 'to refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention'. What are the specific protections for persons with disabilities in relation to state custody? Article 15(1) of the UNCRPD is immediately relevant: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.' Article 15(2) of the Convention places an obligation on the state to protect persons with disabilities from cruel degrading or inhuman treatment and punishment. It says, 'States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.'

The norm of substantive equality, well established through constitutional jurisprudence in India, speaks of the principle of equality that necessarily includes special treatment for persons who are vulnerable. The denial of special provisions, appropriate assistance, and specialized health care access to a person with disabilities in custody, who uses a wheelchair and has special health care needs arising from chronic illness, comes firmly within the meaning of degrading, inhuman, and cruel treatment in derogation of the state's obligation under the UNCRPD.

Particularly where a prisoner with disability requires support and assistance for daily living, placing such a prisoner in solitary confinement and denying the right to accessible facilities for personal care and hygiene is violative of the right to dignity and bodily integrity—both guaranteed under Article 21 of the Constitution, but also under Article 17 of the UNCRPD. The latter simply and pertinently states, 'Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.'

The RPWD legislation that ought to set out these standards in clear and unequivocal terms has been ever in the making in India. The absence of specific legislation, however, need not deter us from the path of justice. Article 14 of the Constitution that sets out the substantive right to equality before law, and Article 21 that sets out the framework for the right to life (with

dignity)—as it specifically applies to prisoners—should at this time be read with the UNCRPD which India has ratified. This is till the time that we put in place policies and national legislation that mandatorily provide for special services and basic needs that prisoners with disabilities might require, and prioritize the conditional and compassionate release of prisoners with high support needs.

Recognizing the vulnerability of women in custodial situations, the Criminal Procedure Code (CPC) provides very different standards for their involvement in criminal investigation. There are also special standards for the treatment of women prisoners and pregnant women in custody. The demand for treatment that is sensitive to the RPWD to dignity and physical integrity and to their specific needs is therefore not unprecedented. Where prison and custodial facilities are not equipped at all to deal with the specific needs of persons with disabilities, arrest and detention in custody should be a measure of last resort.

Disability in Social Research

A crucial aspect that dominates the understanding of disability is the highly individualized approach to disability. Such a view, apart from strengthening the medical model, has serious outcomes in terms of situating disability in the larger social imaginary. The issue of disability is absent from the purview of studies that try to understand the nature of social relations in the relevant field of enquiry.

Discrimination against persons with disabilities impairs progress in all areas of development, and remains the single most widespread driver of inequalities in today's world. The UNCRPD recognizes the discriminations, emphasizing the need to incorporate a disability/gender/child perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities—across disabilities. It recognizes that they are subject to multiple discriminations, and that States Parties to the Convention have an obligation to take measures to ensure that they experience the full and equal enjoyment of all human rights and fundamental freedoms.

Unlike the other International Covenants the UNCRPD provides a holistic standard by integrating civil, political, as well as social, economic, and cultural rights. As it happens one of the major binding factor of the UNCRPD, that is, reasonable accommodation has rarely been used although the Convention through reasonable accommodation reduces (with an aim to remove) discrimination by reasonably adjusting policies and practices that are a barrier to the participation of persons with disabilities. The Government of India and the disability movement is yet to take cognizance of it, although the courts have utilized it in provision of employment opportunities.

Article 2 calls out 'all forms of discrimination, including denial of reasonable accommodation' and calls for necessary and appropriate modification and adjustments not imposing a disproportionate or *undue burden*, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms. The use of Article 2 together with Article 5 is crucial to the establishment of a holistic rights framework. It recognizes that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law. Article 5.3 further states 'in order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided' thus making reasonable accommodation central to our enfranchising mode. The UNCRPD further augments the scope of reasonable accommodation by employing Articles 12 (health) 14.2 (liberty and security) and by extension various articles in Part 3 of the Indian Constitution.

These articles are by default extended to all actors responsible for implementing the UNCRPD. These include government at all levels, education, work (employers, goods and service providers), and public places of recreation and leisure, among others. In providing reasonable accommodation the Convention uses the principle of substantive equality, incorporating both equality of opportunity and outcome. The multi-dimensional use of the reasonable accommodation principles in social science research would provide a threshold for 'conditions of relevance' and to that end create a transformative process of social justice.

This section of the *SDR* addresses the need for correction of inequities through an enabling environment and this is possible by removal of entrenched social practices and by putting in place appropriate and necessary governance structures.

Vulnerabilities, Precarity, and Social Development

Part II of the *SDR* presents issues that are of urgent concern especially in our attempt to redress chronic deprivation, vulnerability, and intergenerational

precarity–concerns that have not been fully explored in previous *SDR*s: ageing, housing, displacement, degrading labour, labour migration, and financial inclusion. The essays in this section do not address disability. In the context of rapid demographic change, there is a shift in the age structure of the population in India with the segment over sixty years of age growing at a rapid pace of 3 per cent per annum. The proportion of the elderly is currently at 8 per cent with female elderly outnumbering male elderly. These changes necessitate provision of social security, health care, physical access to public spaces, and a slew of measures especially to protect the elderly precariat. K. S. James, T. S. Syamala, and Supriya Verma present findings of a new study conducted in the states of Himachal Pradesh, Kerala, Maharashtra, Odisha, Punjab, Tamil Nadu, and West Bengal on the status of the elderly, discussing the challenges before us in ensuring basic rights and social support to ensure a life with dignity for this little-discussed cohort.

Gautam Bhan and Anushree Deb take a critical look at housing policy and suggest ways of rethinking the right to housing, focusing on housing poverty (instead of housing shortage) and highlighting the exclusions that mark housing poverty—insecure tenure, inadequate environmental services, unaffordable housing, and inappropriate policy frameworks. The question of exclusion from housing is a critical concern especially in a situation of rapid urbanization and increase in income-poor, marginalized urban residents. Bhan and Deb argue that housing must be placed ‘as an urban system interconnected with other aspects of the city and household life’, mapping in the process the precarity of the urban poor, most evident in the absence of decent shelter in cities that cannot be sustained without their labour.

We know by now the extent of resources at stake in the mining sector as also the revenues that derive from it. Three states—Odisha, Chhattisgarh, and Jharkhand—account for 70 per cent of India’s coal reserves, 80 per cent of its high-grade iron ore, 60 per cent of its bauxite and almost 100 per cent of its chromite reserves. Forty per cent of those displaced by dams are tribal people (Xaxa Report, 2014). This is an immiserizing growth path that throws entire villages and communities into utter, intergenerational poverty and destitution. Sujit Mishra presents a detailed analysis of displacement induced by mining, comparing the economics of mining with the landscapes of exclusion that mining has historically multiplied in India drawing on published sources as well as his longstanding fieldwork in areas of mining-induced displacement. How may the questions of equity and development be posed from the standpoint of those displaced by mining projects?

The period 2006–13 is one that saw India shining on the neoliberal world stage. During this period, India’s sanitation journey was painfully slow with open defecation decreasing at a meagre 2 per cent per year from 1990 to 2005. Subhash Gatade unpacks the Swachh Bharat Abhiyan, tracing its linkages to the sanitation chain, the global discourse around toilet use, manual scavenging, sewerage and sanitation workers and deeply entrenched practices of caste and untouchability, locating the failures in the government sponsored programme within the stranglehold of untouchability and caste oppression.

The opacity of gender in labour migration and the masking of women’s travels in search of work within larger strategies for family survival make it particularly important to track women’s mobility. Praveena Kodoth offers a counterpoint to the underestimates of women’s labour mobility in the macro data, by unravelling gendered discourses in state policy and probing the conditions that enabled women in Kerala to access international migration.

Providing a comprehensive and historical account of financial inclusion in India, Tara Nair argues persuasively that the responsibility for ensuring financial inclusion cannot simply be fulfilled through a rapid targeted approach to opening accounts. If inclusion is about redressing inequities through instituting appropriate institutional mechanisms and arrangements, among others, these require, time, depth and *longue durée* planning and foresight. Most importantly, financial inclusion cannot be delinked from the larger discourse on social inclusion of which it is an integral part.

Social Development Index

Part III presents the *Social Development Index* that runs in a cumulative manner through all the editions of the *SDR*. Surajit Deb presents composite indices of development that are commonly used to assess the progress in development. This chapter utilizes recent data to construct social development indices (SDI) for 29 state economies in India. The aggregate index covers 21 indicators within six dimensions of social development, viz., demographic, health, education, basic amenities, social, and economic. While the dimensional indices allow us to rank states according to the progress made in a specific development dimension, the composite index provides the summary measure for a particular state by aggregating all the dimensional scores into a single number. Deb presents

the social development indices separately for the rural and urban areas besides the aggregate index for each state. He also constructs separate indices that are disaggregated over social groups, viz., scheduled caste (SC), scheduled tribe (ST) and non-SC-ST groups of population, as well as gender classes, viz., male and female for each state. The eight different series, viz., Aggregate SDI, Rural SDI, Urban SDI, Social SDI for SC, ST and Non-SC-ST, and Gender SDI for Males and Females are used to examine the state-level disparities in various aspects of social development.

NOTES

1. Available at http://www.ndtv.com/video/news/news/let-s-say-divyaang-not-viklaang-pm-modi-on-mann-ki-baat-396494 (Accessed on 22 July 2016). Translated from Hindi by Kalpana Kannabiran. The discussion on 'divyaang' is based on Kannabiran (2016).

2. The bio-psychosocial model adopted by the WHO (2001) integrates the medical as well social models related to disability and environmental factors. A new ICF uses a bio-psychosocial approach to disability and acknowledges socio-environmental factors, socio-demographic factors, and behavioural factors that dictate the subjective experience of living with a disability (WHO, 2001).

3. *Suchita Srivastava vs. Chandigarh Administration* (2009) 9 SCC 1 (SCC: Supreme Court Cases).

4. *Municipal Corporation of Gr. Mumbai vs. Mr. Shrirang Anandrao Jadhav*. Writ Petition No 1900 of 2009. Bombay High Court. Available at https://indiankanoon.org/doc/1053153/ (accessed on 1 July 2016).

5. Mad Pride fights for rights of psychiatric survivors and better mental health facilities.

6. Ministry of Human Resource Development (2016).

7. National Commission for Protection of Child Rights (2016). Recommendations on proposed National Education Policy 2016.

8. Deepa, Sonpal, Unnati Ahmedabad, Gujarat in a discussion with Asha Hans on 22 July 2016.

9. *Suchita Srivastava vs. Chandigarh Administration* (2009) 9 SCC 1 (SCC: Supreme Court Cases).

10. This section is based on Kannabiran (2014).

11. *Mrs. Veena Sethi vs. State of Bihar and Ors*. (1982) 2 SCC 583.

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Part I

Disability, Disablement, and Discrimination

1

Disability and Disadvantage in India

Ashwini Deshpande

Approximately one billion people or roughly 15 per cent of the world's population experience some form of disability (World Bank, 2011).[1] The awareness that development should be inclusive towards persons with disability is increasing globally. One hundred and eighty-two countries have signed the United Nations Convention on the Rights of Persons with Disability, or CRPD.[2] The UN Post-2015 Development Agenda clearly states that disability cannot be a reason for the lack of access to benefits of development or denial of human rights.

In India, however, the awareness that disability-inclusive development ought to be mainstreamed is still lacking. Persons with disability (PWDs), especially the severely disabled, are constrained by several hurdles that prevent their full integration into social and economic life, and/or from leading a dignified life. A pre-condition to developing a set of disabled-friendly policies is to understand the magnitude, the contours, and the various facets of the problem. This not a trivial task, as just the measurement of disability is fraught with various debates related to the conceptual understanding of what constitutes disability. Based on publicly available data, this chapter aims to provide the latest empirical overview of the major socio-economic indicators of the disabled population in India as a starting point towards a holistic understanding of the disability problem. In addition to presenting evidence on specific types of disability separately, it also discusses two disability indices that allow us to examine the economic implications of disability. The chapter highlights the various gaps in the understanding of the disability issue in India, in order to generate a discussion that could potentially pave the way for devising appropriate measurement systems. A proper set of measurements would eventually provide the evidence based on which suitable policies could be devised.

Defining Disability

As other chapters in the volume highlight, defining disability is a complex issue. It is commonly understood as the lack or impairment of one or more parts of normal physical and/or mental functioning. In addition to the tricky issue of defining the precise amount of impairment that would qualify to be counted as disability, in recent years, there has been a shift in the emphasis from the body as the source of disability to social structures that might prevent an individual from full integration into societal structures. Thus, there has been a transition from a medical or an individual perspective (the medical model) to a social perspective (the social model) to now the International Classification of Functioning, Disabilities, and Health (ICF model), an approach which combines the medical, and the social models. The ICF model argues that the medical and the social models need not be seen as contrasting frameworks for understanding disability but more as complements, which together would point us towards pinpointing the basic source of disability—whether from the individual's body or from social structures or a combination of the two.

The ICF model starts with a health condition that gives rise to impairments, activity limitations, and participation restrictions. The latter two include among other things, 'learning and applying knowledge, mobility, self-care, education, remunerative employment, and economic self-sufficiency' (Mitra and Sambamoorthi, 2006: 4022). Thus, functioning and disability are now understood as a 'dynamic interaction between health conditions and contextual factors, both personal and environmental' (World Bank, 2011: 4). According to this,

'disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)'.

The UNCRPD emphasizes that 'disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others'. This understanding of disability as an interaction indicates that physical or medical disability may not necessarily result in activity limitations and participation restrictions, if individuals with medical/physical/bodily impairments could be integrated into mainstream society through a set of policies which reduce attitudinal and environmental barriers to their rightful integration. Thus, defining disability as activity limitations and participation restrictions would yield different estimates of disability as compared to defining it solely as a personal impairment. However, as we will see below, the official Indian definition of disability continues to be tilted towards the medical model or focuses on the impairment of the body. The notion of reshaping the socio-economic environment to ensure full and effective participation of individuals with physical or psycho-social/intellectual impairments is nascent in the official Indian discourse, even though disability activists have been mobilizing opinion in that direction.

MEASURING DISABILITY

There are three disability measures that are commonly used in research and data collection: impairment, functional limitation, and activity limitation measures (Mitra and Sambamoorthi, 2006). Impairment measures include blindness, deafness, mental retardation, and locomotor difficulties. Functional limitations refer to difficulties experienced with particular bodily functions such as seeing, walking, hearing, speaking, climbing stairs, etc. irrespective of whether the individual is impaired or not. Activity limitations are limitations in activities of daily living (ADL) such as bathing, dressing, or eating. These can also include participation limitations in major life activities such as going outside the home to work or to study. In the ICF model, any or all of these measures could be used to define disability, as the understanding of disability is a holistic one.

The two major data sets for disability statistics for India used to be the decennial Census and the National Sample Survey (NSS), which conducts a special disability survey every 11 years. However, with the advent of other large-scale data sets such as the India Human Development Survey (IHDS) and the National Family Health Survey (NFHS), there are now additional data sources available for quantitative analyses of disability. The exact estimates of disability from these sources vary due to different sampling designs, as well as due to non-uniform definitions of disability. It is tricky to rank the various survey estimates in order of reliability or accuracy, as they are strictly speaking, non-comparable. While I refer both to the NSS and IHDS estimates, the bulk of this chapter is based on the 2011 Census estimates, which in addition to being the latest estimates, have the advantage of enumerating the entire population, albeit subject to the caveats mentioned below.

The Census does not give a general definition of disability, but instead asks 'if the person is physical or mentally disabled, give appropriate code number from the list below'. Mitra and Sambamoorthi (2006) point out that the Census does not give a screen for assessing disability. The census enumerators code an individual as disabled if they report the designated disability types (listed in the next section). The NSS lists a person as disabled if the person has restrictions or a lack of ability to perform 'in the manner or within the range considered normal for a human being' (Mitra and Sambamoorthi, 2006: 4023). The NSS, thus, provides a screen for detecting disability, which is based on activity limitations, and this screen leads to a question to ascertain disability types. The IHDS focuses exclusively on activity limitations, and thus, clubs the handicapped, disabled and elderly together in their 'Activities of Daily Living' section of their 'Education and Health Questionnaire' (Section 10 in IHDS-II[3]). It elicits responses on the ease of being able to do activities such as walking one kilometer, going to the toilet without help, dressing without help, hearing normal conversation, speaking normally, seeing distant things, and seeing near objects, and asks if the person can do these activities with no difficulty, with some difficulty or is unable to do it. The IHDS data are not specifically focused on bodily impairments but on activity limitations, with or without specific bodily impairments.

Based on its method of identification described above, the 2011 Census reports 26.8 million persons as disabled, who constitute 2.2 per cent of India's population. The types of disability enumerated in the census are disability in seeing, in hearing, speech, movement, mental retardation, mental illness, multiple disability, and 'any other'. The previous 2001 census reported 18.5 million persons as disabled, which too was roughly 2 per cent of the population then. The Indian figure of 2 per cent is most likely an underestimate of the actual extent of disability for reasons discussed below. The disability sector recognizes 4–5 per cent of the Indian population as disabled; the World

Bank estimates it as 4–8 per cent.[4] In any case, even though 2 per cent might appear to be a miniscule proportion of India's population, we should note that the number of disabled persons in India is larger than the entire population of Australia and of several other countries; thus even the likely underestimate points to a very large set of people.

The IHDS data, because it focuses on activity limitations, finds a higher incidence of disability (in the range of 3–4 per cent for each type of disability), counting individuals who report that they are unable to perform the tasks listed above. Adding to this pool individuals who report themselves to be able to perform these tasks 'with difficulty', the proportions increase to lie between 7 and 15 per 1000 persons older than age 7 in 2005 (Desai et al., 2010: 103; refer to Chart 3 on p. 21). When all activities are considered together, 24 persons per 1000 have difficulty doing at least one of these activities. Of these, 9 have total disability. 'Ten percent have a person who has difficulty doing one of these seven activities'(Desai et al. 2010: 103).

Contours of Disability in India

The bulk of statistics on disability in India, like in most developing countries, are focused on bodily impairments (both physical as well as a narrow range of psycho-social/ intellectual impairments), rather than on social or environmental barriers. Developed countries typically use activity limitations, which lead to higher rates of reported disability than those using only impairment measures. The difference in the two measures can be substantial. This makes the issue of cross-country comparisons very difficult (Mitra and Sambamoorthi, 2006). As we saw above, the IHDS data make an attempt to count disability more in tune with international standards.

In addition to the ambiguities surrounding the conceptual definition of disability, the other issue with self-reported disability status data might be that of likely underestimation. This is so for two reasons: one, disability is deeply stigmatizing, thus, there would be a tendency to deny or under-report the incidence of impairment. Two, given that disability is more a continuum along a scale of functionality rather than a zero-one condition, a given condition might not be recognized or diagnosed as a disability, even when medically speaking it might qualify as a disability. This is more likely to be true for psycho-social or cognitive disabilities. However, despite various limitations and caveats, these data do provide us with a broad-brush view of the state of disability in India. In any event, these statistics, even if skimming the surface of the problem, are the best publicly available data at the macro-level for researchers and policy-makers to work with.

Disabled Population in India

The distribution of the total disabled population in India by gender and rural–urban residence in 2011 is shown in Chart 1.1. As a proportion of total population in 2011, these numbers indicate that 2.2 per cent of the total population is disabled, which includes 2.4 per cent of male and 2 per cent of female population. The proportion among men is marginally higher than that among women.

Chart 1.1 shows that men are 56 per cent of the total disabled population. Almost 70 per cent of the disabled population is rural, with the gender distribution across rural–urban sectors being similar as that for all-India. Many countries take into account age-related disability as well as that induced by diabetes, but India does not, thus these numbers do not include those. The fact that the incidence of disability is higher in rural areas

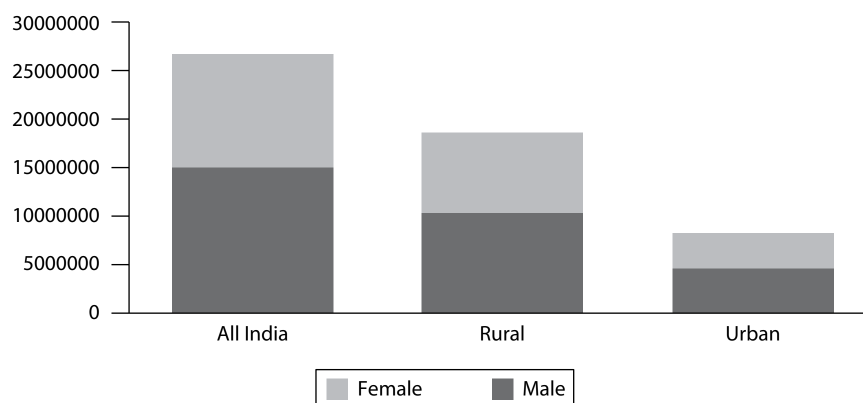

Chart 1.1 Total Disabled Population, India, 2011

Source: Author's Calculations from Census of India, 2011.

indicates that sources of disability lie in factors related to location, habitat, and lower availability of basic preventive health care in rural areas as compared to urban areas. It is clearly recognized that 'health is affected by environmental factors, such as safe water and sanitation, nutrition, poverty, working conditions, climate or access to health care', and that 'inequality is a major cause of poor health and hence of disability' (World Bank, 2011). The higher incidence of disability in rural areas also highlights the vast challenges inherent in implementing a set of disabled-friendly policies, as rural–urban disparities in the provision of health services, safe drinking water, infrastructure such as roads, accessibility to medicines, and so forth are already substantial for all population. Thus, special provision in order to benefit the disabled would need a fairly definite shift of focus in policy.

While the incidence of disability is higher in rural areas, it should be noted that in the disability rights discourse, there is a reluctance to draw a causal relationship between morbidity, poverty, and disability—or on the prevention of disability. Universal health care and elimination of poverty are common concerns for all people living in rural areas and in poverty. The challenge of poverty reduction is not necessarily due to the larger numbers of the disabled; nor can we assess exactly the degree to which elimination of poverty can prevent disability. As mentioned earlier, the reality is that there are persons with diverse abilities on a continuum from the 'normal' to the 'severely disabled' in any society.

Chart 1.2, which shows the total number of PWDs by the types of disability enumerated by the census, shows that the largest type of disability is related to movement. This is not surprising, as until the early 1990s, India had a high incidence of polio, such that between 500–1000 children were getting paralysed daily (John and Vashishtha, 2013). This is not to argue that polio is the sole cause of the incidence of disability in movement, but it is one of the important ones. This is followed by disability in hearing and seeing respectively, the incidence of which is almost identical. The next highest category is 'any other'—it is not clear what exact forms of disability are included in this. The reported disability due to 'mental retardation' is relatively low, with that for 'mental illness' being the lowest. We should note that the terms in usage for mental illnesses as per the UNCRPD are 'intellectual disability' and 'psycho-social disability' respectively. However, data sets continue to use the older stigmatizing descriptors. The issue of (non) recognition and reporting might be underlying these numbers, as disability due to psycho-social disabilities is the most stigmatized, as also the fact that diagnosis of several such disabilities remains deficient due to a combination of poor availability of diagnostic facilities/techniques as well as the tendency towards denial of psycho-social disabilities as a legitimate health and rights issue.

As discussed above, the IHDS focuses on activity limitations and therefore shows a picture of disability that is strictly not comparable with the census categories. It is worthwhile to examine this alternative picture as well. Chart 1.3 shows the distribution, per 1000 persons of age above 7, of people reporting difficulties in ADL. We notice here that the data makes a distinction between near sight and far sight, the former more closely related to ageing. Proportions of people 'unable' to conduct the various

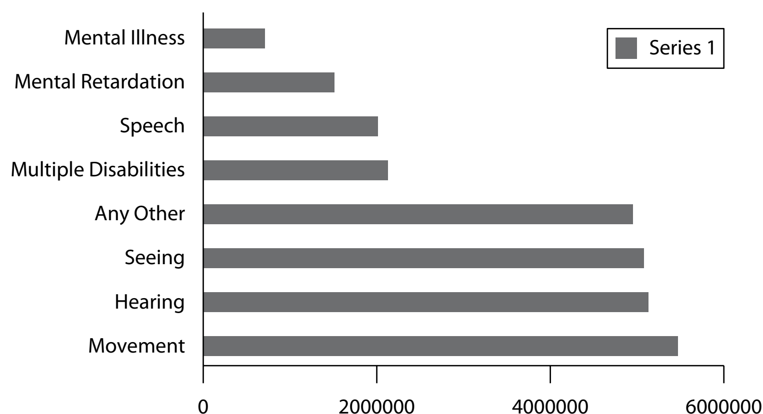

Chart 1.2 Total Numbers of PWDs by Types of Disabilities
Source: Author's Calculations from Census of India, 2011.

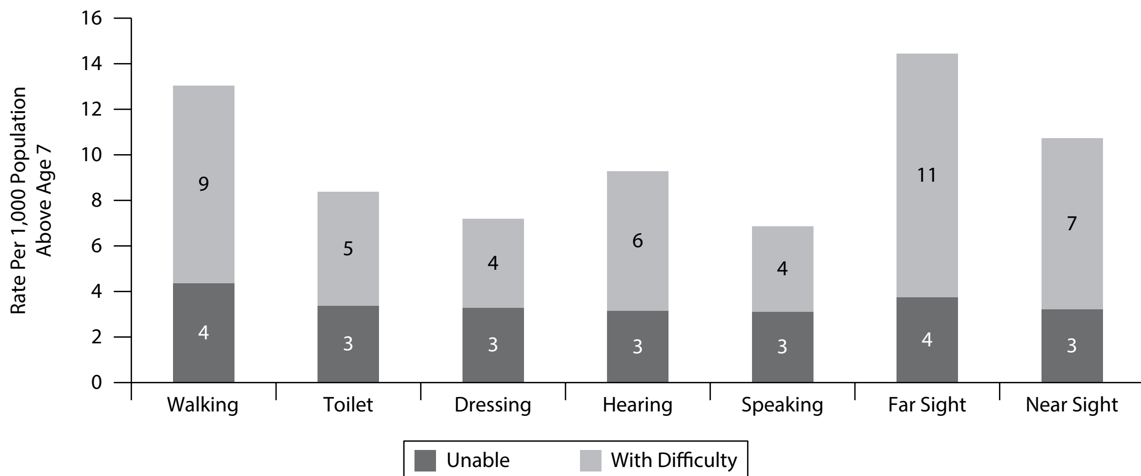

Chart 1.3 Disabilities in Activities of Daily Living, India, 2005
Source: Desai et al. (2010: 103).

activities range between 3–4 per 1000, but adding to this the numbers who are able to do these activities with difficulty, we find that inability to see far (myopia) has the highest incidence (15 per thousand), followed by difficulty in movement (13). This is followed by near sight and hearing.

The IHDS data clearly shows that disability increases with age (Chart 1.4). Thirty-nine per 1000 elderly have complete disability in one of the seven activities of daily living. 'This is more than six times the rate for working age adults (six) and for children between the ages 8–14 (four)'. However, because the elderly are a small proportion of India's population, the majority (58 per cent) of Indians with disability are below the age of 60 (Desai et al., 2010: 103).

Back to data from the 2011 census, we can see from Chart 1.5 the number of persons with the different types of disability by sex and rural/urban location.

Chart 1.5 shows that disability in movement is not only the highest form of disability, but it is also where the gap in urban and rural is the highest. This is followed by disability in seeing, hearing and 'any

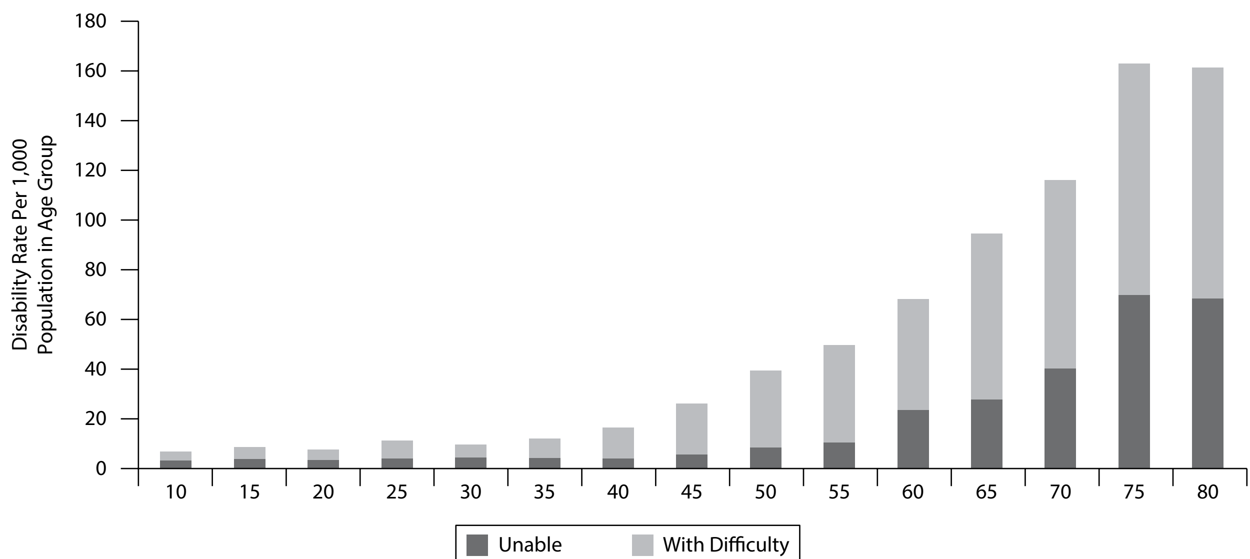

Chart 1.4 Disability in Activities of Daily Living by Age, India, 2005
Source: Desai et al. (2010: 103).

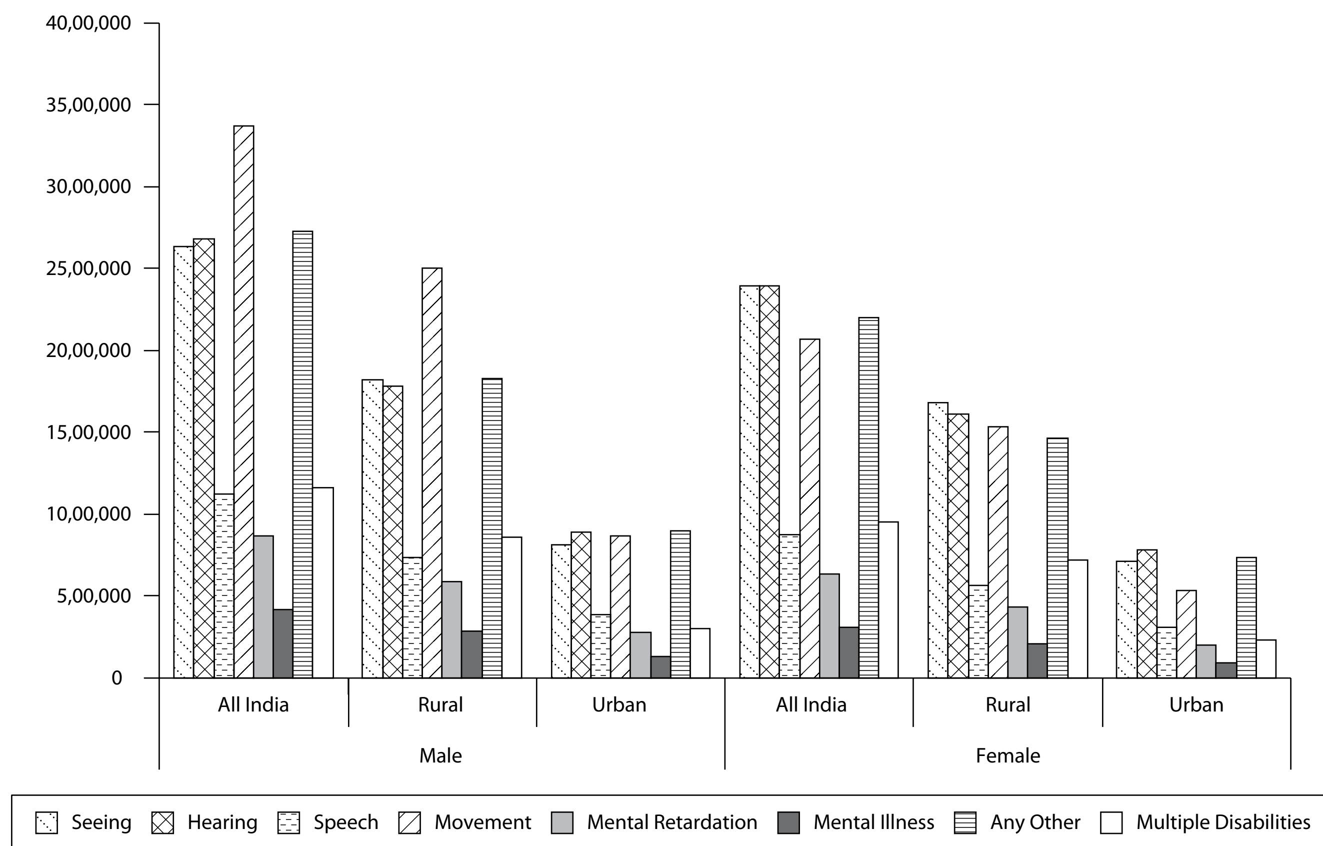

Chart 1.5 Incidence of Types of Disabilities by Sex and Location, All India, 2011
Source: Author's Calculations from Census of India, 2011.

other' type of disability. The gender division within each category reveals that the percentage of women in each of the categories ranges from 45 ('any other' and 'multiple') to 38 per cent ('movement'). Comparing numbers of men and women reporting specific forms of disability by location (all India, rural or urban), we find that there are greater numbers of men compared to women within each category. To what extent does the gender division seen in these numbers reflect the actual differential incidence across the sexes and to what extent is it a reporting bias (where disability among women is under-reported) cannot be ascertained prima facie.

INTER-STATE DISTRIBUTION

Chart 1.6 shows the distribution of PWDs (as a proportion of state population totals) across all states of India, total as well as separately by rural–urban. In terms of absolute numbers, Uttar Pradesh, Maharashtra, Bihar, Andhra Pradesh, and West Bengal are the top five states with the highest number of PWDs among the larger states, Himachal Pradesh, Uttarakhand, Jammu and Kashmir, Assam, and Haryana have among the lowest number of disabled persons. However, as a proportion of respective state populations, Sikkim, Odisha, Jammu and Kashmir, and Lakshadweep have the highest incidence of disability, and Tamil Nadu, Assam, and Delhi among the lowest proportions of PWDs. Most states have a greater proportion of their rural populations as disabled; however, as Table A3 in the Appendix (based on IHDS data) shows, the relationship between place of residence and prevalence of disability is complicated. Less developed villages report lower incidence than more development villages but rural areas (both more and less developed villages) show a lower incidence compared to urban areas (within which metro areas show a lower prevalence compared to other urban areas).

This picture of incidence of disability does not appear to be related to whether the state is relatively rich or poor, as at the top of the distribution, we see a mix of relatively rich (e.g. Maharashtra and Andhra Pradesh) and poorer

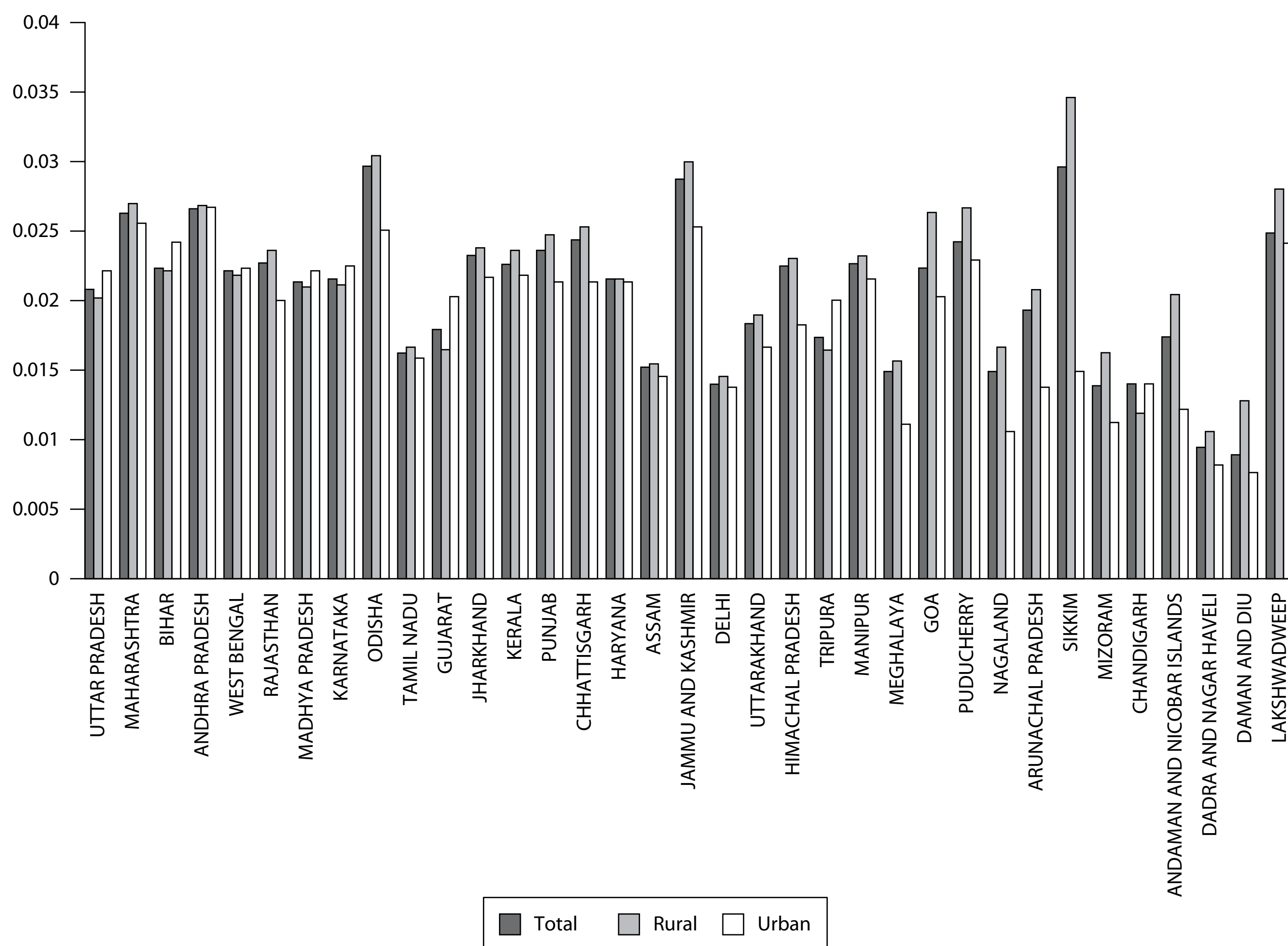

Chart 1.6 Proportion of PWDs: T/R/U by State, 2011

Source: Author's Calculations from Census of India, 2011.

states (e.g. Bihar). This is equally true of the other end of the distribution with relatively poorer states like Uttarakhand as well as relatively rich states like Haryana exhibiting low incidence of disability.

Chart 1.7 shows the share of each type of disability within the total disabled population of each state. The state-wise distribution of the proportion of each type of disability relative to total number of PWDs can be seen in the Appendix through Charts 1A.1 to 1A.5. We see that the top five states in terms of proportions of people with movement disability (in descending order) are Chhattisgarh, Puducherry, Delhi, Daman and Diu, and Rajasthan. The lowest five are (in ascending order) Manipur, Sikkim, Arunachal Pradesh, Meghalaya, and Nagaland.

For proportions of PWDs with hearing disability, the top five states (in descending order) are Arunachal Pradesh, Nagaland, Sikkim, Meghalaya, and Uttar Pradesh. The lowest proportions (in ascending order) are in Kerala, Lakshwadweep, Rajasthan, Daman and Diu, and Delhi. The top five states for sight disability (in descending order) are Manipur, Bihar, Jharkhand, Odisha, and Arunachal Pradesh, while the lowest proportions (in ascending order) are in Tamil Nadu, Puducherry, Chandigarh, Punjab, and Delhi. The analogous top five states for speech disability are Maharashtra, Goa, Andhra Pradesh, Sikkim, and Assam, while the bottom five states are Punjab, Haryana, Rajasthan, Madhya Pradesh, and Lakshwadweep. Chart 1A.5 shows that 'mental illness' constitutes the lowest proportion among PWDs in all states of India, followed by 'mental retardation'. This could be in part due to the stigmatizing nature of psycho-social disabilities, as well as due to the failure to recognize them as disabilities, coupled with poor diagnoses of

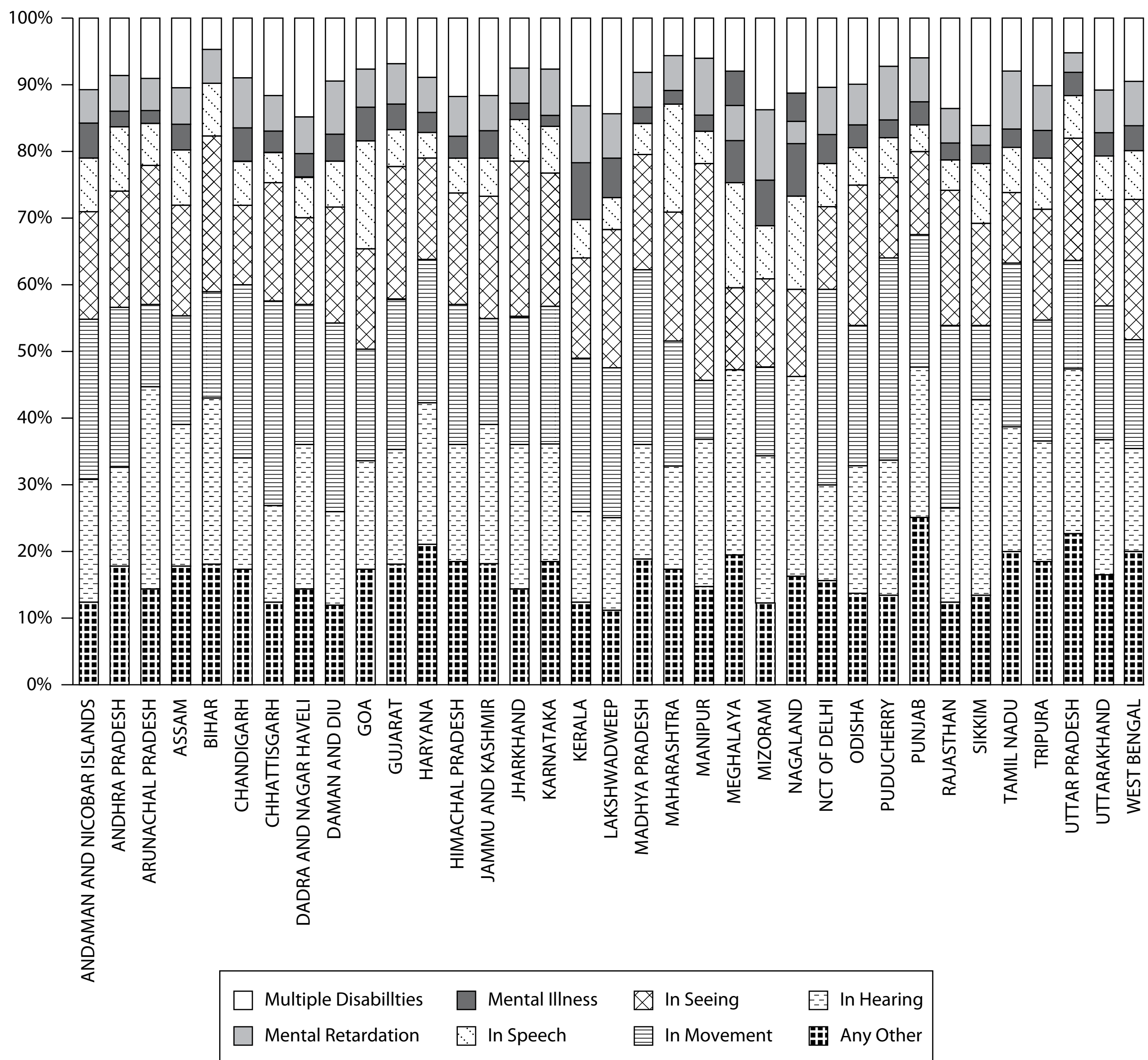

Chart 1.7 Proportion of Types of Disabilities within Total PWDs, by State, 2011

Source: Author's Calculations from Census of India, 2011.

underlying medical conditions. Overall, we see that the north-eastern and eastern states of the country report high proportions of various types of disability.

CHILDHOOD DISABILITY

Table 1.1 shows that a total of 2 million children in the 0–6 age group are disabled. Chart 1.8, based on Table 1.1, shows the distribution of disability by type in this age group. Of the children reporting any type of disability, roughly 20 per cent of such children are reportedly disabled in sight, another 23 per cent in hearing, with another 28 per cent reporting 'any other' disability. Disability in movement accounts for 20 per cent of all disabled, whereas in children between 0–6 years with disabilities, this proportion is roughly 9 per cent. The difference between the two proportions in movement-related disability is striking, and most likely reflects India's success in lowering incidence of polio dramatically. According to John and Vashishtha (2013), the last reported case of polio was in January 2011.

DISABILITY AND LITERACY

Table 1.2 shows the distribution of PWDs by sex, rural/urban location, and literacy status. This reveals that about

Table 1.1 Disability by Type, Sex, Residence in 0–6 Age Group, India, 2011

Type of disability	Total			Rural			Urban		
	P	M	F	P	M	F	P	M	F
Total disabled persons	2042887	1104559	938328	1452303	785922	666381	590584	318637	271947
In seeing	417657	219455	198202	291177	152338	138839	126480	67117	59363
In hearing	476075	247438	228637	328819	170769	158050	147256	76669	70587
In speech	114621	64482	50139	82709	46666	36043	31912	17816	14096
In movement	196890	116245	80645	155062	91642	63420	41828	24603	17225
Mental retardation	91673	51486	40187	63956	35789	28167	27717	15697	12020
Mental illness	16350	9624	6726	11461	6738	4723	4889	2886	2003
Any other	580410	308721	271689	406848	216232	190616	173562	92489	81073
Multiple disability	149211	87108	62103	112271	65748	46523	36940	21360	15580

Source: Census of India, 2011.

45 per cent of all PWDs are illiterate, of which 35 per cent are rural. While 38 per cent of all male PWDs are illiterate, 55 per cent of female PWDs are illiterate. For each category of disability, a greater proportion of women in that category are illiterate than men, with 76 per cent of women with multiple disabilities being illiterate. We see, thus, even the first step towards possible access to decent jobs, viz., elementary literacy, is missing for PWDs. Additionally, rural location and being female compound the disadvantage, making the burden of physical disability much more acute for these groups.

DISABILITY AND WORKFORCE PARTICIPATION

What does physical disability imply in terms of integration into the workforce? Given the high incidence of illiteracy, we would expect to see either a low workforce participation, and/or inclusion in work with adverse working conditions. Of the approximately 26 million PWDs, close to 64 per cent report being non-workers. There is some degree of inter-state variation in this but the overwhelming proportion of PWDs across all states are non-workers or completely excluded from productive work (Chart 1.9). States like Nagaland, Sikkim,

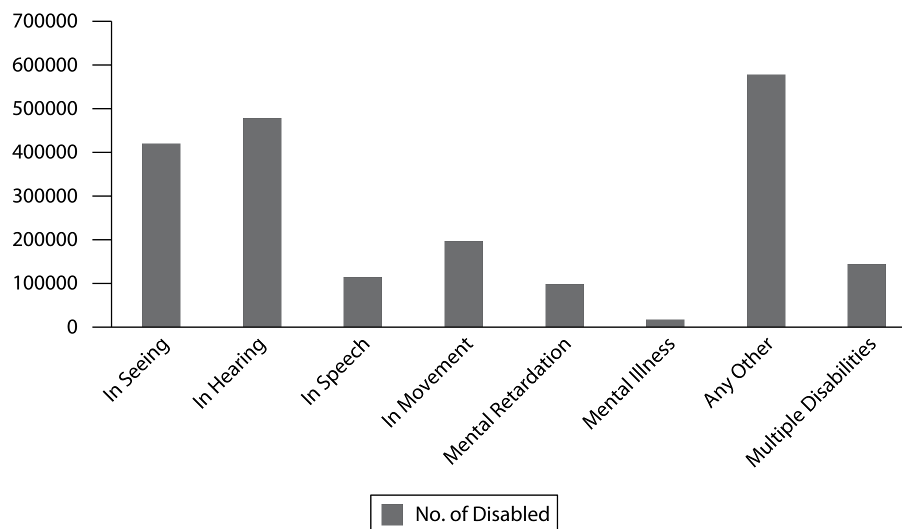

Chart 1.8 Types of Disabilities, 0–6 Year Olds, India, 2011

Source: Author's Calculations from Census of India, 2011.

Table 1.2 Disability by Type, Literacy Status, Sex, and Residence, India, 2011

Type of disability	Sex	Literate			Illiterate			Total	% Illiterate
		T	R	U	T	R	U		
Total Disabled population	Persons	1,46,18,353	91,10,325	55,08,028	1,21,96,641	95,26,033	26,70,608	2,68,14,994	0.45
Total Disabled population	Males	93,48,353	60,31,731	33,16,622	56,40,240	43,78,828	12,61,412	1,49,88,593	0.38
Total Disabled population	Females	52,70,000	30,78,594	21,91,406	65,56,401	51,47,205	14,09,196	1,18,26,401	0.55
In Seeing	Persons	26,55,609	15,95,553	10,60,056	23,77,822	19,08,005	4,69,817	50,33,431	0.47
In Seeing	Males	16,45,880	10,27,558	6,18,322	9,93,148	7,93,890	1,99,258	26,39,028	0.38
In Seeing	Females	10,09,729	5,67,995	4,41,734	13,84,674	11,14,115	2,70,559	23,94,403	0.58
In Hearing	Persons	28,88,577	16,93,081	11,95,496	21,84,337	17,00,647	4,83,690	50,72,914	0.43
In Hearing	Males	17,52,119	10,65,244	6,86,875	9,26,465	7,19,182	2,07,283	26,78,584	0.35
In Hearing	Females	11,36,458	6,27,837	5,08,621	12,57,872	9,81,465	2,76,407	23,94,330	0.53
In Speech	Persons	11,64,981	6,68,896	4,96,085	8,33,711	6,35,044	1,98,667	19,98,692	0.42
In Speech	Males	7,05,927	4,17,928	2,87,999	4,17,060	3,17,070	99,990	11,22,987	0.37
In Speech	Females	4,59,054	2,50,968	2,08,086	4,16,651	3,17,974	98,677	8,75,705	0.48
In Movement	Persons	32,72,514	22,66,321	10,06,193	21,64,312	17,69,420	3,94,892	54,36,826	0.40
In Movement	Males	23,25,572	16,49,745	6,75,827	10,44,929	8,53,784	1,91,145	33,70,501	0.31
In Movement	Females	9,46,942	6,16,576	3,30,366	11,19,383	9,15,636	2,03,747	20,66,325	0.54
Mental Retardation	Persons	6,22,184	3,98,956	2,23,228	8,83,780	6,26,944	2,56,836	15,05,964	0.59
Mental Retardation	Males	3,94,099	2,56,960	1,37,139	4,76,799	3,34,638	1,42,161	8,70,898	0.55
Mental Retardation	Females	2,28,085	1,41,996	86,089	4,06,981	2,92,306	1,14,675	6,35,066	0.64
Mental Illness	Persons	3,52,551	2,24,752	1,27,799	3,70,329	2,71,128	99,201	7,22,880	0.51
Mental Illness	Males	2,33,360	1,52,522	80,838	1,82,398	1,30,936	51,462	4,15,758	0.44
Mental Illness	Females	1,19,191	72,230	46,961	1,87,931	1,40,192	47,739	3,07,122	0.61
Any Other	Persons	29,57,692	17,98,417	11,59,275	19,69,897	14,94,690	4,75,207	49,27,589	0.40
Any Other	Males	18,20,573	11,42,490	6,78,083	9,07,552	6,85,391	2,22,161	27,28,125	0.33
Any Other	Females	11,37,119	6,55,927	4,81,192	10,62,345	8,09,299	2,53,046	21,99,464	0.48
Multiple Disability	Persons	7,04,245	4,64,349	2,39,896	14,12,453	11,20,155	2,92,298	21,16,698	0.67
Multiple Disability	Males	4,70,823	3,19,284	1,51,539	6,91,889	5,43,937	1,47,952	11,62,712	0.60
Multiple Disability	Females	2,33,422	1,45,065	88,357	7,20,564	5,76,218	1,44,346	9,53,986	0.76

Source: Author's Calculations, Census of India, 2011.

and Arunachal Pradesh have a higher than average proportions of workers among PWDs, with Nagaland being the only state in India the highest proportion—little more than half—of the PWDs are engaged in economically productive work. Among the major states, Kerala (somewhat surprisingly, given the reputation of the state for having high human development and social indicators), has the lowest proportion of workers among PWDs (a little over 20 per cent).

Breaking this down by type of disability reveals that in every category of disability, the proportion of non-workers is greater than that of workers (Chart 1.10),

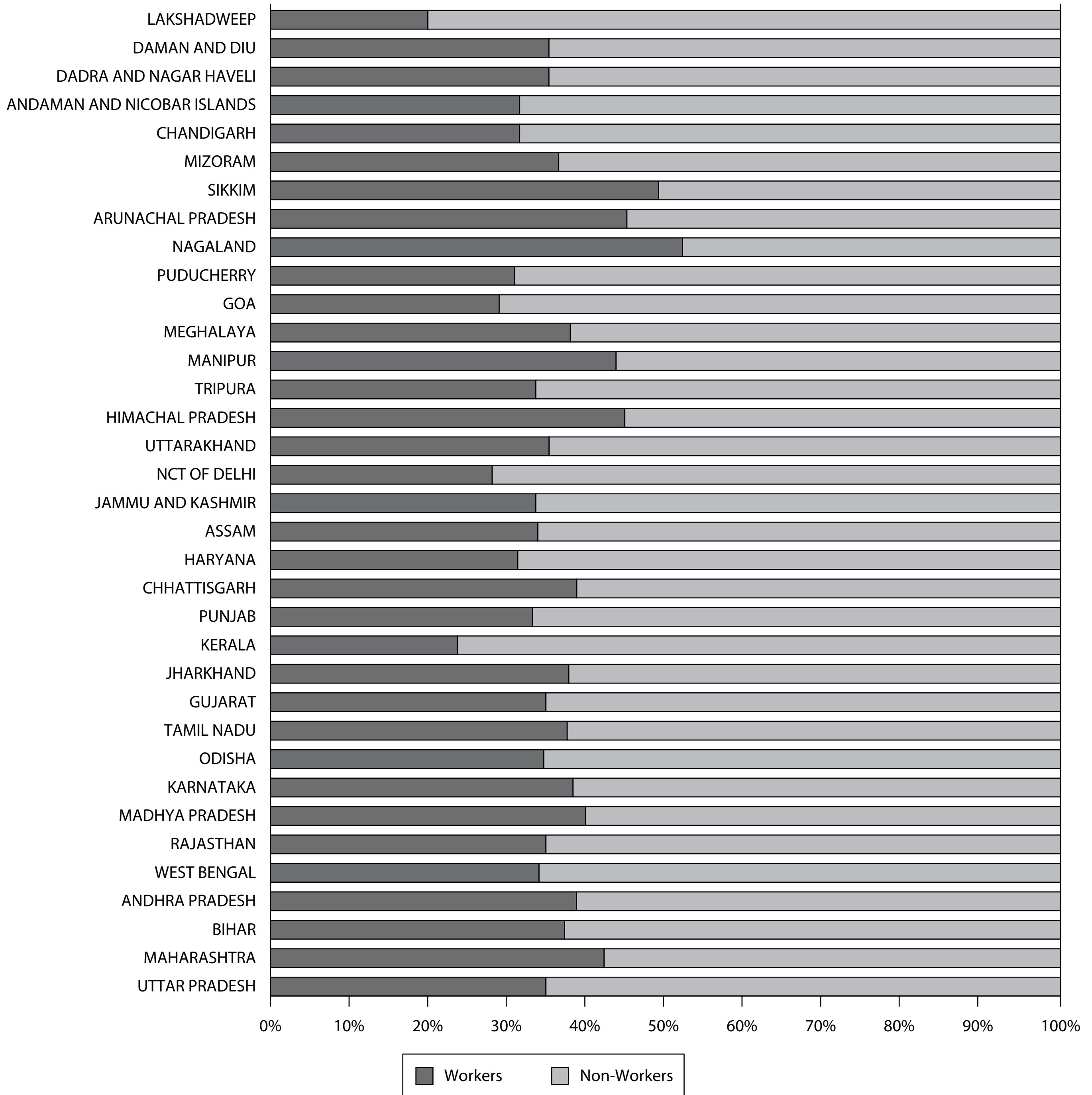

Chart 1.9 Distribution of PWDs by Workers and Non-Workers, 2011

Source: Author's Calculations, Census of India, 2011.

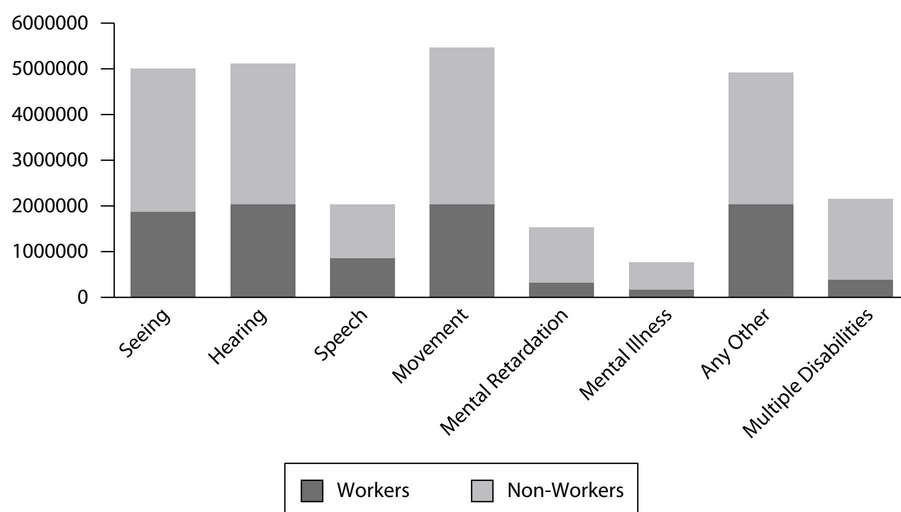

Chart 1.10 Distribution of Workers by Disability Type, 2011
Source: Author's calculations from Census of India, 2011.

with individuals with intellectual disabilities, psycho-social disabilities, and multiple disabilities being virtually out of the workforce.

Table 1.3 shows the division of workers into basic types of work that PWDs are engaged in, sorted by sex, rural–urban location, and type of disability. We see from the top row of Table 1.4 that 23 per cent of all workers are casual labourers, 31 per cent are agricultural labourers, 42 per cent are 'Other' workers and 4 per cent are in household industries. We see a clear rural–urban divide in that a greater proportion of rural workers are casual or agricultural labourers, whereas a greater proportion of urban workers are in the omnibus category of 'Other' work.

Table 1.3 Type of Work for PWDs by Disability Type, Sex, and Residence

			Total	CL%	AL%	HHI%	Others%
Total disabled pop	Total	Persons	97,44386	0.23	0.31	0.04	0.42
Total disabled pop	Total	Males	70,72825	0.24	0.27	0.04	0.45
Total disabled pop	Total	Females	26,71561	0.21	0.40	0.07	0.33
Total disabled pop	Rural	Persons	70,04120	0.31	0.40	0.04	0.24
Total disabled pop	Rural	Males	49,12012	0.34	0.37	0.03	0.26
Total disabled pop	Rural	Females	20,92108	0.26	0.49	0.06	0.20
Total disabled pop	Urban	Persons	27,40266	0.03	0.06	0.05	0.86
Total disabled pop	Urban	Males	21,60813	0.03	0.05	0.05	0.87
Total disabled pop	Urban	Females	57,9453	0.04	0.08	0.09	0.80
In seeing	Total	Persons	18,91919	0.24	0.31	0.04	0.40
In seeing	Total	Males	13,46034	0.25	0.27	0.03	0.44
In seeing	Total	Females	54,5885	0.22	0.41	0.06	0.31
In seeing	Rural	Persons	13,52621	0.33	0.42	0.04	0.22
In seeing	Rural	Males	92,1956	0.36	0.38	0.03	0.24

In seeing	Rural	Females	43,0665	0.27	0.50	0.06	0.18
In seeing	Urban	Persons	53,9298	0.04	0.05	0.05	0.86
In seeing	Urban	Males	42,4078	0.03	0.05	0.04	0.88
In seeing	Urban	Females	11,5220	0.05	0.07	0.08	0.79
In hearing	Total	Persons	20,62058	0.23	0.30	0.05	0.41
In hearing	Total	Males	14,44083	0.25	0.26	0.04	0.45
In hearing	Total	Females	61,7975	0.21	0.39	0.07	0.33
In hearing	Rural	Persons	14,43251	0.32	0.41	0.05	0.23
In hearing	Rural	Males	96,6542	0.35	0.37	0.03	0.24
In hearing	Rural	Females	47,6709	0.26	0.49	0.07	0.19
In hearing	Urban	Persons	61,8807	0.03	0.06	0.06	0.85
In hearing	Urban	Males	47,7541	0.03	0.05	0.05	0.87
In hearing	Urban	Females	14,1266	0.03	0.08	0.09	0.79
In speech	Total	Persons	83,9258	0.23	0.29	0.04	0.43
In speech	Total	Males	60,0179	0.24	0.25	0.03	0.48
In speech	Total	Females	23,9079	0.22	0.39	0.06	0.33
In speech	Rural	Persons	56,6849	0.33	0.41	0.04	0.22
In speech	Rural	Males	38,6552	0.35	0.37	0.03	0.25
In speech	Rural	Females	18,0297	0.29	0.49	0.05	0.17
In speech	Urban	Persons	27,2409	0.03	0.05	0.05	0.88
In speech	Urban	Males	21,3627	0.03	0.04	0.04	0.89
In speech	Urban	Females	58,782	0.03	0.07	0.08	0.82
In movement	Total	Persons	20,34876	0.23	0.29	0.04	0.44
In movement	Total	Males	16,01135	0.24	0.26	0.04	0.46
In movement	Total	Females	43,3741	0.20	0.38	0.06	0.36
In movement	Rural	Persons	15,35250	0.30	0.36	0.04	0.30
In movement	Rural	Males	11,84342	0.31	0.34	0.03	0.31
In movement	Rural	Females	35,0908	0.24	0.45	0.05	0.25
In movement	Urban	Persons	49,9626	0.03	0.06	0.05	0.86
In movement	Urban	Males	41,6793	0.03	0.05	0.05	0.87
In movement	Urban	Females	82,833	0.02	0.07	0.09	0.81
Mental retardatic	Total	Persons	32,2285	0.24	0.36	0.04	0.35
Mental retardatic	Total	Males	23,2298	0.25	0.33	0.03	0.38
Mental retardatic	Total	Females	89,987	0.22	0.44	0.06	0.28
Mental retardatic	Rural	Persons	24,5121	0.31	0.45	0.04	0.20
Mental retardatic	Rural	Males	17,1341	0.33	0.43	0.03	0.22
Mental retardatic	Rural	Females	73,780	0.26	0.52	0.05	0.16

(Cont'd)

Table 1.3 (*Cont'd*)

			Total	CL%	AL%	HHI%	Others%
Mental retardatic	Urban	Persons	77,164	0.04	0.07	0.06	0.84
Mental retardatic	Urban	Males	60,957	0.03	0.06	0.05	0.86
Mental retardatic	Urban	Females	16,207	0.04	0.08	0.09	0.78
Mental illness	Total	Persons	15,4534	0.26	0.36	0.04	0.34
Mental illness	Total	Males	11,1873	0.27	0.33	0.03	0.37
Mental illness	Total	Females	42,661	0.23	0.44	0.07	0.27
Mental illness	Rural	Persons	12,1732	0.32	0.43	0.04	0.21
Mental illness	Rural	Males	85,522	0.34	0.41	0.03	0.23
Mental illness	Rural	Females	36,210	0.26	0.50	0.06	0.18
Mental illness	Urban	Persons	32,802	0.04	0.08	0.06	0.82
Mental illness	Urban	Males	26,351	0.04	0.08	0.05	0.84
Mental illness	Urban	Females	6451	0.05	0.10	0.10	0.75
Any other	Total	Persons	20,46986	0.22	0.31	0.05	0.43
Any other	Total	Males	14,56713	0.22	0.27	0.04	0.47
Any other	Total	Females	59,0273	0.19	0.39	0.07	0.34
Any other	Rural	Persons	14,33820	0.29	0.41	0.04	0.25
Any other	Rural	Males	98,3945	0.32	0.38	0.03	0.27
Any other	Rural	Females	44,9875	0.24	0.49	0.06	0.20
Any other	Urban	Persons	61,3166	0.03	0.06	0.06	0.85
Any other	Urban	Males	47,2768	0.03	0.05	0.05	0.87
Any other	Urban	Females	14,0398	0.03	0.08	0.09	0.80
Multiple disability	Total	Persons	39,2470	0.26	0.33	0.05	0.36
Multiple disability	Total	Males	28,0510	0.27	0.30	0.04	0.39
Multiple disability	Total	Females	11,1960	0.24	0.42	0.07	0.28
Multiple disability	Rural	Persons	30,5476	0.33	0.41	0.04	0.22
Multiple disability	Rural	Males	21,1812	0.35	0.38	0.03	0.24
Multiple disability	Rural	Females	93,664	0.27	0.48	0.06	0.19
Multiple disability	Urban	Persons	86,994	0.04	0.07	0.07	0.82
Multiple disability	Urban	Males	68,698	0.04	0.07	0.05	0.84
Multiple disability	Urban	Females	18,296	0.04	0.10	0.11	0.75

Source: Author's Calculations from Census of India, 2011.
Note: CL: casual labour; AL: agricultural labour; HHI: household industries; Others: other work.

Chart 1.11 shows the distribution, among broad categories of work, of PWDs who are classified as workers. The census categories of work are casual labour (CL), agricultural labour (AL), household industries (HHI), and Others. We see that in most states, persons with disability are mostly involved in unspecified types of work (Other work). In the north-eastern and other hill states such as Arunachal Pradesh, Sikkim, Meghalaya, Mizoram, Manipur, Nagaland, Assam, Himachal Pradesh, and Uttarakhand, we note a high proportion—between

Table 1.4 Disability Index for Sixteen Major States, India, 2002

State	Percentage of disabled			Disability Index	Per capita NDP[1] (Rs)
	Illiterate	Not Enrolled in vocational course	Non-working		
Andhra Pradesh	63.7	98.2	63.63	78.71	14715
Assam	48.4	98.9	67.34	77.31	9612
Bihar	65.5	98.6	66.38	79.93	6328
Gujarat	45.1	96.4	63.84	74.65	18625
Haryana	51.7	98.3	67.43	77.47	21114
Himachal Pradesh	51.5	95.7	58.36	73.92	15012
Karnataka	56.5	97.6	63.96	77.04	16343
Kerala	33.1	95	74.52	75.82	18262
Madhya Pradesh	52.1	98.1	62.4	76.22	10907
Maharashtra	47.6	97.2	66.16	75.98	23398
Orissa	64.2	99.5	67.6	80.39	9162
Punjab	57.8	96.9	71.72	78.87	23040
Rajasthan	58.1	98.5	61.84	77.35	12533
Tamil Nadu	52.8	97.8	58.58	75.35	19141
Uttar Pradesh	58.4	98.5	67.99	78.82	9765
West Bengal	47.9	98.4	66.74	76.82	15569
India	54.7	97.9	65.51	77.25	17527

Source: Mishra and Gupta (2006: 4028).
Note: [1]NDP data advance estimate relating to 1999–2000 as reported by the directorate of economics and statistics of respective state governments.

45 and 60 per cent of all PWD workers—are involved in casual labour. In the eastern-central belt of Chhattisgarh, Jharkhand, Bihar, Odisha and Andhra Pradesh, we see high proportions of PWD workers as agricultural labour. Proportions of workers involved in household industries is small, and does not exceed 5 per cent in any state. Thus the overall picture is that the majority of PWDs are excluded from work (64 per cent), and of the rest, the majority are included in the relatively more adverse forms of work—that is, casual labour and agricultural labour.

Economic Implications of Disability

disability index

Given that disability is best understood as a combination of physical disability and locational or contextual factors, it is important to go beyond the distribution of the incidence of physical disability towards its consequences in terms of lack of access to basic capabilities. Thus, the real question is: how handicapped are the disabled in various basic dimensions that underlie access to a decent life? We saw some dimensions of exclusion in the third section. The individual elements of exclusion can be combined into a composite index to give a single numerical value that encompasses the multiple dimensions of exclusion. Mishra and Gupta (2006)'s 'disability index' is one such exercise. They create the index using data on education, skill development, and employment combining NSS data with data from the 2001 Census. The construction of the index is such that the maximum value of the index is 100 (maximum deprivation). They compute the disability index for seven disability types for 16 major states. They use the UNDP's 2003 Human Poverty Index and measure deprivation along three dimensions:

1. Educational opportunities: constructed using a weighted average of the adult literacy rate, non-enrolment in special schools and lack of pre-school intervention.

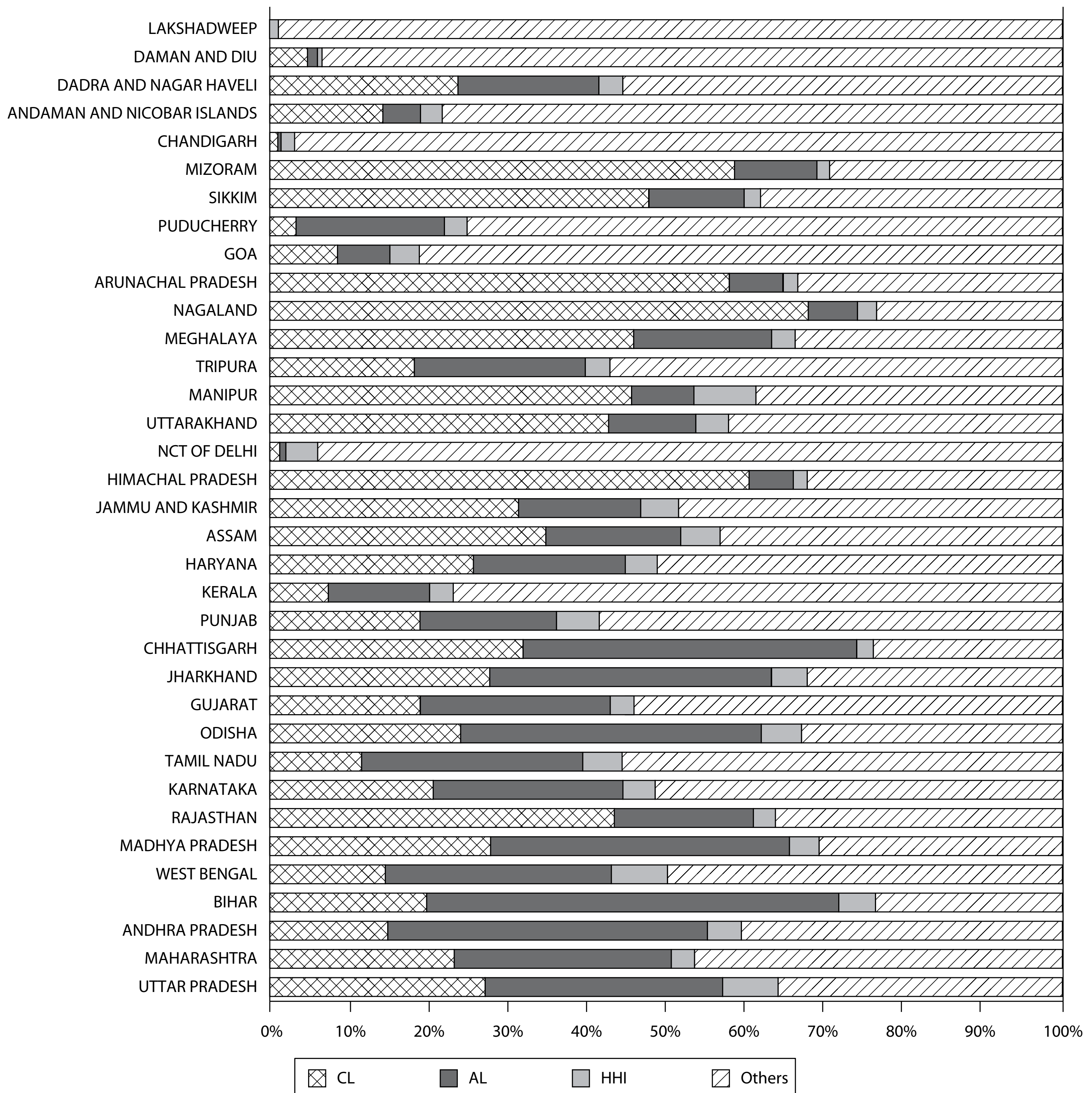

Chart 1.11 Workers with Disabilities: Type of Work by State, 2011

Source: Author's Calculations from Census of India, 2011.

2. Opportunities for skill development: lack of occupational skill as measured by the non-enrolment in vocational training.
3. Employment opportunities: lack of access to any economic activity as measured by the percentage of non-working disabled.

The formula used for calculating the disability index is:

$$\text{Disability Index} = \left[\frac{1}{3}\left(P_1^{\alpha} + P_2^{\alpha} + P_3^{\alpha}\right)\right]^{1/\alpha}$$

where P_1^{α} = ½(adult illiteracy) + ¼ (non-enrolment in special schools) + ¼ (non-enrolment in pre-school

intervention) [percentage among disabled]. The authors assign a higher weight to adult illiteracy identifying illiteracy as a major barrier to inclusion.

P_2 is the percentage among the disabled who did not attend any vocational course.

P_3 is the percentage of disabled non-working population, and. $\alpha = 3$.

The state-wise distribution of the disability index, in Table 1.5, shows that the national disability index has the value 77, which is very high, given that the maximum value it can take is 100. The inter-state variation is not substantial, with Odisha having the highest value of 80.39 and Himachal Pradesh with the lowest value of 73.92. Comparing this to the inter-state variation presented in sections above, we note that the disability index computation has been done for only the major states, whereas the indicators above have been presented for all states in India. Thus, Table 1.4 is not comparable to the evidence above both because it only includes selected states as well as because it is based on data that is nearly a decade older than the census data. Nevertheless, broadly speaking, states with lower incidence of movement disability have a lower index (e.g. Himachal Pradesh).

As the authors point out, while literacy rates in India have shown a remarkable improvement over the last two decades, the incidence of illiteracy is much higher among the disabled population, which is clear also from the 2011 census data in Table 1.3.

While all the three elements of the disability index are important, Table 1.4 shows that not being enrolled in a vocational course is the biggest component of the index. At most five per cent of the disabled population are enrolled in a vocational course, and that too only in one state, viz., Kerala. In the other states, only 2–3 per cent of the disabled population is enrolled in any vocational course. The proportion of the disabled population 'not working' is upwards of 63 per cent, a figure very similar to the 64 per cent average from the 2011 census, reported above, barring the exception of Tamil Nadu, which records the lowest incidence of non-working population (59 per cent). The last column of the table shows the per capita state domestic product, an indicator of how rich the state is. Here a cursory look at the association between the state domestic product and the disability index suggests that the severity of the handicaps imposed by disability is not necessarily mitigated by the relative material prosperity of the state.

We should note that for the country as a whole, capacity in vocational education courses is very low; enrolment in vocational education for population as a whole is very low. Hence, the fact that enrolment of 'disabled' in vocational education is also low is not surprising, given the overwhelming evidence of exclusion.

DISABILITY-ADJUSTED LIFE YEARS (DALYs)

An important index related to the economic implications of disability prevalent in the development literature is called 'Disability-Adjusted Life Years' (DALYs). This indicator was constructed in the early 1990s by C.J.L. Murray as a measure of the 'burden of disease' and was introduced as an input in the World Bank's World Development Report of 1993 to be used as a tool for policy-making in a wide range of countries. DALYs combine 'time lived with a disability and the time lost due to premature mortality'. Years lived with a disability are translated into an equivalent time loss by using a set of weights which reflect reduction in

Table 1.5 Causes of Disability Across Social Groups

Major causes	Dalits	ST	OBC	Others	Total
Moderate or severe anemia	18.3	15.5	20.8	16.1	18.5
Pneumonia	16.8	11.7	15.5	18.9	16.6
Malnutrition	9.5	13.0	10.9	9.2	10.2
Defective gene mutation	9.5	10.8	9.3	8.5	9.2
Congenital defects	7.3	7.0	7.6	8.7	7.8
Depicting impact of heredity	3.8	3.3	3.3	3.6	3.5
Stunted	2.7	2.4	2.8	3.8	3.1
Low level of nutrition	3.4	3.0	2.9	2.8	3.0
Inappropriate services at the time of delivery	3.0	2.8	2.8	3.2	3.0

Source: Pal (2010: 8).

functional capacity, with higher weights corresponding to a greater reduction. In both cases, time spent in the state is adjusted using a set of 'value choices' which weight time lived at different ages and at different time periods differently (through age-weighting and discounting respectively). By definition, DALYs are seen a 'bad' (as opposed to a 'good') which should be minimized.

The DALY approach measures the burden of illness through reduction in 'human function'. The 'multiple dimensions of human function' are mapped onto a uni-dimensional scale between zero (perfect health) and one (death) along which six discrete disability classes are distinguished. Human function is represented by ability to perform certain ADLs, such as learning, working, feeding, and clothing oneself. The space in which ill-health is assessed is limitation in these activities. Thus, the burden of disease in this framework is a measure of ill-health which reflects functional limitation and premature mortality, and is adjusted for age, sex, and time of illness.

One advantage of the DALY indicator is that it allows fatal and non-fatal health outcomes to be combined into a single indicator. Murray argues that the DALY concept has an advantage over measures such as 'potential years of life lost' (PYLL) that consider mortality alone in assessing disease burden. DALYs are used for at least two separate exercises: (1) the 'positive' exercise of measuring the burden of disease; and (2) the 'normative' exercise of resource allocation. The burden of disease is simply measured as the sum of DALYs attributable to premature mortality or morbidity. The idea behind calculating DALYs it to use the estimates of the burden of disease in determining health resource allocation by minimizing aggregate DALYs subject to a given budget.

Anand and Hanson (1997) discuss several shortcomings of the DALY approach to demonstrate how the measure is fundamentally flawed. First, they suggest that the notion inherent in the DALY is closer to the aggregate quantity of ill-health than to a 'burden'. They argue that 'if the goal were measurement of the actual "burden" of illness, more information would be needed about the circumstances of individuals who experience ill-health (e.g. support provided through public services, private incomes, family and friends), and not just their age and sex. Moreover, if the object of public sector resource allocation were to minimize *this* burden of illness, such considerations would clearly be relevant' (emphasis in the original).

They draw attention to the fact that for the exercise of resource allocation, in contrast to measuring ill-health, there is an additional issue of treatment of those who are different along dimensions not included in the DALY information set. The DALY framework fails to make distinctions between those who are unlike along dimensions that are important for resource allocation, such as income and socio-economic status. They highlight some paradoxical implications of the DALY framework: a person with a pre-existing disability, such as a physical handicap, contributes less to the disease burden (for an illness independent of the disability) than an able-bodied person. On a cost-effectiveness basis she will receive a lower priority, yet her claim on public resources should be greater precisely due to her pre-existing disability. In general they show that if the DALY information set is used in conjunction with the goal of aggregate DALY minimization, the implications for resource allocation are inequitable.

They point out that DALYs use standardized life expectancies of 80 years for men and 82.5 years for women, supposedly reflecting biological differences between men and women, which are considerably higher than levels in developing countries. Using these life expectancies in measuring the global burden of disease or cost effectiveness implicitly assumes that health interventions alone can achieve an increase in life expectancies to these high levels. This ignores the basic fact that several non-health circumstances will also need to change to raise life expectancies to these high levels.

The other very important shortcoming of the DALY approach is the weighting scheme. Specifically, it is not clear how weights are attached to different ages and to different disability states. Moreover, the distinction between loss of functionality due to age and that due to disease or disability is not clearly made. As Anand and Hanson point out, an infant cannot do any of the daily tasks without assistance, but does that make it disabled. Also, an individual suffering multiple illnesses might experience loss of functionality due to the overlap of diseases, but the DALYs framework cannot account for the overlap and will thus end up overestimating the burden of disease. All these shortcomings have serious implications for estimating both the burden of ill health and consequently for the resource allocation necessary to combat the burden.

Finally, they raise the important issue of restricting health sector allocations to health interventions alone, which is the underlying assumption of the DALY analysis. It is abundantly clear that non-health sector

allocations could significantly affect health outcomes (for example, provision of clean drinking water or improving mother's education) and that improvement in health outcomes will have implications for the non-health sector in turn, and therefore, the interactions of health and non-health sectors have to be considered in their entirety when deciding on the financial allocations to combat the 'burden of disease'.

WAGE GAPS AND LABOUR MARKET DISCRIMINATION

A standard technique to estimate labour market discrimination is to decompose the average wage gap between two groups, say men and women, or upper and lower castes, into two parts—one, that can be explained by wage-earning attributes, such as education, skills, residence and so on, and two, the residual wage gap, which remains even when wage-earning attributes or characteristics are accounted for. The latter is conventionally taken as a proxy for labour market discrimination—part of the wage gap that is 'unexplained' by individual attributes or characteristics. A great deal of differentiation would have already taken place by the time individuals enter the labour market. In other words, the fact that two groups enter the labour market with different wage-earning attributes points towards discrimination that occurs during the lives of individuals before they enter the labour market. Economists term this 'pre-market discrimination'. This early life discrimination is not included in the estimate of discrimination that comes from the decomposition technique.

We should note that the decomposition technique estimates only that part of the labour market discrimination that manifests itself into wage gaps between two groups. In other words, if due to discrimination, members of one group are more likely to be unemployed, or worse, not be included in the labour force at all, and thus report no wages, then such individuals would not be included in the decomposition analysis. Also, if discrimination results in various forms of adverse working conditions other than lower wages, those cannot be identified through the decomposition exercise. Despite all these limitations, the decomposition technique is a powerful one, as it demonstrates that the entire difference in wages is not due to merit or ability.

Applying this technique to estimate labour market discrimination against PWDs is challenging. For one thing, it is immediately apparent that the most extreme form of discrimination, which results in the majority of the disabled being completely excluded from the labour market (as we see in the third section), would not be captured by this technique. Also, specific forms of disability are not comparable, both in terms of level of difficulty in accessing specific jobs, as well as from the employers' point of view, with each physical type of disability affecting eligibility for different types of jobs. Thus clubbing all PWDs into one group would not capture the differential forms of discrimination against individual forms of disability. In order to that, one would need large volumes of data on each specific type of disability, ideally differentiated by severity of impairment. These types of data do not exist. Thus, it is not surprising that there are hardly any studies that attempt this fairly standard estimation of labour market discrimination.

However, Mitra and Sambamoorthi (2009) is one such study that uses data on 706 households from the Village Disability Survey in 15 villages in one district of Uttar Pradesh. Given that individuals with disability have a much lower probability of being in the labour force, the technique involves statistically correcting for selection into employment. After executing this adjustment, they find that about 8 per cent of the wage gap between disabled and non-disabled workers cannot be explained by wage-earning attributes. We should treat the figure of 8 per cent with caution, as prima facie this indicates a low level of discrimination. We already noted that the current state of data collection is inadequate to capture the extent of labour market discrimination; also, most disabled persons face the most extreme form of labour market discrimination—that of being excluded altogether. One way of interpreting would be to see the 8 per cent as the price as one pays for being disabled even when one manages to overcome multiple handicaps to get into employment (given that 64 per cent of disabled do not manage to do so).

Disability within Dalits and Adivasis

It is well-recognized that socio-economic disadvantage can increase the risk of ill-health or disabilities. For instance, lack of access to adequate micronutrients (specifically Vitamin A) during childhood can cause blindness. Similarly, women's poor nutrition, due to poverty, gender discrimination, or both, could result in children being born with several kinds of disabilities. While Dalits or Scheduled Castes (SC) and Adivasis or Scheduled Tribes (ST) as well as Muslims among the religious minorities are communities that are discriminated against and marginalized, the exact causes and nature of deprivations among these communities are different due to the specific history of each community.

Dalit castes continue to suffer deep-rooted stigmatization and social ostracization on account of their untouchable status, even though untouchability has been legally abolished, and is in fact, punishable by law. Adivasis are disadvantaged due to their location and remoteness of their habitation, as well as stigmatization especially towards the de-notified communities. Muslims bear the brunt of communal polarization and right-wing majoritarian accusations of being outsiders or possible extremists.

While all these communities bear the brunt of severe disadvantage, with high incidence of poverty and deficits in virtually all development indicators, as well as discrimination, this section looks at some aspects the overlap between caste (or tribal status) and disability. Pal (2010) focuses on Dalits with disabilities using the NSS data from the special survey on disability in 2002. Pal points out how being born into a Dalit family implies a life with various social handicaps due to the presence of caste-based discrimination and stigmatization on account of their 'untouchable' status, which though not legally recognized, continues to impose a whole range of social disabilities. The NSS numbers are not directly comparable with the census (for instance, the 2001 census reported a disability incidence of a little over 2 per cent, whereas the NSS estimate was 1.8). This section presents selected numbers from the 2011 census on the overlap of caste and disability.

According to the 2011 census, SCs formed 16.6 per cent of the population, but 18.4 per cent of the disabled population. STs were 8.6 per cent of the population, but almost 10 per cent of the disabled population. The distribution of type of disability for the Dalit (Scheduled Caste) population (Chart 1.12) is not very different from the overall. The major difference is that 'any other' disability forms the highest proportion (23 per cent), followed by movement (21 per cent).

The distribution of disability type for STs (Chart 1.13) shows that movement disability constitutes the highest proportion (22 per cent), which is not substantially higher than that for SCs.

NSS (2002) is the third and latest special survey on disability. While this data is a decade older than the census, it contains some additional useful information. For instance, looking at the incidence of disability by age-group, we see a higher incidence of disability from birth and early childhood among the disadvantaged social groups, *viz.*, among SC and STs. Tables 1A.1 and 1A.2 in the Appendix shows that the number of disabled per 1000 population is highest among SCs and STs, for both boys and girls, between the ages 0 to 14, indicating that the lack of access to basic nutrients and greater incidence of poverty, both in-vitro and post-birth, results in a larger incidence of disability for Dalit and Adivasi children. We should note, however, that IHDS 2005 data (with different definitions, as explained above), finds that 'disabilities are equally distributed across class and caste. The disabled are slightly more concentrated among the poor and less educated, but the differences are small' (Table 1A.3).

Chart 1.14 shows the proportions SC and STPWDs by their literacy and work status. We notice that among SCPWDs, the gap between literate and illiterate proportions is very small, but is larger among STPWDs (40 per cent illiterate). The gap between workers and non-workers is similar across Dalits and Adivasis, and for both groups, roughly 60 per cent PWDs are workers

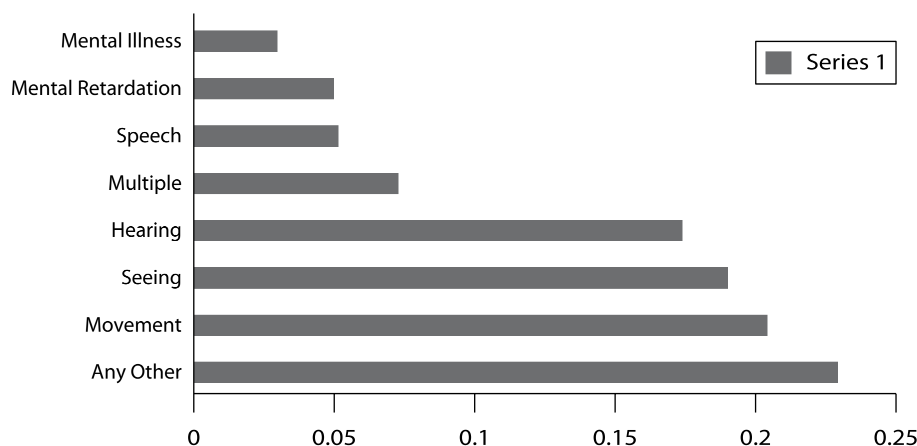

Chart 1.12 Types of Disabilities for Scheduled Caste Population

Source: Author's Calculations from Census of India, 2011.

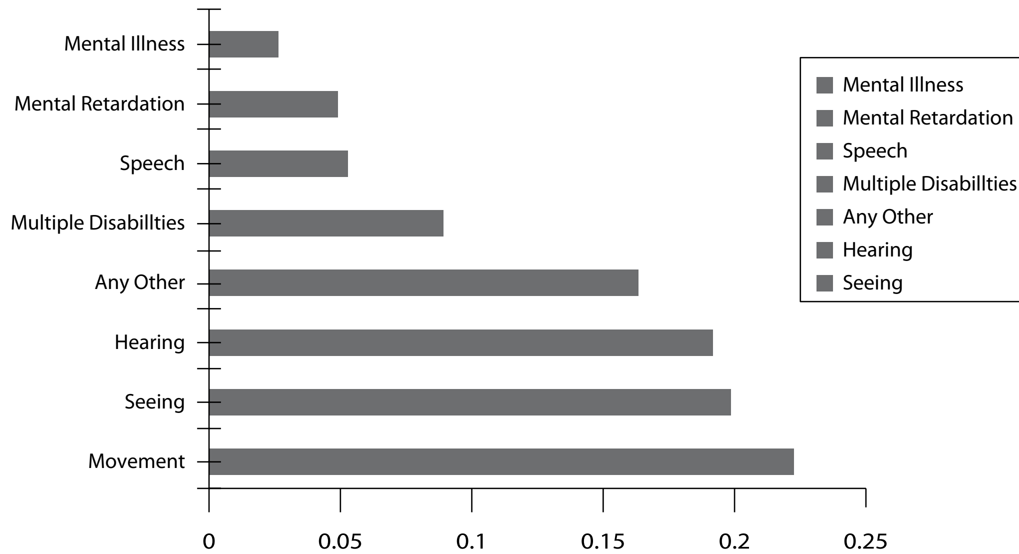

Chart 1.13 Types of Disabilities for Scheduled Tribe Population
Source: Author's Calculations from Census of India, 2011.

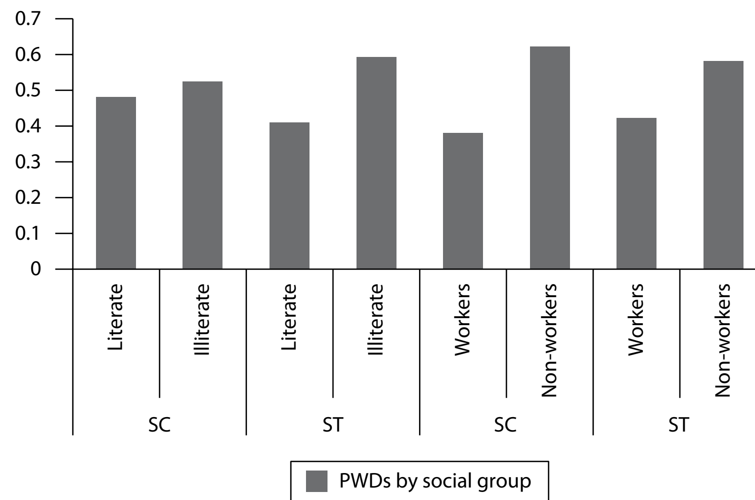

Chart 1.14 Social Group, Work and Literacy, 2011
Source: Author's Calculations from Census of India, 2011.

(lower than the proportion for all PWDs), with the rest being non-workers.

Chart 1.15 shows similar proportions by disability type. The picture from Chart 1.15 for SC and ST PWDs is similar to the distribution of the national PWD population.

Table 1.5, from Pal (2010) reports data from the NSS that shows that the major cause of disability is anemia (19 per cent), followed by pneumonia (17 per cent) and malnutrition (10 per cent). The table shows that the incidence of these factors varies by social group.

One possible reason for higher incidence of disability among SCs could be because of the nature of works performed that exposes them to higher risks of accidents at workplace.

Policy Challenges

India has ratified a UN convention on Rights of People with Disabilities and has a set of policies to ensure basic human rights for PWDs, as well as to ensure their inclusion into the socio-economic fabric of the country. India has four specific Acts specifically targeted towards

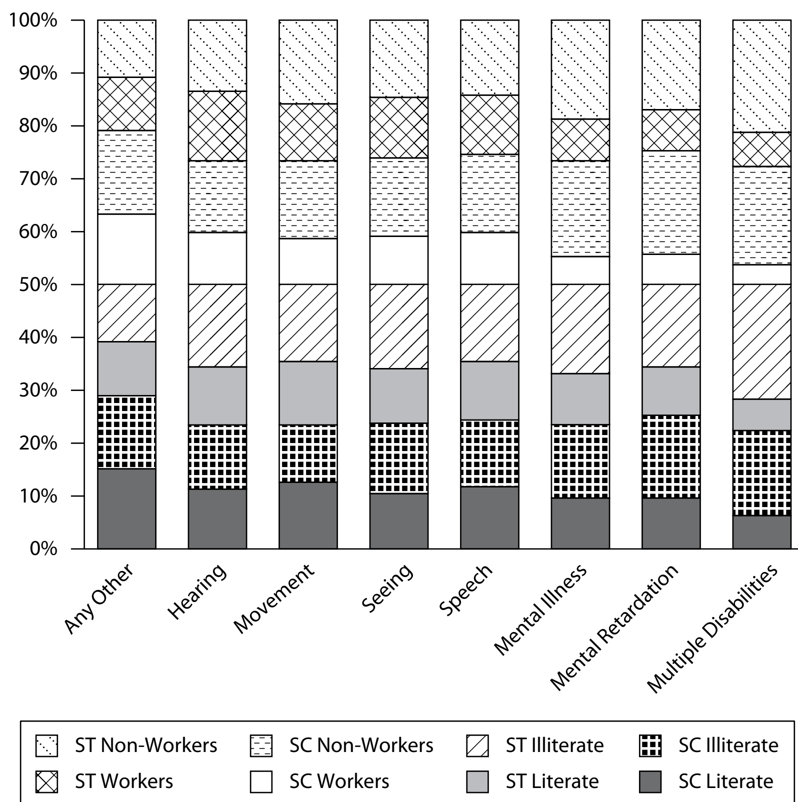

Chart 1.15 Social Group, Work, Literacy and Disability Type, 2011

Source: Author's Calculations from Census of India, 2011.

disability: the Mental Health Act of 1987; People with Disability Act, 1995; Rehabilitation Council of India Act 1992; and The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act of 1999.

The Persons with Disabilities Act, 1995, stipulates that the government and appropriate local authorities shall 'ensure that every child with a disability has access to free education in an appropriate environment till he/she attains the age of 18'. Children with disabilities have the right to appropriate transportation, removal of architectural barriers, as well as the restructuring of curriculum and modifications in the examination system. Scholarships, uniforms, books, and teaching materials are all provided to children with disabilities for free in India.

However, as the literacy figures in the third section show, the gap between the provisions of this Act and the ground reality is very wide, and it is not obvious what, if any, provisions are being made to bridge this gap. This also highlights a problem with several of the legal provisions—a law or Act that looks good on paper might be severely wanting in practice.

Initially, 3 per cent of jobs were reserved for people with disabilities, with 1 per cent each for physically, visually, and hearing impaired persons. In 2014, the government proposed a new Bill that seeks to increase this to 5 per cent, with 1 per cent additional quotas for persons with intellectual and psycho-social disabilities and for people with multiple disabilities. For this purpose, anyone with more than 40 per cent disability in any one of the seven dimensions: blindness, low vision, hearing impairment, locomotor disability, 'mental retardation,' 'mental illness,' and leprosy: would be deemed disabled. This Bill is currently pending, as it is embroiled in controversy. This definition of disability was contested strongly by disability activists for several reasons. One, proving '40 per cent' disability is subjective, even when certified by a competent medical authority. Two, the definition is strictly medical and thus, takes a very narrow view of disability, in contrast to the much more progressive legislation around the world. The UNCRPD suggests 'including those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

Notwithstanding these extremely contentious issues that need to be resolved to make the definition of disability more progressive, at the moment, a narrow section of PWDs are entitled to some form of affirmative action, along with Dalits and Adivasis. However, as we noted above, a prior condition for implementing affirmative action would be to have a pool of eligible candidates who could utilize the reserved positions. Even the first step towards this goal—ensuring basic literacy—is severely lacking, what to speak of higher education that is needed to take advantage of job quotas.

ROLE OF ENVIRONMENTAL FACTORS

Despite the set of laws, accessibility remains far from a basic right for the disabled. Even when the disability is clearly located in the body, a suitable environment can make it possible for a person to integrate into social and economic life. For example, a deaf person might manage to communicate reasonably with a sign language interpreter; a blind person might be able to work on a computer if it has screen-reading software; a wheelchair user might be able to fulfill all requirements of a wide range of jobs (virtually all office-based or teaching jobs) if the environment surrounding the person was wheelchair accessible. Several of these provisions are technologically no longer demanding, nor are prohibitively costly. Most need a change in mindset: e.g. renovation plans for buildings (or new construction) to be handicapped accessible; ATM machines to have braille options so that the visually impaired can access them, and so forth.

Policies such as pre-school interventions can play an important role in preparing children with disabilities for formal schooling. NSS (2002) data reveals that only about 13 per cent of disabled children receive pre-school intervention, with a greater proportion in urban (20) than rural (11 per cent) areas. A higher proportion of upper caste children (18 per cent) receive such interventions compared to Dalits (11) and Adivasis (12 per cent) (Pal, 2010: 20). The use of aids or appliances can greatly enhance the quality of life of PWDs. The reasons for not acquiring the aid reveal that the majority (52 per cent) do not acquire it because it is expensive, with 58 per cent of Dalits citing expense as a reason.

One key issue that policy-makers need to recognize is the need to confront the multiplicity of disabilities, and that a specific policy which focuses on only one aspect of the problem, but ignores the gamut of overlapping disadvantages, could fail completely, however well-intentioned it might be. The example cited by Pal (2010: 1) illustrates this. He cites a case where a physically disabled person from a Dalit community could not use the tricycle presented to him by the government, 'because the caste Hindu "road rules" could not be violated'.

India is very far behind the international standards that are needed to ensure a decent life for PWDs, and needs to urgently address preventable disabilities through the provision of suitable health care. This can only happen if first and foremost, the understanding of disability shifts from the current narrow one, based on certain bodily impairments, to a larger one that encompasses various capabilities and functionings. This reorientation of thinking about disability is necessary, but not sufficient, to change the direction of policy discourse; however it is an urgent first step. The reorientation would also have implications for data collection such that data would be collected in a manner that would deepen our understanding of the issue, as well as specifically aid policy-making.

Appendix

Table 1A.1 Males Number of Disabled Persons by Age-group per 1000 Disabled Persons in Each Household Social Group

All-India							Rural+Urban Male	
Age – group (years)	Household social – group						No. of disabled persons	
	Scheduled Tribe	Scheduled Caste	Other Backward Class	Others	n.r.	All	Estd. (00)	Sample
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0–4	46	31	31	28	0	31	3161	1408
5–9	89	85	80	61	0	76	7810	3376
10-14	118	105	109	92	170	104	10622	4570
15–19	97	101	103	97	94	101	10323	4537
20–24	81	87	86	83	105	85	8717	4095
25–29	62	67	65	71	9	67	6862	3176
30–34	55	57	56	61	0	58	5905	2711
35–39	55	66	56	61	622	60	6129	2801
40–44	56	47	52	57	0	52	5383	2501
35–44	111	113	107	118	622	112	11512	5302
45–49	61	53	56	61	0	57	5857	2486
50–54	50	53	42	51	0	48	4888	2214
55–59	38	47	45	50	0	46	4769	2103
45–59	149	153	143	162	0	151	15514	6803
60 & above	191	201	221	226	0	216	22175	9251
15 & above	747	779	781	819	830	790	81007	35875
All	1000	1000	1000	1000	1000	1000	102600	45229
per 1000 dist.	66	221	413	300	0	1000	X	X
Estimated disabled persons (00)	6778	22663	42368	30774	16	102600	X	X
Sample disabled persons	3551	9393	17244	15031	10	45229	X	X

Source: NSS (2002: 85).

Table 1A.2 Female Number of Disabled Persons by Age-group per 1000 Disabled Persons in Each Household Social Group

All-India							Rural+Urban Female	
Age – group (years)	household social – group						No. of disabled persons	
	Scheduled Tribe	Scheduled Caste	Other Backward class	Others	n.r.	All	Estd. (00)	Sample
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0–4	39	32	33	25	0	31	2218	986
5–9	94	88	82	67	0	80	5707	2218
10–14	97	108	98	90	33	98	7015	2974
15–19	80	81	81	84	17	82	5866	2637
20–24	68	59	62	70	0	64	4597	2179
25–29	38	47	53	54	123	51	3663	1753
30–34	65	50	47	48	0	49	3539	1560
35–39	55	47	47	44	173	47	3360	1596
40–44	42	34	41	50	0	42	3004	1380
35–44	97	81	88	94	173	89	6364	2976
45–49	47	49	42	46	0	45	3231	1483
50–54	62	46	45	41	0	45	3252	1460
55–59	51	59	49	51	40	52	3720	1530
45–59	160	154	137	137	40	142	10203	4473
60 & above	263	300	320	330	615	314	22509	8994
15 & above	770	773	787	818	967	792	56741	24572
All	1000	1000	1000	1000	1000	1000	71682	30750
per 1000 dist.	77	222	411	290	0	1000	X	X
Estimated disabled persons (00)	5537	15890	29455	20789	11	71682	X	X
Sample disabled persons	2845	6296	11848	9750	11	30750	X	X

Source: NSS (2002: 86).

Table 1A.3 Disability Prevalence Rate by Various Socio-Economic Characteristics, IHDS 2004–5 Data

	Disability	
	Difficultyper 1000	Inability per 1000
All India Sex	24	9
Male	23	9
Female	25	9
Age		
6–14 years	8	4
15–59 years	17	6
60 plus years	106	39
Own education		
None	37	17
1–4 Std	21	6
5–9 Std	18	5
10–11 Std	18	4
12 Std/some college	12	2
Graduate/diploma	16	5
Place of residence		
Metro	16	3
Other urban	24	8
More developed village	31	11
Less developed village	20	8
Income		
Lowest quintile	33	14
2nd quintile	23	9
3rd quintile	21	8
4th quintile	22	8
Top quintile	22	6
Social group		
High caste Hindu	26	8
OBC	24	10
Dalit	21	9
Adivasi	19	8
Muslim	21	7
Other religion	68	11

Source: Based on Table A.7.1a, p. 117, Desai et al. (2010).

Distribution of Types of Disability by State, Census 2011

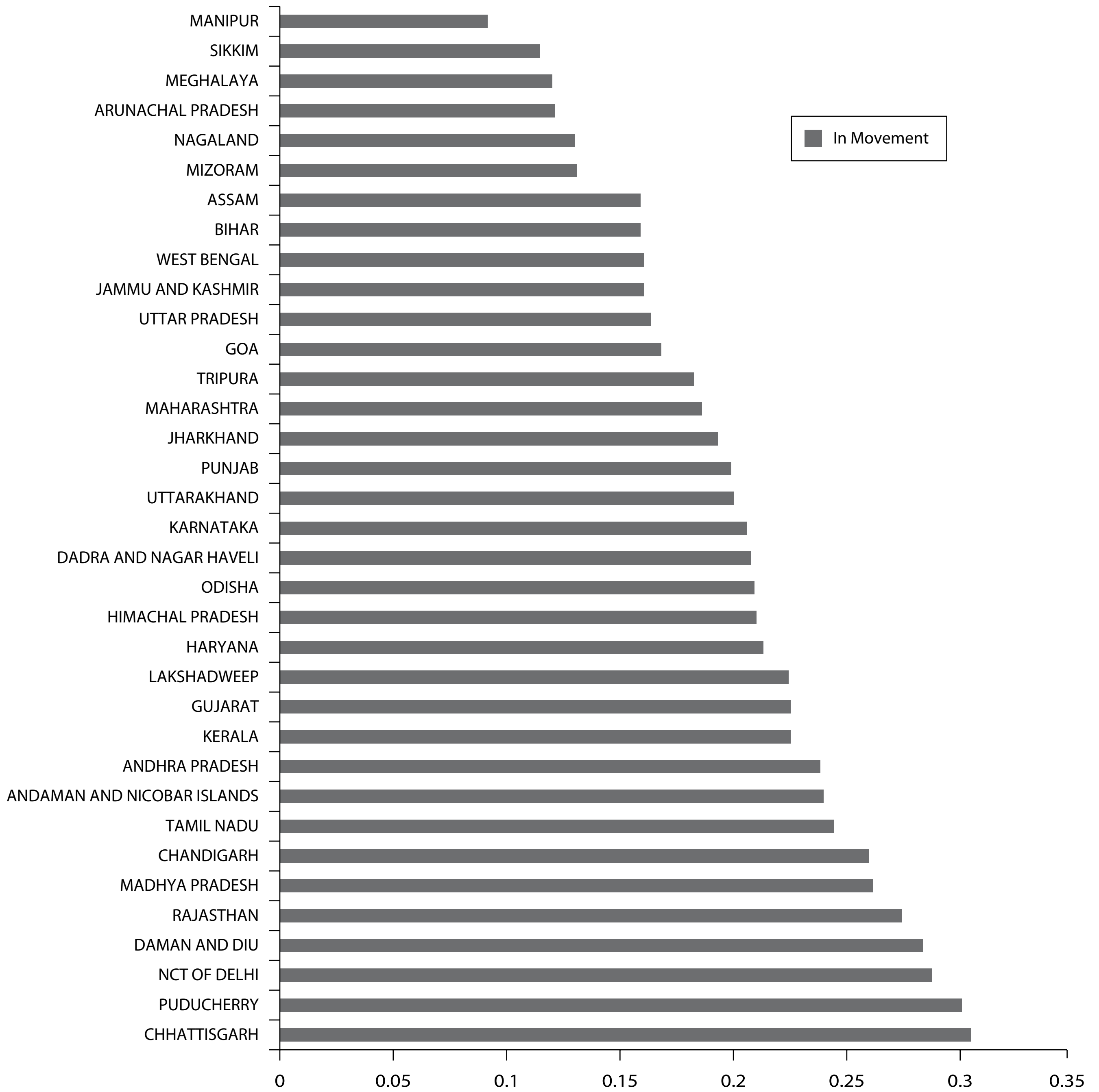

Chart 1A.1 Share of Movement Disability in Total Disability, by State, 2011

Source: Author's Calculations Based on Census 2011.

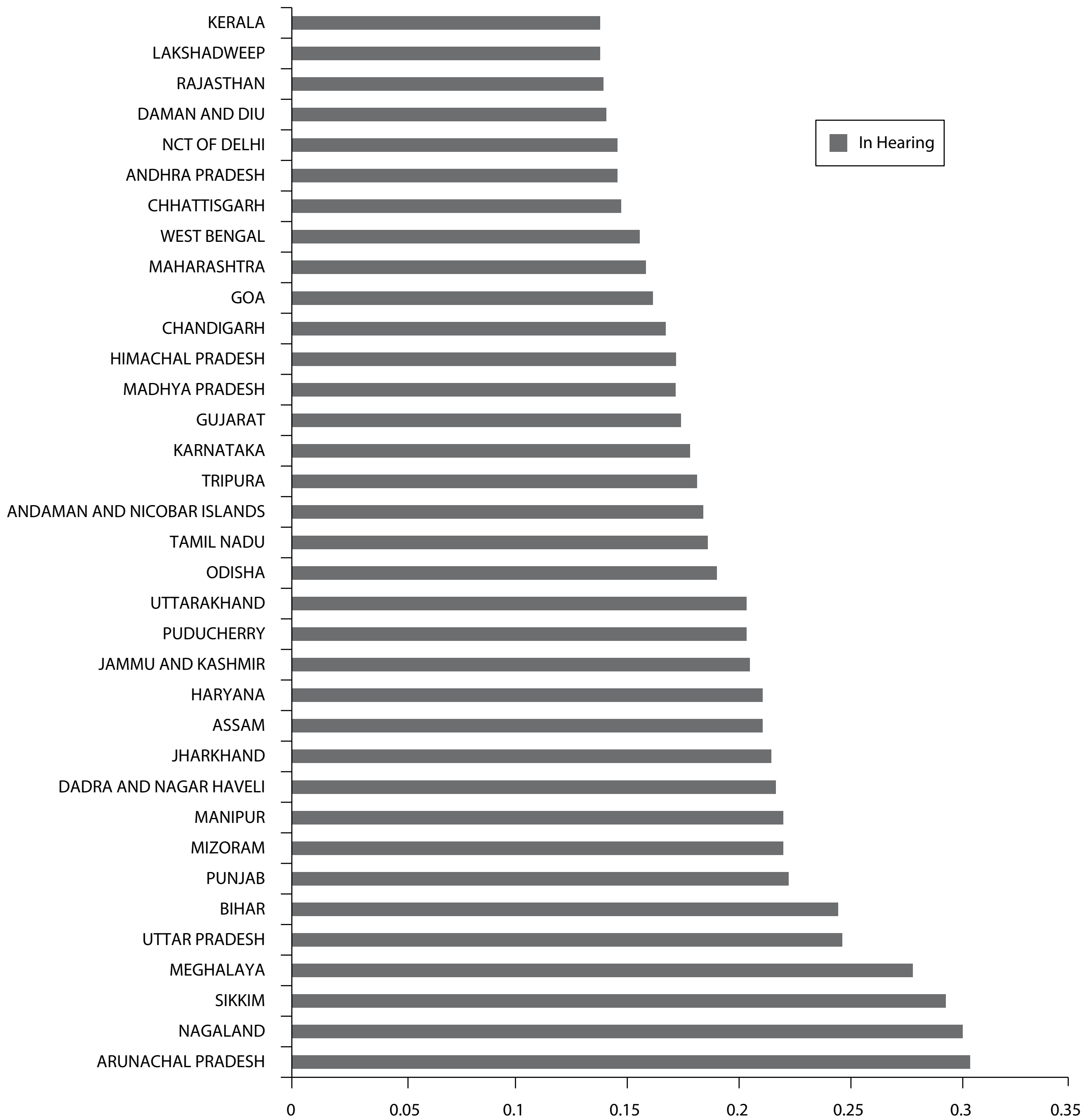

Chart 1A.2 Share of Hearing Disability in Total Disability, by State, 2011

Source: Author's Calculations Based on Census 2011.

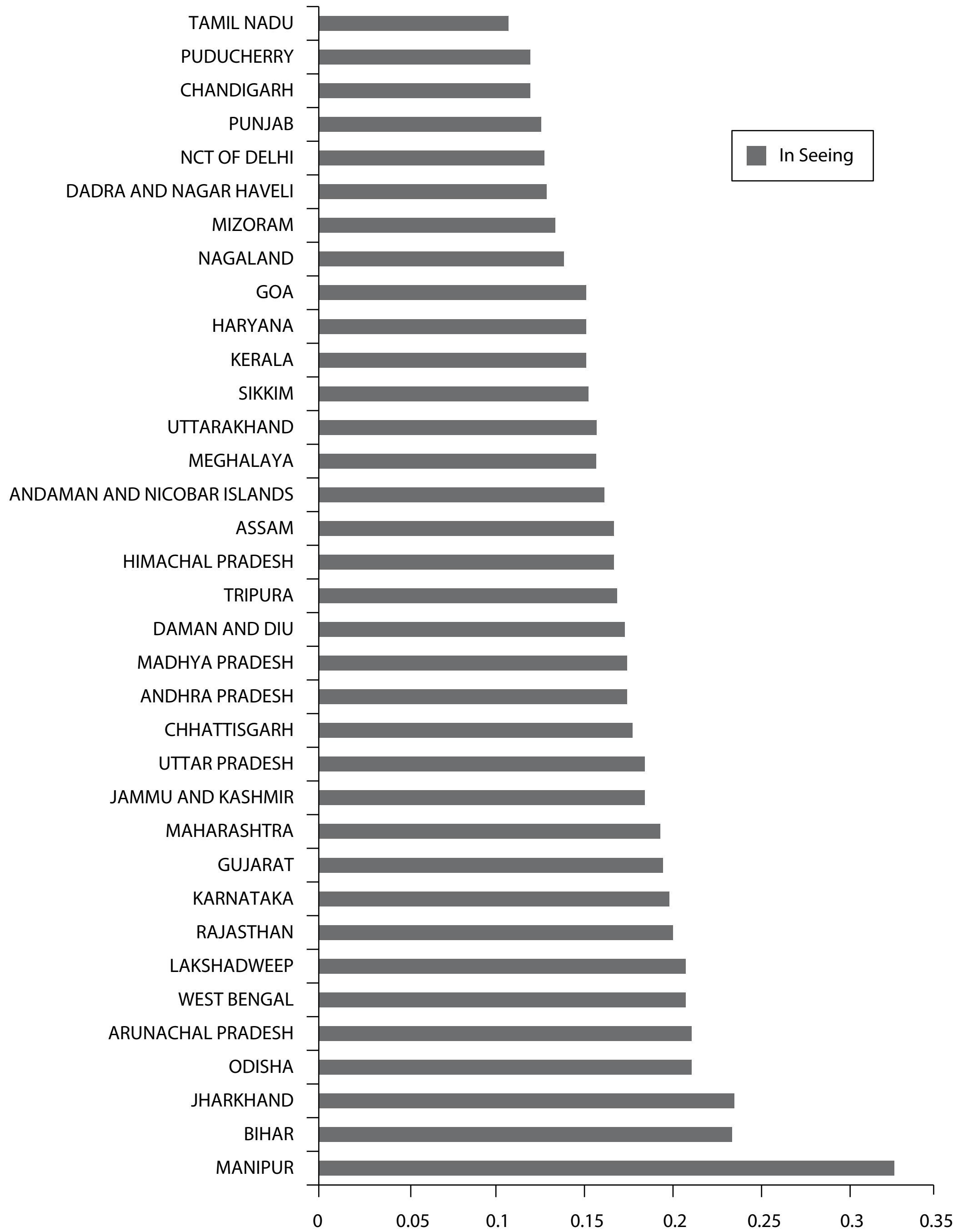

Chart 1A.3 Share of Sight Disability in Total Disability, by State, 2011

Source: Author's Calculations Based on Census 2011.

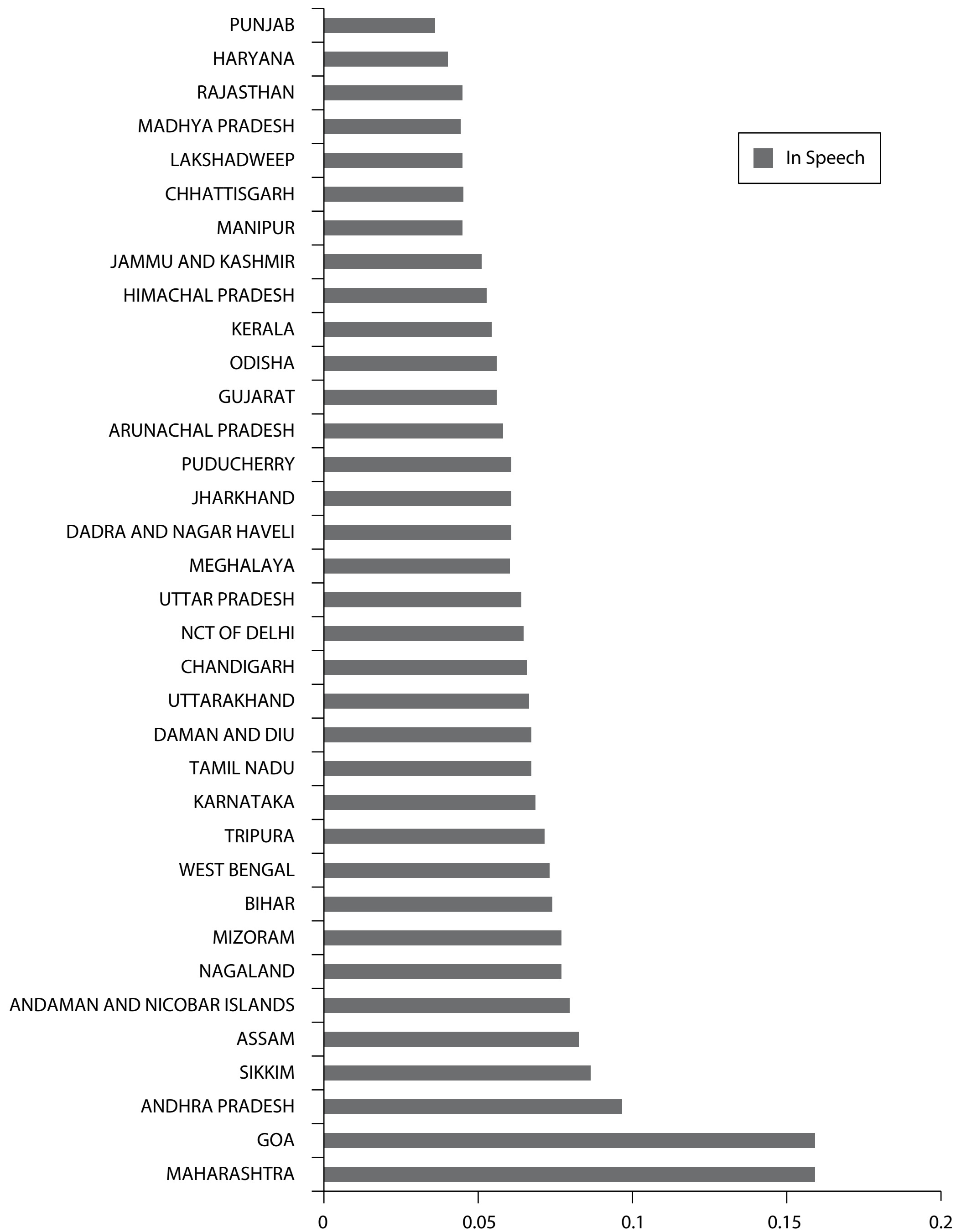

Chart 1A.4 Share of Speech Disability in Total Disability, by State, 2011

Source: Author’s Calculations Based on Census 2011.

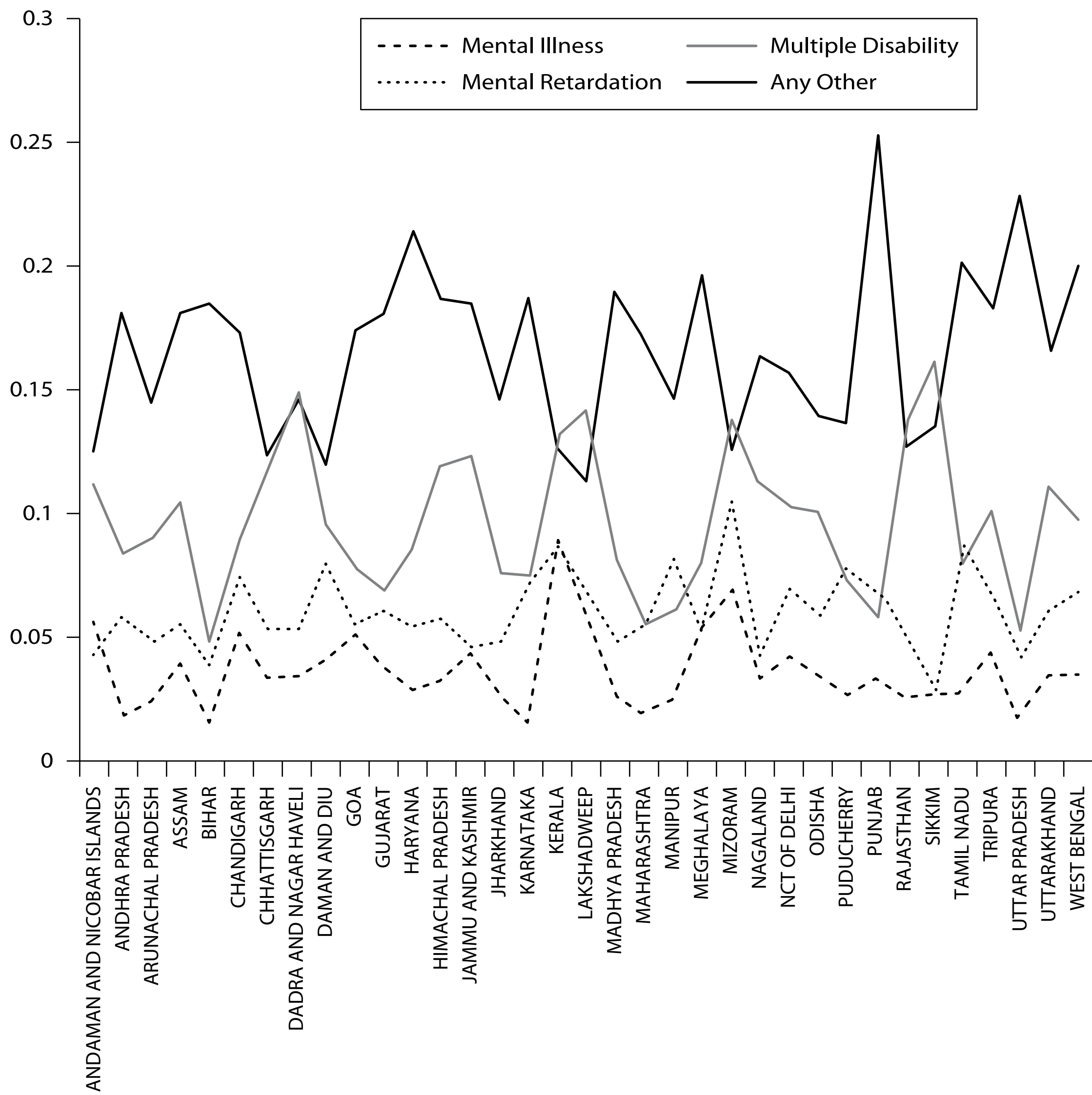

Chart 1A.5 Share of Mental Illness, Mental Retardation, Multiple and Any Other Disability in Total Disability, by State, 2011

Source: Author's Calculations Based on Census 2011.

Notes

1. Available at http://www.worldbank.org/en/topic/disability/overview (accessed 22 March, 2016).
2. Available at http://www.un.org/disabilities/convention/conventionfull.shtml, (accessed March 21, 2016).
3. Available at http://ihds.info/sites/default/files/ihds2ehq.pdf.
4. Available at http://www.livemint.com/Opinion/1rx8tSYGwHB0ZRsvdNFiBP/Indias-missing-disabled-population.html.

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2

Accessing Rights

Women with Disabilities in India

Asha Hans

In recent writings it has been highlighted that women with disabilities live invisibly on the fringes of society with exclusion, stigma, and prejudice as routine aspects of their lives (Addlakha, 2013; Hans, 2015; Davar and Ravindran, 2015; Ghai, 2015). To bring the gender discourse into the centrality of our writings, this chapter will deliberate on the use of two major UN Conventions—the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). They are significant as they intersect and reinforce each other in the context of gendered disability rights and create the necessary synchrony and synergy required in a rights framework (Schulz, 2013).[1]

Discrimination and Rights Protection

The experience of being disabled exposes women with disabilities to multiple discriminations in the domains of culture, society, politics, and the economy. The complex issues affecting women with disabilities, a heterogenous group, intersecting with other Indian social categories like class, caste minority, and rural–urban divide is the denial of autonomy, respect, dignity, and equality of personhood.

The caveats related to inequities are socio-cultural as well as legal. Women with disabilities seem to be falling between the gaps of gender-specific and disability laws, schemes and programmes making it necessary to highlight their needs, and concerns as a separate fundamental principle for strategic intervention. In response to the discriminations, the legal framework which they can access, at the first glance seems very comprehensive since it includes constitutional rights, women related laws and disability laws.[2] However disability laws exclude them and women related laws pay no specific attention, which leaves women with disabilities out of the policy framework. Even the new Draft Disability Law (process started in 2010) is an example of this chasm. It was finalized in 2012 by the Government after long consultations with civil society but was rejected by many women's groups as it did not include women's rights, except in one clause.[3] It also did not include rights of those with psycho-social disability, most of whom are women.[4] The new Mental Health Bill faces the same problem with many civil society groups against its acceptance— and so NAJMI a platform of organizations working on mental health issues was formed (Bapu Trust Pune, Anjali, Kolkata, etc).

The only new disability inclusive law is the Criminal Law (Amendment) Act 2013 brought in after the rape of a young woman in Delhi which aroused the conscience of the nation. When public consultations were organized by the Government on bringing about changes to the Criminal Procedure Code by appointing the now well-known Verma Committee, the women from the disability movement joined the national mainstream and offered their suggestions. Amongst those issues which were included were recognition of communication issues, and use of videography and acceptance of interviewing at home. However, the law has yet to take off in the case of women with disabilities. In a repeat of the Nirbhaya case where a blind girl was raped, tortured, and killed, a case filed in Odisha languishes (High Court of Orissa). In another review of five cases of sexual abuse in Odisha (by the author) after the introduction of this law, it was observed that no action was taken by the judiciary indicating that there must be many such cases (Hans, 2016). The best alternative is to use UNCRPD and CEDAW especially the

latter which has a regular strong monitoring committee, unfortunately the UNCRPD Monitoring Committee has a large backlog of countries to review and India report is one of those awaiting response.[5]

The CEDAW Committee as early as 1991 in General Recommendation 18 on women with disabilities, regretted the lack of information provided for by State parties in their reports and expressed its concern about the 'double discrimination linked to their special living conditions'. It therefore recommended that State parties provide information on disabled women in their periodic reports, and on measures taken to deal with their particular situation, including special measures to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life (Schulz, 2013).

As data was lacking, CEDAW GR 9 Session 8, 1989 (UN Women CEDAW), and Article 31 of UNCRPD both suggested the importance of data in evaluating the status of women with disabilities. In available governmental and non-governmental sources, women (with disabilities) are missing and are therefore invisible and so excluded from policies and programmes. Disability does not figure in the routine macro-data collection endeavours of the state related to women or disability. The only exceptions are the census and NSSO data, the latter being dated. The census data in India 2001 and 2011 shows a marginal increase in female population from 1.87 to 2.01. In terms of gendered differentiation female disabled population is a lower 44.1 per cent in comparison to 55.9 per cent of males. The 2011 census shows highest disability in visual and hearing (2.02) amongst females in comparison to male in mobility (22.5 male vs 17.5 per cent of females). The lowest identified are those with mental illness (2.8 male and 2.6 female). In the intersection of social groups the highest are Scheduled Caste at 2.68 males to 2.20 females and Scheduled Tribe at 2.18 males and 1.92 females (Census 2011). This chapter thus depends on existing research and field research carried out by the author, besides these two data sets.

The Right to Education and Not Leaving Anyone Behind

Education is an important indicator of access to State and non-State resources which contributes to a citizen's quality of life. Starting at this level it is to be noted that women and girls with disabilities fare less well in the Indian educational arena than either their male counter parts or other women without disabilities. In the Census 2011, gender disparity in literacy was found to be wide with female literacy being one-third of male (27.09 per cent gendered difference). The rural gap as expected is slightly higher with a male-female gap of 32.42 per cent. In the other data made available by the Ministry of Human Resource Development, connected to higher education on enrolment, surprisingly, though uneven, it showed an upward trend. It was higher for women with disabilities than men with disabilities in 2010–11 then falling in the next two years from 51 per cent to 41 per cent (2011–12) to 44 per cent in 2012–2013 (Government of India, 2015: Chapter 14). In higher education, there is a better outcome for those girls who access the system. There are some specific fellowships for women with disabilities at the level of higher education. Masters and Overseas Fellowships have been introduced and as seen above they are doing better at this stage.

The statistics on the enrolment of children in school education completely misses the data on girls with disabilities. The overall gender gap in education is therefore ascertained partly through Census and presently available research which contends that that disparity exists and at all stages of education and at varied levels among different disabilities (WWD India Network 2013–2014;[6] World Bank, 2007; Singal 2009). For instance, lowest educational enrolment and attainment are found among persons with multiple disabilities, intellectual disabilities, speech and hearing disabilities primarily due to communication barriers, and the absence of a congenial learning environment; and among these marginal categories within the disability spectrum, figures for women with disabilities were consistently found to be lower than for men with disabilities (Government of India/UNDP, 2007).

There are several hurdles to girls with disabilities accessing and remaining in education. The Government of India has introduced multiple schemes for girl children and children with 'special needs' provisions for inclusive education and appointment of special teachers. Girls with disabilities have thus a dual support system to take advantage of but rarely do so due to lack of awareness and familial and social biases.

A major barrier in the field of education is the condition in institutions which house children with disabilities. A shocking case of institutionalization and neglect amounting to violence has been highlighted in the recent 'Asha Kiran' case. Asha Kiran, an institution in New Delhi for persons with intellectual disabilities and mental illness (children and adults), came under the scanner of activists for its inhuman living conditions. The Delhi High Court set up an advisory committee which found far-reaching abuse (Delhi High Court 2011). Gender-specific issues highlighted were that more girls

than boys were abandoned and of the 143 women only 10 families kept in touch with them. Some girls who came to Asha Kiran had been sexually assaulted. Of 243 persons with mental health problems, 180 were women and girls (Alkazi, 2016).

In response to the alternative report of the Women with Disabilities India Network that was part of the *4*th *and 5*th *NGO Alternative Report on CEDAW* (National Alliance of Women 2014), the CEDAW Committee stated that it was concerned at the low enrolment of girls with disabilities and the low budget of the education sector and called for increased resources for the implementation of Free and Compulsory Education Act and address the causes of low enrolment (UNCEDAW Committee, 2014). It is now for the Government to take this forward, but with no cohesive policy the recommendations falls in the gap between the Department of Women and Child Development who consider it a disability issue and Department of Empowerment of Persons with Disabilities who overlook it viewing it as a women's issue while the Ministry of Human Resource Development remains indifferent. Under these circumstances it is best to take note of the UNCRPD Committee comment that the denial of reasonable accommodation constitutes discrimination and should be immediately applicable and not be subject to progressive realization (United Nations CRPD Committee, 2011).

Inclusion in Work and Eradication of Poverty

Economic independence of women with disabilities is instrumental to their empowerment. However, they are systematically excluded from the mainstream workforce. Census data 2011 on work reflects the gap in main workers male and female which is more than fifty per cent (56.54 per cent i.e. 78.27 per cent male and 21.73 per cent female). This gender gap increases to 64.03 per cent for urban women with disabilities (men 82.01 and women 17.89). This low participation contravenes Article 11 of CEDAW and Article 27 of UNCRPD. As a heterogenous group some women have better access to work than others.

The employment rate of men and women with disabilities is low and women tend to be seriously under-represented in vocational training (World Bank, 2007: 104). Most cases of complaint to the Ombudsman (National and State Commissioners for Disability) are related to not fulfiling the special provision on quota (3 per cent on roster basis) for disabled (even here women with disabilities are not specifically mentioned), promotions, appointments etc. (Office of the Chief Commissioner for Persons with Disabilities Vol. 13, 2008).

The problems faced particularly by women with disabilities, preventing them from participating in the labour force and acquiring a modicum of economic self-reliance, include lack of requisite skills (linked to inadequate and inappropriate vocational and skill development programmes) discrimination and doubts about their working capacity by employers, lack of accessibility, absence of representation of women with disabilities in decision-making positions, absence of monitoring of reservation policy in the government sector, and non-implementation of affirmative action programmes in the private sector (Women with Disabilities India Network, 2013–14).

There is a gender disparity in the access to financial services provided by the State. For instance NHFDC offers financial assistance in the form of concessional loans on convenient terms for setting up an income-generating unit to all persons with disabilities with 40 per cent or more disability and aged above 18 years. To attract women, loans are provided at a low interest of 1 per cent. Despite the incentive only 30 per cent of disabled who access the loans are women (Government of India, 2012: 18). There is a wide range of discriminations from exclusion in flagship schemes of the Government such as Right to Education (RTE), the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), Beti Padhao, Beti Bachao (Educate the Girl Save the Girl), which are also weighed down by lack of fiscal support. A recent study on programme financing says that 'there is no focus on gender and gender responsiveness on any of the programmes related to persons with disabilities across the country' (Equals, 2016). Gender-budgeting policy has not been applied for women with disabilities even in the disability-specific policies and schemes.

It seems that misleadingly being projected as incapable of productive work and a burden on the society, these stereotypes frame women with disabilities as being unfit either in the traditional role of homemaker or the newer role of wage earners. Additionally, stereotyping as asexual and lacking intelligence may further hamper opportunity and growth in the work market. One example is provided by women writers with disabilities emphasizing the issues of sexuality and asexuality (Chib, 2015; Goyal, 2016; Padte, 2016). Even though strong stereotypes of asexuality and hypersexuality configure the disabled identity, the complexity of disabled sexuality is lost in policy debates. It is therefore important that the State ensures through UNCRPD reasonable accommodation

in infrastructure and access to its programmes. The need for a specific mechanism to address harassment faced at work is particularly essential to their involvement in the workforce. For women with disabilities, this factor is reinforced by other elements, which override their dignity. In large multinationals that employ women with disabilities, it was observed by the author that the women are infantilized (pinching cheeks) or sexually abused. As explained, toilets are unisex so when a woman on a wheelchair goes in she cannot close the door and needs another woman to act as a guard.[7]

Laxmi Puri, Deputy Executive Director of UN Women, speaking at a panel with the author at the 58th Commission of Status of Women on financial inclusion of women with disabilities, very succinctly stated that 'the key to the economic empowerment of women with disabilities is with Member States. There are two international conventions and agreements that address women and girls with disabilities and offer guidance, including CEDAW and UNCRPD. Member States need to take full advantage of the reporting process to these conventions to put in place and expand national initiatives to support the financial inclusion of women with disabilities'.

Health: The Use and Misuse of Women's Rights

In policy development in India, following the medical model disability forms the central health concern for persons with disabilities. For women it has a wider connotation because of its linkage with overcoming barriers in health services including the high degree of violence inflicted on their bodies as a result of non-consent in medical practices. Indian policy does not take into account Article 12 of CEDAW and Article 25 of UNCRPD which provide for informed and free consent besides the right to reproductive and non-discriminatory health care. In the National Family Health Survey the main data source for women's health in India does not include data related to women with disabilities. Ultimately we lose out on our understanding of a very large group of women's health. In this area, a flagged realm of concern is rights of women with psycho-social and intellectual disabilities as they are most vulnerable in the system and are subjected to forced treatment and institutionalization on the grounds of care and protection regimes.

More women than men are found in mental hospitals/asylums and while men are admitted for treatment in early stages, women are dumped and abandoned only after their illness becomes chronic. A study of 20 reception orders for committal or continuation of detention in a mental health facility revealed that the person being committed is not presented before the court and has no say in a matter, which leads to the deprivation of his/her liberty and legal capacity (Davar, 2013).[8] Besides fraudulent confinement, the misuse of shock treatment through electro-convulsive therapy (ECT) continues despite its ill effects.[9]

> *Instances of Rape in Institutions*:
> In Kannauta, Rajasthan, five young girls with hearing and speech disability were raped by four NGO staff running a residential school. Two were repeatedly raped and two were beaten consistently (Delhi CEDAW Consultations 18th June 2013 by participant from Rajasthan).
>
> In Panvel, Mumbai, 5 girl children were raped in a shelter home in 2012 (Pune CEDAW Consultations 8th April 2013).
>
> Girls with visual and hearing disability were raped and subject to sadistic torture in Chandigarh, Lucknow, Allahabad, and Haryana, in large numbers (Cases compiled and presented by Bhargavi Davar, Pune, CEDAW Consultations 8th April 2013).

Human Rights Watch carried out a survey of 52 women incarcerated without their consent in Indian institutions. The appalling conditions in the institution ranged from unsanitary neglect, involuntary treatment, and violence. Twenty women and 11 girls had undergone ECT without consent contravening all human rights norms. Health care is not available in these institutes. Further, when women have been sent out to other hospitals, cases of sexual abuse have been noted on return but no action has been taken. As families and carers were the main perpetrators of violence, it is not surprising that the women did not have access to justice (Human Rights Watch, 2014: 10–25).

Contraceptives provide women with reproductive choices, but in the case of women with disabilities they are a cause in the violation of women's rights. Forced sterilization within institutions and by family is public knowledge although it is a human rights violation (Phadke, 1994).[10] Non-consensual use of these deprives women with disabilities of legal capacity and violates their right over their bodies. In recent years, the availability of sterilization methods using certain drugs is being tried out in urban India; in rural areas most resort to surgery and home methods.[11] Forced sterilization, hysterectomies, and forced abortion of women with intellectual disabilities are forms of 'menstrual management', that are human rights abuses, which have been challenged in the

Suchita Shrivastava case.[12] The UNCRPD under Article 23 and the CEDAW General Recommendations No. 19 (11th session, 1992), General Recommendation No. 24 of 1999 and General Recommendation No. 21 (13th session, 1994) recognized the existence of forced sterilization and has recommended for the ending of this violation.

In the case of surgery, medical and psychiatric treatment, abortion and sterilization of people, especially girls and women with disabilities, the UNCRPD Monitoring Committee has directed its prohibition through repeal of law, formulation of new law, and strict compliance with a code of conduct regarding full and informed consent (IDA, 2013). Despite CEDAW and UNCRPD Committee recommendations there are no legal provision that prohibits non-consensual sterilization of women with disabilities. The women are rarely involved in family planning services related to pregnancy and post-natal care.

The Office of the High Commissioner for Human Rights has argued that the lack of sexual education amongst women with disabilities who are wrongly perceived as non-sexual beings contributes to violence against them as they are unable to distinguish behaviours (Office of the High Commissioner for Human Rights, 2012). Consequently the UNCRPD Committee also recommended that sex education be taught to adolescents with intellectual disabilities (United Nations CRPD Committee, 2011a). The CEDAW Committee also called for a gender-sensitive education on sexual and reproductive health and rights in schools (CEDAW, 2013). Sexual education is a contentious issue in the country.

A minimal human rights health regime is threatened further by policies of euthanasia. A marked preference for male child with link to increased diagnosis of the sex of the unborn child has resulted in use of sex determination methods across India. The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act (1994) prohibits sex selection but unfortunately allows abortion/selection on the basis of disability. Social and medical pressure by use of genetic counselling to do away with the foetus takes away women's rights over their bodies. The outcome of the Act is the strengthening of social construction of disability as an affliction that can be removed by technology when the aim should be to create gender equality.

Violence and Torture on Women's Bodies in Public and Private Spaces

Violence in all its facets remains a serious area of concern for women with disabilities, both as an individual experience and a structural reality that systematically oppresses them in all areas of life. Adding to the greater vulnerability of becoming victims are a multiplicity of other factors, such as severity of the disability, dependence on the abuser, communication limitations (for instance, women with speech and hearing disabilities, intellectual disabilities), easy access to women in institutional set-ups, low or non-credibility to complaints of harassment and abuse by women with disabilities (particularly women with psycho-social and intellectual disabilities), myths around sexuality (women with disabilities are asexual or hypersexual) and the whole range of socio-economic and cultural factors that configure the lives of non-disabled women in patriarchal society. A recent snapshot review of media reportage on sexual violence against women with disabilities shows a variation of perpetrators (neighbours, fathers, and strangers), increased violence as per type of disability, age of disability (children to women of 90 years) across India.

In cases compiled by the author from press reports on 16th April 2016:

- A *60-year-old* woman with *visual impairment* was raped by an unidentified person in a village who *entered the house* of the woman (*New Indian Express,* 3 April 2016).
- A *28-year-old* Nepalese woman with a *psycho-social disability* went missing on 1 February in the town of Rohtak in Haryana, where she was seeking *hospital* treatment. Her mutilated body was found in a field on Wednesday. A post-mortem examination has confirmed multiple sexual assaults (BBC, 9 February 2016).
- A *30-year-old* woman with *hearing and speech disability* was allegedly sexually assaulted by a 22-year-old man inside a *private bus* at Pushp Vihar in south Delhi. The woman was on her way back after getting food from a shop (*Times of India*, February 4, 2016).
- A *45-year-old* woman *with hearing and speech disability* was allegedly gang raped and thrown from a *train* at Lalitpur Railway Station on Friday night in Uttar Pradesh and thrown from the train while it slowed down at the railway station (IBN Live, January 23, 2016).
- A *17-year-old* girl with *psycho-social* disability became pregnant after she was allegedly raped repeatedly by her *father* in East Godavari district of Andhra Pradesh (*Times of India*, 6 January 2016).
- The Karnataka police arrested two people for allegedly raping and killing a *speech and hearing-impaired* woman in Bagalkot, central Karnataka (*India Today* in News September 8, 2015).
- *An 85-year-old* woman with a *visual impairment* was been raped at a *border village* Shahpur Jajan under

Dera Baba Nanak, by a 45-year-old a resident of same village and who, under the influence of liquor, entered the house and raped her (*DNA*, 21 August 2014).

- Jashpur police arrested three youths for *gang-raping* a *16-year-old visually impaired* tribal girl multiple times soon after which the girl got pregnant and delivered a baby (*Times of India*, 7 May 2014).
- Police registered a case of rape, after a woman with a *psycho-social* disability aged *about 30 years* was found to be 14 weeks pregnant in the Meghaninagar area, raped by an *unidentified man at an unknown place*, New Delhi, she was admitted into a government run mental hospital in the area (*Zee News* 16 July, 2015).

Other instances from research include a parent battering a young child for not being able to meet the 'normal' standards of studying, locking up, or beating a girl with intellectual disability because she does not understand the societal gendered norms, and using forced hysterectomy on a young girl because she does not comprehend the standards of hygiene or may be 'raped', leading to pregnancy. The pregnancy is terminated as she 'may' not be able to take care of the child.[13] These examples establish the similarity between torture and violence in disability situations, as the perpetrators enjoy impunity despite the cruelty and an escalation of harm that results in avoidable and severe physical and mental torture (WWD India Network, 2013–2014). The extent of sexual violence can only be estimated based on media and civil society reporting and localized research as the National Crime Records Bureau which provides data on violence against women does not provide any on women with disabilities.

The critical areas of concern on the issue of violence are found both in public and private spaces especially in the latter (Hans, 2016). Institutions in relation to women and girls with disabilities includes mental health facilities, care-homes, residential hostels, halfway homes, homes for the destitute, juvenile homes for children with special needs and religious places. Within these locations, violence can range from chaining, filthy living conditions, non-provision of clothes especially during menstruation, physical abuse, and sexual violence often repetitive in nature. However, there is no governance response to the problem of systemic violence of this sort (WWD India Network, 2013–14 and Hans, 2016).

As per the Mental Health Act of 1987, the only penalty for privately run institutions is revocation of license, which can be renewed after payment of fine and improvements suggested by the authority. Thus, State responsibility and accountability of personnel becomes even less in institutions run by private entities and non-existent in case of religious places, where it is very common to take women with psycho-social disabilities for treatment through prayer and black magic. Sexual violence within mental hospitals still is a largely unaddressed area apart from the other forms of mental and physical violence that is experienced by the women housed therein. Moreover, the insensitivity of officials, staff of institutions, and carers towards issues of abuse only compounds the problem. In recent years there has been increased reporting of violence against women with disabilities also in shelter homes, training institutes and schools,[14] which portrays an extensive array of spaces where violence takes place (Women with Disabilities India Network, 2014).

Although the Protection Against Domestic Violence Act, 2005 in India is being implemented to address issues of violence and abuse in the domestic setting for all women, women with disabilities continue to face serious abuses at the hands of relatives.[15] These include the deliberate acts of seclusion, denial of basic amenities, chaining, mental abuse, emotional deprivation and abandonment (Women with Disabilities India Network, 2014). For women with disabilities, abandonment happens at two levels, one due to their disability and the other when they are discovered to have been victims of sexual violence, especially in instances where they have conceived as a result of the abuse. In both cases, their vulnerability increases to more sexual abuse in the society by their unprotected and homeless state of being. From the point of view of disability, there are striking shortcomings in addressing violence and abuse in the home setting, as the law does not cover carers. Incest is another problematic issue to counter in a society which keeps women powerless and their low esteem stands in the way of their standing up to violence. Although abuse and violence within families for gaining control of property (immovable and movable) left for the benefit and care of a disabled family member is common, women with disabilities caught in such scenarios are worse off than their counterpart men with disabilities due to the added dimension of gender.[16]

Most of the violence is manifested as a power structure of not only male power over female power but is also extended in the case of disability to female power over women with disabilities. This patriarchal order posits a hierarchy of moral inclusion and exclusion divided by those with more value than others. CEDAW (Article 15) and UNCRPD (GR No 12 and Article 16) recognize the issue of violence and provides for protection from

torture, ill treatment, exploitation, abuse, and violence. To address issues of State responsibility these provisions, when read along with the broad principles of equality and non-discrimination and the specific provisions of elimination of prejudice under Article 5(1) and legal capacity in Article 15 of CEDAW, would provide a more responsive legal framework, a stricter mechanism of monitoring and accountability.

Wives and Mothers

The discourse on motherhood is a continuation of a long-standing feminist concern, however women with disabilities have remained outside this discourse. Though motherhood should be a conscious choice, in the case of disability, it is burdened by various compulsions laid down by society and the health system. Many women with disabilities, especially those with intellectual disability are denied family life and motherhood. Stereotypical views of women with disabilities results in their staying outside family life. Many women with disabilities are married off as second wives, with no legal standing to claim any matrimonial benefits or protections, thus getting entrapped in marriages where they are exploited, abused, and violated with no system of checks.[17] Incapacity laws in family courts, for instance in Pune, used 'unsound mind' in most divorce proceedings. One marriage was annulled on the basis of finding a 'moderate depressive episode with somatic syndrome' and a case filed on ground of insanity, fraud, and supposedly six previous sexual relationships (Women with Disabilities India Network, 2014).[18]

This exclusion of women with disabilities from their home and role of wife extends to motherhood.[19] A mother with a disability confesses that while parenting is perceived as a normal feature of adult life, in the case of women with disabilities, society, including professional organizations, friends, and family think that they cannot be good mothers (Limaye, 2015: 133). Most women are advised by doctors not to have children, and some have to undergo multiple abortions (Hans, 2016).

To overcome this instead of using the legal framework many States have started a systematic coercion into marriage. A shockingly unethical scheme is in operation contributing to increasing violence on women with disabilities in the guise of enhancing their matrimonial opportunities. States like Maharashtra, Odisha, Chhattisgarh, and Himachal Pradesh are running schemes of paying financial benefits ranging from 5,000–50,000 rupees to non-disabled persons to marry Persons with Disabilities (Gupta, 2010).[20] Women with disabilities not only lose their dignity but may be highly prone to being used as a means to access this incentive money. In-depth research is needed to recognize the impact of this scheme. Women with disabilities in general have disapproved it and suggested work to make women independent so that they do not need State support.

Achieving Justice and Equality Before Law

To contest the multiple levels of discriminations equality remains central to a human rights discourse and must be attained within the broad parameters of justice. Inequality in the space of rights, gender being the prime example affects the choice of many women, especially those at higher risk. Under the UNCRPD (Article 5.1), States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law. Inequalities which exist at various levels, can be removed by the adoption of a framework of justice. Ideologically, justice surfaces as the overarching normative principle under which disability policies should operate generally and specifically within the broad structure of a disability-oriented feminist thought.

To realize justice is not an easy task as sometimes the law itself is unequal and unjust as reflected in the fact that women with disabilities continue to remain far from achieving either de-facto or de-jure equality. A legal interpretation of equal recognition before the law has been covered in various Conventions, ratified by India. The two crucial components, legal capacity and access to justice are found in CEDAW (Article 15) and UNCRPD (Articles 12 and 13). In India, The Persons with Disabilities Act, 1995, did not include legal capacity and The National Trust Act limits equality by providing guardianship arrangements for those with autism, mental retardation, cerebral palsy, and multiple disabilities. The 'unsound mind' clause in the Constitution of India deprives men and women with certain disabilities such as psycho-social, intellectual disability, and autism from exercising rights as provided by law. For instance, the Representation of People Act 1950 disqualifies them from electoral rolls and standing for elections. No attempt has been made to remove this provision, which takes away a person's right to citizenship.[21] A large part of family laws are about people of unsound mind, and deny capacity to be married, stay married, adopt, inherit, terminate a pregnancy, choose a pregnancy, etc. Some of these laws have guardianship

provisions which limit women's right to an independent life. Conditions are placed on the capacity of persons with disabilities in making a will as a 'lunatic' cannot probate or administer a will. Persons who are blind or 'deaf and dumb' can make a will provided they can understand what they are doing (Davar, 2012).

The failure to provide reasonable accommodation is a signal that the system as provided by the UNCRPD is not working. Article 13 of UNCRPD on Access to Justice requires the abolishing of rules that limit or establish as void the capacity of persons with disabilities to testify, thus connecting this article with the issue of legal capacity. The laws that enable the removal of legal capacity and substituting it with guardianship need to be removed and replaced with a system of supportive decision-making. The right to full legal capacity is the recognition of the legal status of a person in the eyes of the law. It establishes a regime of rights to full inclusion and participation, and enjoyment of fundamental rights.

The notion of justice and equality resonates in Article 1 of the Universal Declaration of Human Rights, which states that all human beings are born free and equal in dignity and rights. Women's own contribution to the justice and equality debate began earlier in 1792. In her seminal work 'A Vindication of the Rights of Women', Mary Wollstonecraft wrote that justice, rather than charity, is wanting in the world. It is no historical irony that this statement fits into our present day discussion related to women with disabilities (Hans, 2015: 4). In spite of all the discriminations, the invisibility and the stigma a leadership amongst women with disabilities has emerged. The four hundred women who contributed to the CEDAW Alternative (Shadow) India Report have been leaders in their own right. From academics, to rural SHG leaders, to NGO heads to indigenous women their contribution to women's cause cannot be denied. As more women come out to lead the disability movement, the patriarchal structures start to crumble beginning a new era of equality and justice.

* * *

It is submitted that any comprehensive plan for transforming the status of women in the country must be both gender and disability-sensitive. This can be enabled using the two existing Conventions by bringing them to the attention of the women and the State. It is also imperative that we highlight the Concluding Comments and General Recommendations made by both CEDAW and UNCRPD Committees. This Chapter did not include many other issues such as using bodies for testing by drug companies, trafficking, conflict zones, safe cities, and accessibility. It limited itself to the issues brought before the 4th and 5th India Periodic Report 2014 before the CEDAW Committee. The CEDAW monitoring committee in return in its Concluding Observations (COs) at their 58th session in response to 4th and 5th India Periodic Report (2014) provided wide ranging recommendations to the State which included collection of data, including of women in the Rights of Persons with Disability Bill (2014). It incorporated a specific section to protect women and girls with intellectual disabilities from forced sterilization, recommended repeal of laws, and disability based detention of women, including involuntary hospitalization and forced institutionalization (United Nations, CEDAW, 2014). It is now the work of the government and civil society to take the issue forward so that justice is done to a mostly invisible group of women.

Notes

1. This chapter updates the report submitted to the CEDAW Committee (1 July 2014) in response to the Combined Fourth and Fifth periodic India Report. The author is thankful to the Women with Disabilities India Network and especially Renu Addlakha who helped write the report. Also to Bhargavi Davar, Anjlee Aggarwal, Meenakshi Balasubramaniam, Ratnaboli Ray, Jeeja Ghosh, Shampa Sengupta, Reena Mohanty, and many other women who contributed to it. The chapter was part of the alternate report prepared by the National Alliance of Women's Organization. The author carried out, with Shanta Memorial Rehabilitation Centre, 15 workshops across India and met about 500 women with disabilities, whose suggestions were included in the chapter.

2. The Constitution of India under Articles 14 and 15 can be applied in the context of disability. Directive Principles of State Policy mention disablement.

3. In a query made to the Ministry of Social Justice by the author the Bill is 'under examination' but public has no information on its content (letter dated 3rd May 2016 by Under Secretary to Government of India No 13-19/2016-DD.III).

4. The bill was stalled and after the new Government (BJP) came to power in 2014, it was sent to the Standing Committee of Parliament. At this stage after advocacy by women's groups, the Standing Committee included a full chapter on women. However the Government referred the old draft bill supposedly to a three member Group Of Ministers in 2016. The letter above (note 3) does not mention that it is with the GOM.

5. Intersection could take place using: Gender equality: UNCRPD Article 6 and CEDAW Article 3. Education

UNCRPD Article 24 and CEDAW Article 10 Work and Employment UNCRPD Article 27 and CEDAW Article 11 Health UNCRPD Article 25 and CEDAW Article 12 Equal Recognition Before the Law CRPD Article 12 and CEDAW Article 15 Violence CRPD Article 16 and CEDAW General Recommendation No 12 (8th session 1989) Home family marriage CRPD Art 23 and CEDAW Article 16 Social Protection CRPD Article 28 and CEDAW Article 11 and 14. Besides there are a large number of Recommendations by the CEDAW Committee and as a Committee member has argued all the CEDAW provisions are applicable for use by women with disabilities (Schulz, 2013).

6. The Women with Disability Network founded in 2012 by the author carried out consultations with women with disabilities from 2013 to 2014 for a shadow report. These meetings across India were with assistance of Shanta Memorial Rehabilitation Centre Bhubaneswar funded by the Disability Rights Fund.

7. CEDAW Consultation by author Bangalore 4 February 2013. See also Agarwal (2014).

8. An RO is an involuntary admission made under the MHA, by bringing a person before a court for certifying as mentally ill and adjudicating right to liberty, to further admit that person in the asylum. A total of 20 reception orders were looked at of 2010, from the court of the chief magistrate, Pune district court, Pune.

9. A young women sitting quietly and listening to Malini Chib, an icon in the women's movement speaking on sexuality in a meeting the CEDAW Consultations in Pune on 8 April 2013, finally broke silence to speak of her husband having her incarcerated forcefully and treated in a mental asylum. Separated from her children she was told by the doctor that she was being treated for being angry and suspicious. Put on high drugs and ECT without her consent finally she broke free and stopped her medication and found that she was better without them. Her husband then filed for divorce and filed for custody of the children and their flat. Her case is in the family court, her husband pays her INR 7000 as interim maintenance when his earning is INR 15,0000 per month and has taken the children from her (Pune women with disabilities meeting).

10. This was a major point of discussion at the regional meeting of the women with disabilities, India Network, organized in Hyderabad on 23–24 February 2013.

11. Women with Disabilities India Network. 2012 and CEDAW Consultations in Bangalore on 4 February 2012. Information by local NGO using these methods.

12. In a strongly fought case with Supreme Court intervention, a High Court ruling of forceful termination of pregnancy of a girl with intellectual disability who had been raped in a state-run shelter was overturned and the girl allowed having the baby. *Suchita Srivastava vs. Chandigarh Administration*. (2009) 9 SCC 1.

13. *Suchita Srivastava and Anr vs. Chandigarh Administration* (2009) 9 SCC 1.

14. On 8 August 2013, a female trainee was raped by an instructor in the Vocational Rehabilitation Centre for Handicapped, Bhubaneswar.

15. A 30-year-old woman reported that her husband married her sister after she sustained a spinal injury, and after two years she had been abandoned by them (Bhubaneswar, CEDAW Consultations 8th January December 2012).

A woman with disabilities was married as a second wife near Madurai in Tamil Nadu. But once the government benefits were announced after forty days of marriage, she was tortured and could not file a case as she was from a rural area there was no legal aid (Chennai CEDAW Consultations, 6th February 2013).

16. 'I have a property. My brother has forcefully taken it away. I am now living in a small hut sleeping on the ground' (Chennai CEDAW Consultations, 6th February 2013).

17. This was raised as a serious area of concern by women with disabilities during the CEDAW consultations held on the issues of women with disabilities by the author from October 2012 and June 2013.

18. Cited in Pune on 8 April 2013 during CEDAW Consultations. Also see *Vinod Vilas Arabale vs. Ms Shilpa Vinod Arabale* Petition No. A No. 487, 2011.

19. Nita Panchal, a disabled due to the earthquake in Bhuj on 26th Januray 2001, went on to marry and when she was pregnant her doctor counseled her not to have a child. Nita went ahead and is today the mother of a 10- year-old son. Nita is an activist leader in Gujarat.

20. Shivani Gupta's initial discussions with disability activists started a process of protests.

21. Section 16 subsection 1; Section 102 sub section 1; and Section 191 subsection 1 are the articles of exclusion. Other Acts which entrench the exclusion are the MHA 1987, RCI Act 1992 and National Trust Act 1999.

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3

Girls with Disabilities in India

Living Contradictions of Care and Negation

Nandini Ghosh and Supurna Banerjee

'People said so many negative things when Subu was born with a disability…But we no longer feel disappointed, Subu's resilience, confidence, and courage has given us hope.'

—(Subu's mother, Odisha)

'She likes to dance. She has some instruments made of plastic. She herself plays those instruments and dances when she is alone in home.'

—(Rupa's mother, Jharkhand)

'We cannot afford to spend too much, but we work very hard to ensure Shila continues her education. I want her to study and do well.'

—(Shila's mother, West Bengal)

The life experiences of young disabled girls have to be understood within the realities of poverty, illiteracy, and lack of support that characterizes the lives of these girls and their families. At the same time, these are also narratives of courage and resilience not just of the girls themselves but with them, often of their families too. According to the Census of India 2011, 2.21 per cent of India's population is disabled, of which disabled men constitute 2.41 per cent of the total male population of the country and disabled women 2.01 per cent of the total female population. This seems to suggest that prevalence of disability is higher among males than females. In the age range of 0–19 years, persons with disabilities formed 1.6 per cent of the total population accounting for 1.7 per cent of the male population and 1.5 per cent of the female population in this age range. However the differences in the prevalence of disability across all age groups can also be explained by gendered cultural contexts we live in, where sons, disabled or not, are treasured and thus counted within family while daughters are usually still considered a liability.

This chapter attempts to unravel the specific situation of girls with disabilities in India in the age group of 0–18 years in order to understand their life experiences within their socio-economic and cultural contexts. It proposes to examine the lives of these disabled girls, across a range of impairing conditions, from mostly rural settings, in order to reveal the present situation in terms of access to services, support structures, and entitlements, both institutional and non-formal, which impinge on the lives and everyday experiences of these girls and their families. This chapter, is based on case studies conducted in three states in Eastern India—West Bengal, Odisha, and Jharkhand. The chapter explores the role of families and communities in the ways in which they offer support to or discriminate against girls with disabilities in specific ways that affect how these girls are allowed or denied the enjoyment of rights and a basic quality of life similar to all others in their own socio-economic circumstances.

Situating Girls with Disabilities: A Review of Literature

In a context of persistent poverty and marked social inequalities, women and girls living with diverse forms of disabilities are triply or multiply challenged (Hans, 2003). The violation of rights of persons with disabilities through multiple physical, social, economic, educational barriers reveals the level of neglect, isolation, stigma, and marginalization that characterize the lives of disabled persons, especially disabled women. The situation of women with disabilities is particularly poignant as they suffer from 'triple burden of oppression' due to their disabilities, gender, and economic status.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) defines disability as 'an evolving concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full-participation in society on an equal basis with others' (Chappell, 2014). However discussions around disability have ranged from medical-psychiatric discourses to a social and human rights perspective. Disability activists have focussed primarily on the social and environmental barriers associated with the public sphere which inhibit the participation of disabled people in different realms of social living. Disabled feminist scholars posited an alternate understanding of disabled women in order to understand how bodies—marked by gender and by disability, by impairment and sex—are formed in, created by, and acted upon by society, and also act within and impact society (Morris, 1998; Schriempf, 2001). The simultaneous experience of gender and disability highlights the ways in which bodies interact with socially engineered environments which includes the natural environment, built environment, culture, economic and political systems, and psychological factors, and conform to social expectations (Garland-Thomson, 1997). The disability of an individual interacts with the different gender role expectations determined by historical, religious, ideological, ethnic, economic, and cultural factors (Bacquer and Sharma, 1997). The experience of being disabled does not operate in isolation, but interlaces closely with other variables of gender, social class, caste, religious affiliations, geographic location, and family composition; gender being the most defining element in the disability experience. In this sense, disability, then, is a comprehensive identity category that cuts across the others and draws its membership from several other identity groups (Hans and Patri, 2003).

Research around disabled women has often argued that they experience simultaneous handicap, because they are female in a patriarchal society, disabled in an ableist society and also as they are disabled women (Lloyd, 1992). In the areas of education and employment, most studies found disabled women to be grossly disadvantaged. Women with disabilities receive less education than non-disabled women and men with disabilities (Traustadottir 1998). Disabled women from differing social situations felt that rehabilitation programmes were designed to suit disabled men's aspirations for recovering their masculinity and sexuality, while the needs of disabled women were often ignored (Begum, 1992; Morris, 1993). Most studies reveal that disabled women have less access to the benefits to be gained from governments and other organizations than disabled men. Although people with disabilities face discrimination in employment, women with disabilities fare worse than disabled men, in terms of training as well as employment. The belief that men are breadwinners and women homemakers has a great influence on training and employment patterns of disabled men and women. Disabled women are more likely to be unemployed, or engage in unskilled labour that also pays less (Lonsdale, 1990). Women with disabilities have historically been denied the traditional roles of homemakers and mothers, which were considered inappropriate for them (Asch, 2001). As disability is linked with asexuality, marital and reproductive prospects of disabled women are seriously affected.

Indian and other Asian studies have corroborated the findings of studies conducted in the western countries. Disabled women have lesser access to rehabilitation services like health care, education, vocational training opportunities, mainly because of their social and cultural isolation and the reluctance to approach the predominantly male service providers (NCPEDP-NAB, 1999; Thomas and Thomas, 2002). There are rural urban differences in the ways in which women with disabilities face double discrimination. In rural areas, disabled girls are more prone to life and health risks because of parental apathy towards the girl child (Maqbool, 2003). In India, a sizeable number of girls and women with disabilities have been reported to be permanently in poor health, with the added risk of falling ill frequently (Bacquer and Sharma, 1997). In cultures where daughters are looked down on, a disabled daughter is seen as a curse as she has to contend with disappointment over her birth as well as her disability (Ghai, 2002). Often disabled girls are forbidden to leave the home as her presence brings shame and dishonour to the family. However restrictions on disabled women vary culturally as well as by the type of disability. In spite of the external cultural restrictions, girls with disabilities have been found to participate equally in most types of household work carried on within the home (Abu Habib, 1997).

Women with disabilities face double invisibility both as subjects and objects of desire, as the social perception of disabled people as asexual impinges on their identity and experience as feminine beings (Ferri and Gregg, 1998). A major area of concern that has emerged in developing countries is the abuse of women with disabilities within the home, at the institutions they may be living or working in, by medical professionals, and within the community. Disabled women are more vulnerable to domestic violence, and their social isolation usually acts as a barrier to seeking help. As disabled women are in

a state of physical, social, and economic dependence, they experience abuse for longer periods, and are likely to be abused by a greater number of perpetrators, with increased risk for women with disabilities living in the cities. The violations against disabled girls go unreported as they as well as their families do not have the courage to approach the legal and police systems (Bacquer and Sharma, 1997; Maqbool, 2003). Being on the fringes of society, with less knowledge, protection culture, women with disabilities become potential targets of rape and sexual violence. Systematic prejudice and gender discrimination continues to violate women and girls' right to experience their sexuality, and/or to have sexual relationships/families.

The inclusion of disability in Indian legal jurisprudence and public policy is a fairly recent development. Concerns on the rights of the disabled in India gained visibility through a cluster of legislations enacted by the Parliament—Rehabilitation Council of India Act (1992); Mental Health Act of 1987 which came into effect in 1993; Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act (1995) and National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act (1999). Landmark judgements delivered between 1996 and 2007 under the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act consolidated disability jurisprudence in India. The UNDP-Government of India report (2007) on the socio-economic status of women with disabilities in India revealed the numerous challenges faced by disabled women—'in the absence of well-coordinated government policies aimed at integrating disabled people in mainstream activities, disabled women live under extremely difficult conditions'.

Methodology

The report is based on empirical data collected from the three states of Jharkhand, Odisha, and West Bengal using qualitative research techniques like in-depth interviews and case studies. Fifty-eight girls with disabilities in the age group of 6–18 years and their families were met in a period of three months to try to understand the ways in which disability and gender influences their life experiences. In case the girls were unable to communicate with us, we spoke at length with their parents and family members who were their primary caregivers. The respondents were mostly from rural areas and belonged to poor families. Tables 3.1, 3.2, and 3.3 give a spread of the respondents in accordance with their disabilities, religion, and caste.

Looking at the range of these disabled girls in terms of religion, there are 38 girls from Hindu families, 8 girls each from Muslim and Christian families, and 4 girls from families that practise tribal forms of religion.

Table 3.1 State-wise Distribution of Disability

Disability	Odisha	Jharkhand	West Bengal	Total
Hearing impairment	2	5	3	10
Locomotor disability	8	2	6	16
Mental retardation	5	7	3	15
Multiple disability	3	2	–	5
Visual impairment	1	2	1	4
Cerebral palsy	–	2	6	8

Source: Fieldwork data, 2015–16.

Table 3.2 State-wise Distribution of Religion

Religion	Odisha	Jharkhand	West Bengal	Total
Muslim	–	2	6	8
Hindu	18	7	13	38
Christian	1	7	–	8
Tribal religion	–	4	–	4

Source: Fieldwork data, 2015–16.

Table 3.3 Caste-wise Distribution

Caste	Odisha	Jharkhand	West Bengal	Total
Scheduled caste	6	3	3	12
Scheduled tribe	8	15	–	23
Other backward castes	–	2	5	7
General	5	–	12	17

Source: Fieldwork data, 2015–16.

The ethnic distribution of the disabled girls reveals that 12 girls belong to scheduled caste families, while 23 of them are from scheduled tribe families. There are 7 girls from other backward castes and 17 girls belonging to general caste families.

There is a clear trend in the three different states with the contexts influencing the experience of disability as will be discussed later. Across the states, however, the girls with severe disabilities remain in the most fragile condition.

Living with Disabilities

This section explores the lived experiences of the girls with disabilities in four primary areas—access to rehabilitation facilities, care and support from parents and other caregivers, neglect and abuse, and access to education. While these areas have been conceptually separated in order to be able to better represent the lives of the girls with disabilities, it must be kept in mind that these are not exclusive compartments but have considerable overlaps with each other. Each of these circumstances in the girls' lives influences the others, but for analytical convenience the four areas have been highlighted separately as each reveals the ways in which the quality of life of girls with disabilities is affected in significant ways. It is the combination of all these areas that together shape the life experiences of these girls.

Rehabilitation: Access to Treatment and Institutional Support

The experience of disability has been linked to the severity of the impairments that one has but it is also clear that early identification and interventions towards management of impairments can lead to a better quality of life for any disabled person, especially as they grow older. However in India and especially in the rural areas, there are hardly any services available for early identification and intervention and this clearly affects the life chances of all children with disabilities, and especially girls with disabilities. Among the three states where the research was conducted, the girls living in West Bengal have benefitted most from such rehabilitation services, but this can be attributed to the fact that they are located close to the urban centre. Another facilitating factor is the presence of a NGO working specifically with disability, and this is evident both in West Bengal and Odisha which has helped parents and families of disabled girls to link up with or themselves provided rehabilitation support services at the community level. There is also a clear disability-wise divide in access to state sponsored rehabilitation services—many of the girls with locomotor impairments have been able to access mobility aids like wheelchairs, tricycles, and callipers and crutches, while girls with hearing impairments have to some degree, been able to access hearing aids. However, the availability of regular interventions like sign language training, training in Braille, and training for mentally impaired girls in life skills and daily living activities are completely missing. In terms of linking disabled girls to entitlements, the disability certificate which is the official document that grants access to government benefits, has been accessed by only 50 per cent of the disabled girls, with the highest number in West Bengal and the least in Jharkhand. The difficulty of accessing the disability certificate which involves not only a lot of paperwork but also several trips to the district hospital deters many families from getting one, as they cannot afford to miss work and thus the pay to spend money on something which is of little value to them.

One thing that emerges clearly, contesting the theories of neglect of girls with disabilities, is that across states, although parents are devastated by the onset or birth of a girl with disability, almost all families have sought some medical or other intervention to improve the condition of their impaired daughter. Almost all the girls with disability were taken to the doctors, mainstream, or alternative, within the first two years of the onset—by this time all parents realized that their daughter was not developing like other children and needed help. While in West Bengal and Odisha most parents went to the district hospitals and Primary Health Centres (PHCs),

in Jharkhand there is a clear trend of accessing alternative medical service providers as these are readily available while the mainstream service providers are only available in district hospitals which are not always easily accessible to them. Piya (West Bengal) was born with club feet and was taken to doctor's clinic at the age of 1 month. She underwent her first surgery at 6 months of her age and subsequently had 2 more operations to correct the deformity, which cost the family Rs. 25,000. From the PHC to the district hospital to private doctors, families have spent large amounts of money trying to mitigate the effects of the impairment.

However these efforts have often been in vain as even trained medical doctors in the district hospitals and in the PHCs mostly do not have any knowledge of possible interventions for disabled people, thus turning them away by asking them to address malnutrition, rather than the condition of the child. When Rupali (West Bengal) was born with a 'deformed' right hand, her parents took her to a government hospital at the age of 1 month. After examination, the doctor informed them that as this condition was 'incurable', they should look after their daughter's nutrition. There was no proper guidance about the possibility of using a prosthetic limb. Hence even though there was early identification, it was of little use as there was no access to early interventions. In other cases negligence and lack of proper treatment have exacerbated the condition of the child. Mita (Odisha) at the age of six or seven started having epileptic fits. Once when she had to be admitted to the district Hospital as she was unconscious, she was administered saline. She regained consciousness but lost use of the left hand, where the saline needle had been inserted. Lata (Odisha) started having mobility problems at the age of 10 years and doctors diagnosed it as juvenile arthritis. In 2014 she suffered a fall and broke her leg, which was then not set properly in the local government hospital. Since then she has been confined to bed and cannot walk at all. For girls with hearing impairments, lack of specialists and awareness hampers their development process. Phool (Jharkhand), 10-year-old girl with deafness, was taken to government hospital when she was very young, but came back because there was no ENT specialist.

Families with access to urban centres and through the NGOs to Kolkata have sought the best possible advice and intervention for their daughters. Rupa (Jharkhand) and Saloni (Jharkhand), both deaf, were taken by the local NGO to another NGO in West Bengal that specializes in deafness. From there, both have received hearing aids which have improved their lives to some extent, but the ongoing sign language training is helping them further to communicate better with friends and family. Reema (Jharkhand), having congenital shortening of left leg, was taken by the local NGO to a NGO run hospital in Kolkata for surgery, mobility aids, and gait training in 2013, resulting in improved mobility for her at home. Early interventions have resulted in the improvement of the girls' condition and led to a better management of the impairment. Jaya (Jharkhand), 13 years and having locomotor disability, has been guided by the field workers of the local disability focussed NGO in the past few years leading to a vast improvement in her physical condition. Jaya's mother recalls, 'In the beginning Jaya would cry due to pain and would vomit. But, we persisted as this was the only hope we had. Now she is able to move about and go outside also'. Julie (West Bengal) who has cerebral palsy has improved much after the field workers of the local NGO showed her mother exercises to improve her mobility, although it has taken years before the changes were visible. Parents seek help from other parents in the similar situation. Lipika's (West Bengal) mother said that they had tried everything—from doctors to medicines to therapy—for her but nothing helped. 'When I was running around hospitals with Lipika, we met Riju's (a boy with cerebral palsy) father. He told us to take her to the NGO where his son was going, where they said physiotherapy is the only cure and it was actually helpful'.

Alternative to medical treatment, families and parents have gone to traditional healers, *vaids* and even spiritual *gurus* in the hope of finding a solution to cure the impairment of the disabled girls. This is because most parents want to give the best possible upbringing to their disabled daughter. Tara (Jharkhand), 10-years-old, with profound mental impairment was taken to a *vaid* in the village. 'We were told that there is no cure for this child. We have taken her to various doctors and *vaids* and even to the district hospital and spent a lot of money on oil for massage to help her to get up and walk'. Usha's (Jharkhand) parents are both daily wage earners yet they have tried their best to ensure she improves her condition. From different hospitals in Jharkhand and Kolkata to *vaid*s to *tantrik*s to a *kabiraj* in West Bengal, they have tried medicines, massage, and totems. However many find it difficult to sustain the expensive treatment recommended by these different groups of healers.

Contact with NGOs that provide disability related services and link them up with public and private medical services have helped in mitigating the situation. Parents guided by grassroots level workers of the local NGOs, wherever possible, have taken initiatives to help

their disabled daughters to gain their developmental milestones. Hema's (Jharkhand) father has built a bamboo structure for her in their courtyard within which she can stand upright and practice walking. Muni's (Jharkhand) father has crafted a crudely made walking frame for walking around so that she does not become further disabled. Parents have been taught how to help their child to perform activities of daily living and exercises for achieving the developmental stages. 'We regularly did the physical exercises shown to us by the NGO staff. When we started, she used to move forward with the support of her chest. After a few months she was able to sit up and then crawl', says Lipika's mother (West Bengal). But many parents find it difficult to make time for the same given the fact that they have to labour hard for their living and existence. Usha's (Jharkhand) parents have not been able to continue the exercises shown to them as both have to toil hard for their living throughout the day.

Thus, as mentioned before, girls with locomotor disability have benefitted the most from the rehabilitation services like surgery, mostly at private institutions and supportive aids and appliances like callipers, crutches, wheelchairs, or tricycles. However use of callipers and wheelchairs, etc. depend, both on the degree of impairment and also on the terrain in which the girls operate. In the village, use of wheelchairs can be quite restrictive as the girls are not able to move out of the home at all. Usha (Jharkhand) having cerebral palsy and confined to a wheelchair finds herself further restricted because of the terrain in and around her home. The mud house, surrounded by a large field offers minimal opportunity for Usha to move out of her home into public spaces, as she is unable to walk at all. However older girls with disabilities who are accessing schools use the tricycle more in areas where roads are in a good condition. Piya (West Bengal) uses a special shoe fitted with an iron plate, which helps her stand straight as well as help her to put her foot flatly on the floor. Moreover, they are regularly doing physiotherapy at home with the advice of the staff of the local NGO to enable her to walk properly. Lipika uses a calliper or a walker when she goes out of the house. Shila (West Bengal) who has CP has been fitted with callipers and leg braces with the support of the NGO to help her to walk.

Some of the hearing impaired girls have been able to access hearing aids or sign language services provided to them by the NGOs operating in the area. Learning sign language has also led to a change in the quality of life of these deaf girls. Mou (West Bengal, 15) is continuing studies in a mainstream local school with the help of a hearing aid, which she uses regularly. Janhvi (Odisha), after coming in touch with the local NGO is pursing sign language classes in a group and is slowly coming more confident about her ability to communicate. Tuktuki (West Bengal) feels that the sign-language training given by the NGO has helped her to be more confident. However cost of batteries towards maintenance of the hearing aid sometimes is exorbitant and families find it difficult to sustain it.

The girls with disabilities who remain invisibilized within the meagre provision for medical intervention and rehabilitation are the girls with mental impairment. Often these girls also suffer from epilepsy, which intensifies the effect of impairment and hampers their physical and cognitive development. Yet medicinal support is hardly available to them at the local government medical set-ups. Parents of girls with severe mental disabilities, with associated physical and social impairments, feel a sense of despondency as they do not know how to train the child better. Tara who has severe mental retardation usually sits in one place and cannot move about by herself at all. She needs full support from her mother and father—to be fed, cleaned, dressed after using the toilet, and for any other need. Similarly Arya (Jharkhand), 15 years and having severe mental retardation, can only express hunger and discomfort if wet, by crying, as she does not speak at all. Both girls living in remote areas of Jharkhand have never received any kind of support from professionals about how to better address their severely disabled girls. This has affected their own lives and the mothers have become burdened with the care of the now growing girls.

'USE PADHANA CHAHATI HOON': SCHOOLING AND EDUCATION

Access to education becomes one of the major indicators of access to development for disabled girls. The Aaina Status Report of 2008 data collected from 8 districts of Odisha, revealed that almost 60 per cent of the women interviewed in the survey were illiterate and had no awareness of the scholarships (mainly in higher education) that they were entitled to. The vast majority of disabled girls still access mainstream education, especially in the rural areas where it is the closest and only option available to them. In urban areas, many of the girls are able to access some form of special education, until it becomes difficult for parents to take their children to school. This means that for a lot of girls with mental retardation and multiple disabilities there is no option

but to drop out, even of the special schools in the urban areas where built environments and transport systems are inaccessible. The mainstream school experiences of the girls are varied—issues from seeking admission to accessible classrooms and toilets to actual learning outcomes—all are influenced by the experience of gender and disability. The issue of admission has become almost regularized with the Sarva Shiksha Abhiyan (SSA) the RTE Act becoming instrumental in assuring all children including disabled children admission into schools.

Most of the girls who participated in this study were enrolled in school. Of the nineteen case studies conducted in West Bengal, eighteen of the girls were enrolled in and were attending school, and only one had dropped out of school, because she was unable to cope with the studies. In Odisha, the number of girls who had been enrolled in school but have dropped out was high. Of the nineteen girls, while one has never been enrolled in school, six of the disabled girls have dropped out of school mainly because of problems of physically accessing the distant schools and at present, twelve girls are continuing with their schooling. The picture becomes more dismal in Jharkhand, where of the twenty girls involved in this study, four of the girls had never been enrolled or attended school, two of the girls have discontinued their schooling and one was enrolled but never attended school. Thirteen girls, however, were enrolled in and attended school. Adding up the fifty-nine cases, the number of girls enrolled and attending school are forty-four, which is over 73 per cent. But do these numbers give us the entire picture? While enrolment in schools serves as an indicator of access to education, for girls with disabilities does this really translate into gaining from education? An in-depth interaction with the girls and their parents actually reveal quite the opposite picture.

The discussion here will focus primarily on mainstream New Para schools as the RTE Act of 2009 guarantees universal access to education for all learners and as most of the girls in this study attend mainstream schools. Only four disabled girls living in urban Kolkata are attending special school, where the curriculum, unlike mainstream schools, focuses on developing life skills like counting, communication, and vocational training oriented towards providing them with some form of self-sufficiency.

Access to education for girls with disabilities has to be understood at two levels—(a) the accessibility of schools, that is, how disability friendly the schools are in all ways; (b) learning outcome. The education experiences of the disabled girls in the three states of West Bengal, Odisha, and Jharkhand showed certain regional variations but there were significant commonalities between them too.

‘ACCESSIBLE’ SCHOOLS

Majority of the mainstream schools are limited in terms of the specific support needed for providing educational inputs. The question of accessibility needs to be addressed on the count of physical access, attitudinal access and curriculum and teaching-learning support. This becomes more important when one considers that learners have different needs in terms of accessible support, depending not only on their impairments but also according to one’s socio-economic status and family support.

For girls with locomotor disability, physical access into and within the school, is an important factor. Many of girls with limited mobility prefer to go to schools close to home as these are easy to reach. Some of the girls like Tithi (Odisha), Dolon (Jharkhand), and Sushmita (West Bengal) find it difficult to walk and thus cycle to school. Lakshmi (West Bengal) walks to school now as it is close to her home but her parents are doubtful whether she can continue with her education as the high school is quite far away and that distance will be difficult for her to travel and expensive for them to bear her transport by vehicle. Pinky’s (West Bengal) mother accompanies her to school even though she can go alone in her wheelchair, to help her in case the wheelchair falls into potholes. Shila (West Bengal) says that on days when her mother is not well, she has to miss school. On some occasions the mothers dropped their children to school and came back home to complete their housework, going back once again to fetch them. Friends often become a support in going to school, as Ariza (West Bengal) says, ‘they carry my books and bag so that I can walk without any burden’.

Physical access within schools is even more problematic, as many schools are without proper ramps and high schools that are often multi-storied are completely inaccessible to disabled girls on their own. Girls with severe locomotor disabilities have to be accompanied by their mothers, who help them to reach the designated classrooms. ‘The classrooms are mostly on the 3rd floor and I have to carry her up the stairs.’ School authorities are also unresponsive to the situation, as is evident from Shila’s experience. ‘I had asked the school authorities to change the classroom but the headmistress refused. She said I should admit Shila in a lower class that way she will be able to attend classes on the ground floor, I refused to do this’, recalls Shila’s mother. Pinky says that she cannot learn computers in school as the computer class is in an elevated area and she cannot climb the steps and go there.

Though the school has promised to either construct a ramp or provide for a computer within her reach, missing the classes has taken a psychological toll on her, leaving her feeling excluded. Inaccessible toilets become another reason why it is difficult for growing disabled girls to continue in school. Pinky cannot go to the toilet in her school without help, so she wears a diaper to school. 'The washroom is quite far from the classroom. Moreover it is always wet and dirty, so I cannot change my diapers there as I have to sit on the floor to take off my callipers in order to do so. So I use the same diaper for the entire day and drink less water.'

The question of accessibility takes on different dimensions for the deaf and blind girls, as for them the question of physical accessibility of the schools did not pose that great a problem, but being able to access and understand what was being taught posed a major challenge. Phool (Jharkhand), a hearing impaired girl who studied in a mainstream school can neither read nor understand much of her class topics, but could copy what was being written perfectly. This is because no additional support was available in form of learning materials or sign language instruction in the mainstream school. Similarly Rupa (Jharkhand) studying in class V and Saloni (Jharkhand) a student of class III in state run schools in their area, cannot read their school text books as they have very little language concept. There are no teaching learning materials provided for these hearing impaired girls, nor is there any provision for learning sign language in the rural areas. Mila (Jharkhand) who is visually impaired was taken out of school by her parents as she was not making any progress in her studies. Their action was indicative of how mainstream learning methods could not address the learning needs of such children. Arunima (West Bengal) says that she finds it really difficult to follow what is written on the blackboard. She copies from her friends but even that is an uphill task for her. Her mother says that straining her eyes is also affecting her eyesight adversely.

Access to specialized services however changes lives of disabled girls. Janhvi (Odisha) is studying in a state-run school but has received sign language training from the local NGO, which has helped her to communicate better in school. Sita (Odisha) is an example of such a story. Having received a hearing aid from the government enables her to detect sounds like the honking of cars on the road which makes it easier for her to travel. Sita's sign language tutor notes that she has shown remarkable improvement in learning sign language, which has also opened her mind, given her a sense of determination and instilled optimism in her parents about her future. Realizing the need to be self-reliant, she has started concentrating on vocational training by learning sewing on a sewing machine.

Most of the girls in this study are too poor to go to special schools and has to depend on extra-institutional support to learn sign language, which in these cases were the NGOs that they worked with. There were, however, also difficulties associated with this. Tuktuki (West Bengal) could go to her local NGO only once in three months, as her mother could not afford to miss work to take her to the NGO regularly. Mou (West Bengal) has been learning sign language for the last four years, but due to lack of practice she often forgets the signs. Moreover since the teachers in her mainstream school have no knowledge of sign language, understanding lessons in school or even from a private tutor becomes difficult. Her mother is, however, happy with the progress she has made after learning sign language as it has given her confidence to talk even with strangers.

Attitudinal access is the most significant barriers that can help mitigate the other access barriers. Stories of disabled girls being teased and heckled about their disability emerge behind reasons of dropping out of school or wanting to change schools. Piya (West Bengal) reported that some classmates tease her calling *Haat kata* (amputee). Munni (Jharkhand) stays at hostel and she says that she does not have many friends there as the girls tease her for being blind. While teachers and hostel superintendents have reprimanded the other children for teasing the girls, such stigmatization continues in various covert ways. Baha (Jharkhand) recounts, crying profusely how some of her classmates in her hostel avoid her believing that by mixing with her they will also fall prey to her illness. This in effect also has a debilitating effect on her self-confidence. The question of exclusion took many forms, some of which arose from the social structures within which these families were embedded. Rama's (Jharkhand) mother recounts how some of the Yadav students of their village have demanded that she be put into a lower class. The mother says that probably due to her caste accentuated by her disability they do not want to sit with her in the same classroom. The teachers have remained supportive of Rama and not heeded to these demands, but such questions of exclusion still very much remain a part of her school life.

Yet the school serves a social function by enabling such children to mix with other students and developing certain levels of friendship. For girls with intellectual disabilities, schools also were an important

space to form friendships and increase their horizon of social interaction. Rama (Jharkhand), a girl having severe mental retardation made more serious by epileptic seizures is a student of class five in the local school in her village. Her mother informs us that she likes to go to school very much and cries on days when she cannot go. Reema's (Jharkhand) mother says that though she does not understand anything taught in school, she likes going to school—'going to school and playing with her friends make her happy'. The mid-day meal scheme offered by all state run schools is another reason why disabled girls from poor families attend school—the additional nutrition provided in form of food, becomes the reason they survive amidst difficult circumstances.

While the mainstream lessons taught in the class do not become accessible to the students with severe mental retardation, drawing often provides them with a form of self-expression. Reema (Jharkhand) and Barsha (Odisha) both indicate that they love drawing, which is one of their primary attractions to going to school. Subu (Odisha) having congenital absence of upper limbs loves to draw with her toes. She has even won a prize in school with her drawing. Most of the parents we spoke to say that while the teachers in the school lack the special skills required to communicate the lessons to these students, they were mostly supportive and caring towards the children. However, none of the girls in all the three states recall any special educator coming to support them in their school despite the fact that the SSA has recruited resource teachers for each block. The only support available is from trained workers of grassroots level NGOs who alongside providing supportive treatment are also trying to plug the breach in their education. There is no modified equipment for disabled children requiring seating and writing support, there are no enlarged books for girls with low vision to use, there are no educational kits for girls with hearing impairments and complete lack of sign language teachers in rural India.

But for some of our respondents, the question of forming social networks was of insurmountable difficulty. In the absence of special schools or other forms of support, the mainstream schools often reproduced the isolation that these children anyway had to manage in their everyday lives. Rukmini's (Odisha) mother says that she was admitted to a local school not for her education but in the hope that she will be able to avail the government scholarship. The case is similar with Anupama (Odisha) whose father takes to school for official attendance so that she can avail of the scholarship. Gauri (Odisha) also goes to school once a month. The other students in the school are afraid of her and they don't interact with her. In terms of accessing educational entitlements from the government, there are some benefits gained by the girls in Bengal but almost none by the disabled girls living in Jharkhand and Odisha. Many of these scholarships or stipends have been accessed only one time, although they are meant to be given annually. In Jharkhand, due to the preponderance of mission run school, some of the disabled girls are able to access an education as they live in the hostels provided.

Learning Outcomes

Although teachers in the mainstream schools are sympathetic, they are hardly aware of and do not follow the small methods that can help the disabled girl students to benefit from classroom teaching. The teachers feel that concentrating on one or two of the disabled girls will be unfair to all the other students in the classroom. Hence they allow the disabled students to sit in class and do not make a fuss if she is unable to cope with the school syllabus. So disabled girls, especially the hearing impaired, can copy whatever is written in the blackboard but miss out on what is being taught. As Tuktuki (West Bengal) says, 'Sometimes the teacher talks very softly and it is hard to follow what she is saying.' Shruti's (West Bengal) mother says, 'All teachers do not give special attention to her. Unlike other students, she is not very quick in taking notes or writing off the board, as a result many of her lessons remain incomplete.' Girls themselves are scared or shy to ask for special attention in class as it makes them stand out.

Parents, most of whom are sending their children to school as they never got a chance to study are generally happy with the progress of their children. Lipika's (West Bengal) mother says, 'They did enough. Her teachers would constantly check with her to see if she's understood the lessons, whether she would be able to write it in the exams or not.' Friends, too emerge as a support system, helping with books, class notes and any other help required by the disabled girl. Many of the girls spoke of how their friends came to fetch them from home to go to school, helped them to understand lessons, and in general provided a support structure to make the difficulties of school more manageable.

In West Bengal where overall parents are more aware and conscious of the need for education, parents see a hope in the possibility of education for their disabled daughters. Most of the younger girls are interested in studies—it is only once they reach senior school that they start experiencing problems in learning outcomes, lag

behind others, and then drop out or discontinue their studies. Except for West Bengal, all other parents living in the remote rural areas of Odisha and Jharkhand had very little idea of how to ensure a good education for their disabled girls. Families in West Bengal are investing in their disabled daughter's education in different ways—many of the girls also have private tuitions and others go for training in singing, dancing, painting, etc. Aspirations of disabled girls, especially those with locomotor and visual impairments in West Bengal, have risen as they are better able to cope with the school syllabus compared to girls with other disabilities. Jaya (West Bengal) usually finds a rank in her class merit list. In keeping with her aspirations her parents too want to save money for her future. Piya (Odisha) wants to go to an English medium school as she feels she can achieve more there. Lina (Jharkhand), having harelip, has also been put into a private school by her parents as they feel that this will give her better education.

Thus the question of access to rehabilitation or schooling is hardly limited to these formal institutions only. Rather dealing with disability and preparing them for self-dependence entail close attention, intensive care, and consistent support and encouragement of the primary caregivers.

'MERA BACCHA HAI MUJHE HI KARNA HAI': CARE AND SUPPORT

The severity of disability coupled with the nature of impairment determines the experience of disability in everyday life. Severe mental retardation often not only affects the mental growth of the disabled girl but also impacts the physical and functional development of the child. One of the issues that clearly emerge, especially in case of moderate to severely disabled girls, is the nature of care needed by them and the fact that this care is mostly gendered with the onus of it falling on the mother. For girls with severe visual impairment or deafness, physical and thus functional limitations are less, and hence in rural areas, they can function almost similar to other girls in the community. However girls with impairments that completely restrict their movements and girls with severe mental impairments require full time care and support by their family members. Most of them require support for even fulfilling their daily basic needs of hygiene, feeding, clothing, and shelter, while many of them require support in certain activities that they find difficult to perform due to the nature of their impairments.

Depending on the severity of the impairment and the range of functional limitations, disabled girls are dependent on their parents and families in varied ways. From complete physical and functional support to assistance in some of the daily living activities, girls with severe disabilities require a lot of time and attention from their families, which often in poor families becomes a liability. Tara (Jharkhand) sits in one place and cannot move about by herself. Her parents have to feed her, bathe her, and clean her after she uses the toilet (which can occur any time as she has no toilet control) and also ensure that she does nothing to harm herself. Usha (Jharkhand) has cerebral palsy and hence has very poor hand control—therefore other than dry food like biscuits and *roti*s, she has to be fed along and needs help with all other personal care activities like dressing, using the toilet, and bathing.

Mothers emerge as the primary caregivers for the disabled girls especially as they grow older. As mothers take over the entire care responsibility in poor families this means that one earner becomes less, which has implications for the family's survival. Arya's (Jharkhand) mother regrets that she cannot earn any money at all as she has to take care of her daughter—she feels that money could have been used to provide her with better care and support. As girls grow up and become heavier, it often becomes difficult for the mother to provide the physical care–lifting up grown-up daughters to help with all activities of daily living becomes a strain on the mother herself. Arya (Jharkhand) has to be fed lying down on her mother's lap. Her mother is now finding it difficult to fit her on her lap as she has grown both tall and heavy, and it is often a strain to hold her in the lying position. Mothers devise strategies for attending to their daily household and other work while fulfilling their care-work. Sitara's (Jharkhand) mother puts her on a charpoy in the open courtyard as she goes about her work so that she can keep an eye on her all the time. When Hema's (Jharkhand) parents have to go for work, they leave her in the vicinity of her younger sister, with food and water within her reach so that she can eat when she is hungry. However, very few of the mothers ever complain about the burden of care. While other studies (Ghosh, 2010) have found that siblings, particularly sisters, also act as caregivers, in most of the families contacted during this study, brothers and sisters play a peripheral role in the lives of the severely disabled girl.

Mothers also find their ways of communicating with their verbally disabled daughters—Arya's mother has learnt to recognize that her daughter starts crying as she does not like to stay alone at home and she does not like to eat food without salt. They also learn to read the

messages given to them by their often non-communicative daughters regarding their basic needs. Arya's mother has learnt to differentiate between her crying for food and crying when she is wet. Burdened with the responsibility of care for the severely disabled daughter, mothers hardly have any free time to themselves. Tara's mother says that she can never go anywhere as she has to be present for Tara all the time. Yet there are few regrets and an acceptance of the child who is so severely disabled.

Except for Bengal, almost all families in Jharkhand and Odisha did not have toilets and this becomes an additional burden for the mothers—either they have to take the child to the faraway fields which is used by the village as a toilet, which is often difficult as girls with disabilities often do not have control nor can they vocalize their toilet emergencies or attend to toilet needs at home. Menstruation is another area of concern for mothers who have to provide support to disabled girls, and many mothers hope that these girls will be spared the hassle of menstruation while others hope for a delay in the onset. When Munni (Jharkhand), who is visually impaired, started menstruating, she got very scared and went to her mother. It was her mother who then showed her how to use the cloth pads. In rural areas, as most of the families are poor, packaged sanitary napkins are not easily available and are often expensive for the families to afford. Coupled with this, is the fact that the thicker and bulkier cloth pads are more convenient for girls with different impairments to use and manage their menstrual cycle, as these do not shift along with their awkward gaits or sudden movements. For severely disabled daughters, mothers have to deal with period-related matters. Gauri's (Odisha) menstrual cycle started when she was 11 years old, but her periods are mostly of 10–13 days in duration. As she is unable to even communicate that she has started her period, her mother has to keep watch over her all the time and ensure that she changes her pads regularly during her periods. In other cases, mothers train the disabled girls to take care of their menstrual cycles and associated problems as they do for their other daughters. However families rarely seek help if there are any problems with the menstrual cycle. Rama (Jharkhand) started menstruating in 2013 but after a few months, she has stopped having her periods, but till date her parents have not even thought about taking her to a doctor for check-up.

Most of the fathers play a minimal role in the care of the disabled daughter reinforcing the gender stereotypes and the cultural taboos. Shila's mother said clearly that her husband did not extend any help in terms of her care. 'Yes, he is very attached to her, he loves her a lot, he will buy her whatever she wants but at the end of the day he won't take any responsibility for her. He contributes financially but taking care of Shila is only my responsibility.' However, fathers do play a prominent role in terms of ensuring the severely disabled daughter has access to assistive devices. Munni (Jharkhand) who has cerebral palsy and can barely walk, has a walker fashioned out of bamboos by her father. It is a frame of shoulder height and has been made so that she can stand upright holding it and also walk a few steps if she so wishes. Lata's (Odisha) father has made for her a wooden draw-cart more suitable for the rural terrain. She can sit on it and hold on to the side bar while somebody pulls it by ropes to take her around. Some times Lata's friends take her out in this cart to the playground. This is also some relief for her mother, as Lata has put on a lot of weight in the last few years. On the contrary Mum's (West Bengal) mother, who has undergone specialized care-giving training for her cerebral palsy-afflicted daughter, insists that her husband shares the work of primary care giving with her. 'It is not enough to pet her and love her, it is imperative that both the parents are able to take care of the child.' Being an urban educated woman it was possible for some extent for her to challenge the gendered expectations of parenting. But for the bulk of our respondents such sharing of responsibility was unimaginable.

Parents have to keep a close watch on girls with intellectual impairments as they are vulnerable not just to abuse but to self-destruction too. Anupama (Odisha) was found missing one evening from her home and after searching far and wide, her father found her roaming near a dam about one kilometre away. Similar incidents happened twice before and she has been located near the path going towards the dam and the jungle beyond. Her mother said that Anupama does not do this out of her own will—she keeps moving and then cannot remember the way back home. Once, during monsoon, she fell into the clogged well and was saved only because a local boy heard the sound of her splashing arms in the water and called her father for help. It was a life and death situation. Fear for the disabled daughter and her safety also prompt parents to take decisions that sometimes affect their quality of life. Tara's (Jharkhand) family which has built a *pucca* Indira Awas Yojana home in the end of the village are unable to shift to that house because her mother is afraid to go and live there in isolation considering that she may need to leave her daughter alone for some time. At present neighbours provide support in keeping an eye on the child when the mother has to go out for some work for short periods of time.

The cosseting of the severely disabled daughters by their families, especially mothers, sometimes becomes a barrier to the process of their development. Munni is not allowed to do any of her personal care work—her mother brings water and bathes her, takes her for toilet in the fields and cleans her afterwards, helps her change her clothes and is there for any other demand she may make. Rama's (Jharkhand) mother does not allow her to do any work by herself fearing that she might hurt herself in the process. This has affected Rama's wish to be involved in her own and family's work. Kokila's (Odisha) mother never asks her to do any of the household work, even though she is visually impaired and can manage to do many things on her own. Sometimes this results in the disabled girl feeling privileged in comparison to her other sisters. When Piyali (West Bengal) is asked to do any household work, she gets out of it by asking why her younger sister is not also being asked to do the same thing. Her mother also lets her off as she feels that it is difficult for Piyali to take up these household chores. On the other hand sometimes siblings are made to feel responsible for their disabled sister. Pinky's (West Bengal) mother said that they have taught her younger sister from childhood that she must look after Pinky. 'We have taught her that her elder sister has a physical problem in moving about, so she must help her in every way-to fetch her clothes and any other kind of assistance.'

The protectiveness of Lata's (Odisha) family is evident in the way in which her family members always insist that she is not able to do things as she cannot walk. Her father said that they had got a wheelchair for her but it was too high for her to sit so they have not used it at all. When the NGO suggested giving her special shoes and callipers, the family were worried that she would experience pain and so refused the offer. This kind of over-protectiveness on part of families, though with the best of intentions, often prevents girls with disabilities from making the most of opportunities in life. Yet on the other hand, Lipika's (West Bengal) mother revealed that a tricycle was offered to the daughter who has moderate cerebral palsy but she refused it. 'The problem is she always wants to be carried. If she had the tricycle then she would never walk.' However she also pointed out that she looked for her daughter's comfort when she was walking with callipers and crutches. 'She used to walk with the crutches and I tied a cloth at her waist which I held at the back, so that she would not fall.'

Disabled girls become lonely as they grow up–with siblings and friends either engaged in studies and work or married off, girls with severe disabilities become isolated within their own homes. Usha (Jharkhand) says that she is lonely and without company for much of the day, as her siblings go out to play and her mother goes out to work. Some of the younger girls however spend time with friends and thus the service organizations are now looking at these friends to provide support to the disabled girls. Janhvi's (Odisha) friends use sign language to communicate with her and to explain what she is saying to others who do not know sign language.

Parents are worried about the future of these severely disabled girls. Arya's mother asks if there can be any disability grant made available to Arya so that her siblings can be bribed into taking care of her. She says that they are dying slowly for the child, as there are so many problems. Vani's story highlights the acute need for proper institutional care. Orphaned, having severe mental retardation and restricted mobility means that she is completely dependent on her elderly grandmother. But there is no answer to what will happen to her after her grandmother dies, as there is no one to take care of her. On the other hand, some parents repose a lot of faith in their daughter in terms of achievements in life. After two of their children were born blind, and one died at the age of three years, Munni's (Jharkhand) parents decided to stop having children and concentrate on Munni's upbringing. Shila's mother said, 'I want her to study and learn so that she can help herself. Some of our relatives had said, "she cannot do anything, she doesn't have a future". My husband and I decided no matter what happens we will put in all our efforts to raise Shila and in the end she will be the one who will take care of us.' She further elaborates, 'I want her to be self-dependent; she should lead a respectful life, that's why I constantly push her to do things on her own, to be more self-reliant. Yes, she has a disability but she has to overcome it, she has to study very hard and be a strong person'.

'Khub Koshto Hoe': Narratives of Neglect and Abuse

In contexts where the neoliberal State is in the process of withdrawing from care, and erstwhile familial structures are disintegrating due to increasing nuclearization and urbanization, families with disabled members require not just financial and medical support from the State but also psychological support-services. Testimonies of mothers of young adults with cerebral palsy shows how parents with disabled children experience feelings of anger and helplessness, apprehensions about their children's future and hence, are in need of psychological support-services (Chakravarti, 2008). In absence of these, the children

often become susceptible to neglect and sometimes even abuse. Disabled girls are liable to be subjected to physical, sexual, and emotional abuse regardless of age, class, and type of disability. Their vulnerabilities become even more pronounced with their marginal social position and severity of conditions of disability. The questions of care and neglect have been of central concern to academics and activists working in the area of disability studies.

As our study indicates, the issue of neglect is multi-layered and spans an entire spectrum from abject abuse to more everyday forms of neglect. By looking at this entire range of negative experiences we can see that issues of neglect are not always straightforward or easily discernible. The question of neglect is not simple and cannot often be reduced to a deliberate lack of care. During our field-work we actually came across very few cases of intentional neglect by the primary care-givers. Rather the neglect that we witnessed was often a result of combination of factors such as abject poverty, lack of access to information and facilities, lack of consciousness and a resultant sense of fatalism. Therefore to explore the question of neglect and negligence divorced from the social reality within which these families were embedded will be inadequate.

The question of neglect and negligence, while working in tandem with potential for abuse, operates at a more everyday level. This was also discernible among the primary care-givers of the children. One of the ways in which this found expression was in the case of non-initiative in case of seeking treatment. Sumi (Odisha) had locomotor disability from birth but her father says that they had never taken an initiative to take her to a doctor, to the extent that they do not even know the exact nature of her ailment. Having heard others say that her brain 'is out of order' he has been convinced of the futility of seeking treatment and thus decided not to waste money on this. Mita's (Jharkhand) mother Dumni Devi says that her husband spends all his time and resources in gambling and drinking. He is very negligent towards his daughters—'we don't have sons, there is no point in spending money on the daughters'. Interestingly in this case we see that Mita is not singled out due to her disability, rather along with her sisters she is a victim of negligence because her father prefers to spend his resources on his own pleasure rather than providing support to his daughters. Given that Mita has special needs, this disregard naturally affects her well-being more than her able bodied sisters. Without his support it becomes difficult for Dumni Devi to manage and take care of her daughters specially Mita.

Neglecting the girls with disability was not always the result of lack of resources. The case of familial structures impinging on care was also discernible for Mou (West Bengal). Mou's mother, Ajmira, had told her mother-in-law several times that there might be a problem with Mou's hearing but the latter had paid no heed. In this case the extant hierarchies prevented Ajmira to the very access of treatment for her daughter. Shree's (Odisha) family is not poverty-stricken as her father is posted in Arunachal Pradesh and earns a steady salary. Her mother informed that they have discontinued her medicines as she could not find them in the local market. She cited the problem of the father being posted away as the primary impediment for her to do these things. She hinted that the father was given to regular drinking and was more focused on their other three children. As Shree's father enjoyed a high social standing within the Santhal society, he deliberately avoided too much focus on Shree as it would affect his status. Therefore the question of neglect here is not just a matter of negligence but also of social stigma within the community. Similarly, Rita who comes from a business family in urban Kolkata has cerebral palsy but after attending a special school, she had developed her ability to communicate. The caregiver in the school, however, informs us that for the last eight months she has been very disturbed and all the progress that they saw has been reversed. She further explains to us that there is no one in the house to engage with her, she spends her days sitting alone by the window talking to herself. 'If she cuts cucumbers and makes a salad, no one in the family eats it.'

Often both poverty and family responsibilities are cited as reasons for seeming neglect of the disabled girls. But what lies under such reasons is the gendered culture in which the girls and their families are situated. As Tuktuki's (West Bengal) mother's daily wage work prevents her from taking her daughter regularly to the NGO to learn sign language, she asked Tuktuki's father to take her there on his cycle. To this he says that 'What is the point of this? What will she learn anyway?' For poor people like Tuktuki's parents dependant on their daily labour, the cost of dropping Tuktuki for her sign-language lessons must match upto the time that has to be spent for that. In a society where special skills has no place, the learning of sign-language naturally did not occupy a position of priority for him. Similarly once Garima's (West Bengal) brother was born, her mother found less time to take Garima for treatment. While she clarifies that she spends adequate time with Garima, it is quite clear that their expectations and investments are tilted towards the able-bodied son. In a context of very limited resources,

there was a tendency to focus more on the able-bodied child, more so as he was a boy.

Negligence often arises from the lack of awareness and limited resources which plagues many of these families. The neglect of Janhvi (Odisha) in terms of her education or treatment can also be mapped to the same issues of lack of awareness and resources and a sense of fatality which results from these. While Janhvi herself shows great interest in learning sign language, her family is not supportive towards her education as they feel that her impairment can never be cured. Mita's (Odisha) family is sending her two sisters to a residential school, but her education has been completely neglected, even though she herself has expressed her interest in going to school. Usha's (Jharkhand) parents feel that schooling will not be of much help for her and hence have never bothered to admit her to the local school. Lack of awareness also extends to carelessness and a complete lack of faith in the governmental structures. Hema (Jharkhand) had a disability certificate, which has been lost but her parents do not plan to apply for it again since they had not received any benefit from it. In the context of the remote villages of Jharkhand and the difficult conditions within which they live, the disability certificate remains a piece of paper without much value.

The degree to which neglect and apathy is embedded within the societal structures become most evident when parents were asked about future plans. A large section of the respondents' parents were unable to conceive of a future for their disabled girl child. Their socio-economic conditions did not allow them to save sufficient money for the child and their lack of awareness impeded the training of these children in such ways that they can be self-sufficient to varying degrees. It was quite obvious that grinded by extreme poverty it is impossible for the parents to think beyond each day, they cannot conceive a future for themselves let alone for their daughter. For parents who could visualize a future for their disabled daughter, the primary focus is on education as most of the parents express their hesitation to think of marriage as a future alternative for these girls. Lakshmi's (West Bengal) mother says, 'She cannot walk properly, what's the point in thinking about her marriage? She will stay at her home.' Resistance to marriage can be understood from a deep-seated fear that the parents' have of ill-treatment in the marital home coupled with the practical consideration of higher dowry as a price for the disability and even questions of stigma. Since many of these girls require quite a lot of help in self-care, they fear that their daughters might not be able to perform all the chores expected of them in the marital home leading to abuses against them. Tuktuki's (West Bengal) mother clearly said, 'I prefer a *ghorjamai* [resident son-in-law]. My daughter is not clever, so I will have to train her. I will tell my son-in-law that my daughter will stay with me. I will tell him, 'you can do whatever you wish to as long as you can take care of her'. I won't let him take her out alone.' In a situation where education as the alternative life course seems inaccessible to most and marriage being negated by the majority, these girls in many cases look at future mired in uncertainty. Tithi (Odisha), prepares herself to be peon of the local post office. Struck by the limitedness of her dream when we ask her the reason, she says, 'We don't have enough resources so I don't dream big.' This, in fact, often becomes the very basis of the context within which others like Tithi live, a context which is embedded in a condition of socio-economic negation of girls with disabilities.

In such a scenario of neglect and apathy, most disabled girls are also subjected to varied forms of abuse. The mildest form of abuse faced by most disabled girls is in the form of taunts and ridicule by classmates, neighbours, and the like. Although Meenu (Jharkhand) has friends in the village, sometimes they taunt her for not being able to play games like *kabaddi* thus making her angry. Saloni also faces name-calling by children in the neighbourhood who call her *goongi* (mute). Sushmita (West Bengal) says that sometimes children in the village tease her by imitating the way she walks. This hurts her very much. While most respondents said that neighbourhood, schoolmates and teachers are mostly friendly, they have been victims of such incidents of taunting and name calling on some occasions.

Piyali (Jharkhand) who has severe mental retardation has the habit of roaming around the village. Taking advantage of this, she was raped by one of her distant uncles. The plight of the family did not just end with the act of rape. As the perpetrator was an influential person in the area, the police remained inactive, even after the family reported the incident to the police. The father suspects that they had been bribed by the perpetrator. Not just the police, even within their *santhal* society they were not able to establish his guilt. Conversely they were blamed of false accusations based on a 'mad girl's' story and forced to pay compensation in the form of two goats to the accused's family. Not only did Piyali face sexual abuse but also social stigma and disbelief on account of her mental condition. This is in tune with findings of other research studies that have documented how disabled girls are subjected to denial of abuse within communities.

Sexual abuse faced by mentally retarded have been highlighted by disability scholars and activists alike. In case of Vani (Jharkhand) too such incidents have been reported. Vani lives alone with her grandmother. The latter had to go out for work and often returned late. The care-worker, who visits Vani once a month, tells us that Vani had been raped at least twice to thrice. In this case too, in spite of having strong suspicions, they have not been able to prove anything to the police who refused to even record such cases. Both Vani and Piyali not only become accessible target for such sexual predators, their or their family's accounts of such abuses on them are not taken up by either social or state institutions. The families thus live in constant fear for the safety of their children. Tuktuki's (West Bengal) mother, says, 'I have always been around her like her shadow'. She recounts how one of the boys in the neighbourhood was being very friendly with Tuktuki in a way that aroused her suspicion. She confronted the boy and warned off his family.

Schools emerge as another space where the possibility of abuse looms, with minimal supervision by school staff and total absence of any support structure in schools. Garima's (West Bengal) mother described how a drunken man had befriended Garima at school and used to offer her food everyday during lunch time. Garima's mother became suspicious when she suddenly started using abusive words and after questioning her she found out that he took all the money that she used to give Garima. This incident also highlights the neglect by school in this regard. One of their students was interacting with a stranger everyday but the school staff seemed to be either unaware or unconcerned regarding this. Such incidents of negligence on the part of schools made these children more prone to be facing abuses. Similarly Shila (West Bengal) recalls that she had to wait for her mother to come and fetch her as she was unable to put on her callipers on her own. Often she was left alone in the classroom after the class with the teacher not even realizing that she was there on her own. It was only when one of the carers (*ayah*) went in to clean the room did she find Shila sitting there and crying. Such incidents of negligence had happened quite few times in her case. In almost all such stories, mothers have been instrumental in maintaining greater vigilance to safeguard their disabled daughters.

* * *

An exploration of the lives of the girls with disabilities reveals the multidimensional nature of their existence, structured through daily experiences within families and communities. While the literature (e.g. Maqbool, 2003; Ghai, 2002) speaks of parental apathy, our fieldwork reveals the extreme care and concern of the parents towards their disabled daughter. This concern, reflected in over-protectiveness of the girl, often stands in the way of her physical, functional, and social self-dependence. While almost all parents have attempted to ameliorate the effect of impairment through medical treatment, the lack of sensitized and trained personnel and infrastructure in the state and private-run medical institutions available in the community have posed barriers in the process of development of these disabled girls. The situation is further exacerbated by the lack of institutional support in the form of rehabilitation services, support for integrated or customised education and regularized access to benefits from the government. The situation becomes even more complicated for girls coming from extremely poor households in remote rural areas.

Yet the disabled girls and their families are attempting to carve out a meaningful existence, with alternative forms of support in the shape of a supportive peer group, encouraging teachers, vigilant neighbours, and dedicated care-workers of the NGOs becoming the backbone of this support mechanism. While the support available from these alternative care networks might not always provide the specialised care that these children need, they often provide succour in terms of emotional needs. The case-studies seem to suggest that the children who have shown the most improvement are the ones who have been able to make use of these alternative networks and also received consistent practical support from their primary care-givers through regular exercises, practical training, and vocational skill development.

The role of the NGOs too was significant in providing the parents with the support and guidance they need for tending their children. The field-sites in Jharkhand were the least developed state in terms of access for disabled girls and their families to resources–whether technical like medical or rehabilitation support or financial like scholarships and stipends. The field area here was remote with poor communication facilities, poor public transport system, and therefore low levels of awareness of families regarding possibilities of accessing services and resources. Hence very few people have been able to access disability certificates which open the door for many other entitlements. In the field-sites in Odisha, it was seen that although the areas remain remote and the families are poor, the presence of an organization that works with disabled people has impacted the condition of the disabled girls in terms of access to interventions and entitlements. Many of the disabled girls in Odisha have disability certificates and some form of access to entitlements like scholarships

and disability pensions. Levels of awareness of families are better with regard to services and resources available, although many have not been able to access the same. In West Bengal, as the field area was very close to the city of Kolkata, knowledge regarding services and resources as well as access to the same is definitely better with almost all the disabled having received some form of interventions and access to disability certificates. Both awareness and knowledge have a clear impact on aspiration of parents for their disabled daughters as in evident from the data.

The parents' aspirations for the girls' future revealed the persistence of certain gendered expectations but also reversal of other roles. Marriage was rejected by most parents as the future course for their daughters. But this did not mean a reversal of gendered expectations, the negation of marriages rather seemed to suggest an intersection of several marginalities of disability, poor economic conditions, gender, and the perceived inability of the concerned girls to perform the role of the 'wives'. But this negation often forced them to think of other life choices for their daughters, which includes certain seriousness attached to education and trying to ensure financial security for their disabled child so that they can have a better future.

In the final analysis the brief glimpse into the lived experiences of the girls with disabilities can be read as a heartbreaking narrative of multiple deprivations. In the absence of institutional care, for orphans like Vani with her grandmother as her sole guardian, the question of uncertainty of future loomed large. But these narratives also need to chronicle the courage and resilience shown by some of these girls in overcoming these odds. As Sita says, 'I am determined to do something in future. I will work hard and make something of my life.'

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4

Will All the Included Children Please Stand Up?

Making Educational Inclusion Real

Jo Chopra-McGowan

Stories are the cornerstone of all human understanding. We make sense of the world and of new information through stories—how did these same things happen to other people? How did they deal with what we are experiencing right now? What can we learn?

As schools around India struggle to adapt to the challenges the Right to Education (RTE) Act has introduced, particularly regarding children with special needs, I want to share the story of a little girl named Moy Moy.

Moy Moy was her mother's thirteenth child. Her mother had been sterilized after baby #12, but the operation had not worked, and Moy Moy was conceived anyway. Her mother then decided on an abortion. She came down to Dehradun from her village in the Himalayas and approached the only doctor she trusted in the entire city. This doctor also happened to be the only one in the city who did not believe in abortion and would not perform them. She convinced the Mom to have the baby and promised her she would find it a home.

A few months later, coming down for a routine prenatal appointment, she went into labour in a bus. The bus pulled over and Moy Moy was born on the side of the road. She was 12 weeks premature and weighed just under a kilo. Her mom wrapped her up in a shawl, climbed back on the bus and went to the hospital where she left her with the doctor as planned.

Two weeks later, two young American doctors were volunteering at the same hospital. They heard the story of the baby girl who needed a home and one of them said: 'My sister will adopt her.'

The sister was me. Moy Moy came into our family at the age of two weeks. She was our third child and our second daughter. Being so premature and so small at delivery, it was not surprising that she had cerebral palsy and an intellectual impairment.

I tell this story partly to explain my life and partly to establish my credibility. Moy Moy is now 26 years old, and that makes me something of a disability expert. But I was not born that way. When Moy Moy arrived, I was an ordinary mother with two typical children. I had zero experience, no training whatsoever, and absolutely no idea about anything related to disability. All I knew was that this child was now mine and it was my responsibility to bring her up. If there was something I did not know, I needed to learn it. If there was a skill I did not have, I needed to acquire it.

There is a stark clarity about parenthood which every parent understands instinctively. Love and duty are indistinguishable. You do not debate your responsibilities to your own children. You do not wonder if you 'have' to do something your kid needs to have done. You simply get on and do it, whatever it takes.

Why should schools be any different? School leaders should not get to choose the children who sit in their classrooms, any more than families do. Families are, of course, the original democracy. If your family is anything like mine, it is full of people you might never choose as friends. And yet you cannot imagine your life without them. Even when they confuse you, make demands you do not feel like giving in to, act strangely, or hold political views you find repellent, they are yours. They are family.

This ability to co-exist with a wide variety of people is partly, I believe, what gives human society its remarkable adaptability, resourcefulness, and problem-solving abilities. As a species, we are admirable. We have built a world which is staggeringly complex and sophisticated, conquering time and space and meeting challenges of

monumental proportions. We did not do it by staying in a tiny compound and mixing only with people exactly like ourselves. As the world has evolved, we are seeing a sea change in the whole concept of family, kinship, and relationships. Even once immutable laws of nature are now questioned and transformed (think about gender identity, same sex marriage, and surrogate parenthood).

My own story is emblematic of how this is unfolding. I was born in a small city in the United States but I married a man from Mumbai and settled in Dehradun, in the foothills of the Himalayas. Our children were raised in India but two of them hold US passports. Our son recently married a girl from China and they are living in London. Our older daughter is in love with a boy from England and they are both at the University of Chicago doing PhD (she is a practicing Catholic, studying the Hebrew Bible; he is a secular Jew doing Islamic Studies). Our youngest was birthed by a village woman from the Garhwal Himalayas but has traveled all over the world; she has met both the Pope and the Dalai Lama and presides calmly over the mini-empire her disabilities inspired me to start.

There are many who totally reject the premise of such wild, unlikely stories. They are the same ones who believe that we should all stay in our own contracted circles, marry only our own kind, and produce children who think and behave just as we do. ISIS, RSS, born-again Christians, Jewish zealots—God bless them all, but the world has moved on. Our children simply are not interested in that kind of limited life.

I believe the same thing should be true for our schools. Educational institutions should be just like our world. We should be able to stand at the open door of any school and say with pleasure and anticipation as the children rush in: Here comes everybody!

Poor, rich, girls, boys, smart, slow, fit, and disabled: everyone is welcome here. The idea that schools are for everyone, that every single child has the right to an education, is one of the most revolutionary concepts in the world. It is the foundation of democracy, the great equalizer—it is what makes it possible for a boy born in poverty to end up as a prime minister or president or for a girl born in a tiny African village where no one knows how to read to end up winning a Nobel Prize in Literature.

But it is more than that. Because education is richer, more vibrant, and more sustainable when everyone takes part. Schools are more creative, more interesting, and more effective when they welcome and encourage all kinds of learning. That is how we change the story.

Including children from diverse backgrounds *meaningfully* in our classrooms guarantees a better education. Everyone benefits. This is documented and evidence-based, not just a disability advocate making claims.

While Howard Gardner's theory of multiple intelligences has attracted criticism from the scientific community, teachers and parents—particularly of young children—have responded enthusiastically, and with relief, to the idea that 'one size fits all' is a misnomer not only in clothing but in schools. To them, it is self-evident. Any parent of more than one child will testify to how different her kids are to each other—even though they are growing up in the same house with the same parents. Teachers, dealing with many children of the same age, have even more evidence.

It stands to reason, then, that schools need to cater to as many of the 'intelligences' as possible. Gardener's original work (1983) listed seven: linguistic, logical-mathematical, musical, bodily-kinesthetic, spatial, interpersonal, and intrapersonal; later he added naturalist intelligence and now says there may be even more.

Gardner himself advises teachers to see students as individual learners and then to mix it up:

> 1. Individualize your teaching as much as possible. Instead of 'one size fits all,' learn as much as you can about each student, and teach each person in ways that they find comfortable (and which allow them to) learn effectively. 2. Pluralize your teaching. Teach important materials in several ways, not just one (e.g. through stories, works of art, diagrams, role play). In this way you can reach students who learn in different ways. Also, by presenting materials in various ways, you convey what it means to understand something well. If you can only teach in one way, your own understanding is likely to be thin.

This attitude is fundamental to inclusive education and goes to the heart of the problem India faces in achieving it. Are schools actually convinced that 'reaching' students—all students—is the goal of their teaching? Or is it simply to get through the syllabus, cover the material, and sign off on another term? Anecdotally, most teachers and principals locate the problem of children not doing well on exams to their failing to learn; I have seldom heard them admitting that they may have failed to teach.

Children with disability only provide the starkest illustration of learning differences. Their difficulties are apparent to anyone with even the most limited powers of observation. But in fact, every single classroom in every single school in the country is full of children with a wealth of abilities and a wide range of learning styles, intelligences, strengths, and weaknesses. There are also transgender and gay kids, children whose families are migrants, children whose first language is not the one being used in school, kids who regularly witness or experience domestic violence,

or who are being sexually abused by a relative. Yet most teachers are trained to teach as if all those children share similar backgrounds and come into the classroom with more or less the same perspectives on life. They teach as if all their students learn the same way and as if 'chalk and talk' is an effective way to reach each and every one of them.

It is not, and we know it well. But that stubbornly clung-to belief has spoiled the educational experience of untold millions. It has turned generation after generation of bright, curious children who are hard-wired-to-learn into at best, run of the mill, unimaginative adults who have not achieved anything close to their full potential. How could they when their own realities are dismissed, ridiculed, or simply ignored? At worst, it creates adults who are unhappy, depressed, unfulfilled, and afraid of trying anything new because they have been told too many times their opinions are worthless or irrelevant or that they are failures before they have even begun.

And these are children with no disability to contend with. They are typical children in every sense of the word: they see and hear normally, they have no physical impairment and their intelligence is average or better. For whatever reason—a rural sensibility in an urban environment, a girl's body in a boy's world, a highly developed imagination, an offbeat sense of humour, a rebellious streak, a propensity for dreaming, an artistic sensibility—they simply do not fit in to the average mainstream classroom. Through no fault of their own, they do not learn the way that most schools teach. As Albert Einstein is credited with saying: *Every child is a genius. But if you judge a fish by its ability to climb a tree, it will live its whole life believing that it is stupid.*

This is the backdrop against which inclusive education in India must be considered. We will return to it.

India's RTE Act specifically addresses the issue of children with disability in school. It says clearly and unambiguously that no child can be denied an education because of a disability. Yet we all know that a law on paper and a law which the public accepts and believes in are two entirely different things.

Let me tell you another story. This one is about a little girl named Shefali. Her father is a scientist in a prestigious government research institute in Dehradun. Her mother has a master's degree and teaches in a renowned preparatory school. Shefali was born premature and has cerebral palsy. She needs some help to get around and her speech can be hard to understand until you get used to it. She is a little slow to grasp new concepts, but she is eager to learn and she is curious about the world. She is a friendly, engaging girl and is very easy to like.

Because her parents are so aware, they enrolled Shefali in our early intervention centre when she was still an infant—and she did beautifully. When she turned five, we encouraged her parents to admit her in a good mainstream school. Because of the RTE, her parents were able to get her in the Kendriya Vidyalaya in their neighbourhood and we went for the initial interview to help the school help Shefali make the transition.

Right away, we knew it was not going to be easy. The principal was deeply opposed to any 'child like Shefali' attending her school. What that even means I have no idea. What is a 'child like Shefali'? Whatever this principal thought she knew about her, without ever having even met her, she was adamant that it would not work for her to be in class with so-called normal kids. She was determined that Shefali's 'intelligence' would not match up to the standards she had set for acceptance in her school. And she set out to prove it.

A principal who is reluctant to accept inclusion can sabotage the best laws any activist can frame, any legislature can enact, and any Supreme Court can uphold. This principal told us that her hands were tied. She could not legally refuse to admit Shefali, but she could—and she did—make sure that the child was so miserable that in a short time she would beg not to be sent to school.

The ayahs were told not to do anything extra for her—to the point that her mother had to come in every morning to take her to the toilet. The class teacher was told that she should make no allowances for Shefali's difficulties—either she would keep up with the others or she would fall behind. The children were encouraged subtly and overtly to isolate her, going so far as to leave her alone in a darkened classroom when all the others went out to play.

The greatest barrier to inclusion is not overcrowded classrooms, untrained teachers, inaccessible toilets, or lack of money. The greatest barrier is a bad attitude, an attitude which insists that it cannot and will not work.

A school that truly *wants* to include children will do it. They will figure it out as they go along, just as my husband and I did when we adopted Moy Moy. They will treat each child who walks through their door as a person with a right to be there, a person with potential and something special to give. They will see their own role as the enabler, the one who has to make it happen, the one who has to make it work. This is, dare I say it, the sacred duty of a teacher.

And that brings me to my last story. Gamru is a simple school in a small village in Himachal Pradesh. No fancy equipment, no major funding. What they have got is

a genuine love for children, a bedrock belief that every single child has both rights and potential, and a principal who stands like a rock of conviction and belief.

Gaurav is profoundly deaf and has cerebral palsy and intellectual impairment. Kailash was born with a severe disfigurement of the skull which has left him with only one eye and a very strange looking face. Both of them went first to other schools where they were 'deeply unhappy'.

At Gamru, they were welcomed and included. Their teachers helped the other children to accept and embrace them through preparation, example, direction, and high expectations. They adapted the learning environment so that it worked for both boys. They encouraged the other children to be friends and, in Gaurav's case, to help him with his classwork (Kailash is highly intelligent and does not need much help). Both boys are not only thriving academically at their own different levels but are happy, popular, and emotionally healthy.

Gaurav and Kailash demonstrated their potential for learning once they found the right school. They succeeded—each in his own way. Isn't that what school should be about? Turning on the light of learning in a child's eyes; helping her find her path, helping him discover what he was sent here to do.

And is not this actually what we want for all our children? Whether they have disabilities or not, do we not we want them to grow up to be good people, caring people, people who accept others as they are, people who are capable of seeing beyond appearances and differences and are willing to look out for one another? Even more important, don't we want them to be people with imagination and a genuine appreciation of diversity, an understanding of the complexity of the world, and an awareness that different situations require different approaches; that what works here may not work there?

It will not happen on its own. Nature itself rejects the weak, and the survival of the fittest is accepted as the natural course of events. Babies react with distress to a stranger of another race. The smallest children can be cruel to another child who acts or looks different. Teachers are products of the same intolerant society we are all a part of. And with the best will in the world, some differences just *are* frightening, off-putting, or downright hard to live with.

A blind or a deaf child can make a teacher feel inadequate and insecure; it is her job to explain concepts and ideas through words and reading assignments and she has not a clue how to do this for a student who cannot see to read the assigned texts or hear to listen to her lecture. A child with a physical impairment may need to be carried in an inaccessible school; his bathroom needs may feel intimidating and beyond the call of duty, especially if the teacher is from the opposite sex. A child with intellectual impairment may have a very short attention span, difficulty in understanding basic concepts, and inappropriate behaviour for her age. A child with autism or a mental health problem may disturb others in the class or find the normal chaotic school environment overwhelming and upsetting.

Creating an inclusive classroom, in short, is not simple. It challenges our ideas of comfort and capacity and it stretches us beyond the limits we may have established for ourselves. It forces us to step into the unknown and to reimagine learning using senses, experiences, realities, and skills we are unfamiliar with. For teachers, accustomed to being the authority in the classroom, this is asking a lot. Acknowledging that a child from a village knows more about agriculture than I do, for instance, is humbling; appreciating and making use of the speed with which children develop a sign language that works to communicate with a deaf classmate is even more so.

Inclusion puts us face-to-face with vulnerabilities which cannot be hidden; and most of us prefer to keep our weaknesses to ourselves. We don't like seeing them on display in others unless they happen to be ones we share. Inclusion also forces us to share the same room with people whose experiences are so different from our own as to require us to reconsider our beliefs, assumptions, and values. Accustomed to certainty and unexamined dogma, we are surprised to discover that others have the same certainties about their own beliefs.

Once we acknowledge and account for the wide range of experiences in a typical classroom, it becomes more difficult, if not impossible, to continue with the fictions which pass for truth in our society. Try talking about the institution of marriage as the foundation of a good society to a classroom in which 50 per cent of the children have witnessed their fathers beating their mothers. Try extolling the virtues of democracy and the rule of law to a classroom which has dalit children sitting beside the children of corrupt politicians.

Fundamentally, inclusion forces us to reconsider the true purpose and meaning of education. By ignoring differences and excluding anyone and anything which deviates from the so-called norm, it may be possible to continue thinking about school as an early reckoning place of aptitude and achievement, a place for the tallying and fair distribution of life's prizes and as a clear-cut, time-bound location in which learning occurs.

Done well, inclusion changes that. Now, with so many differences to play with and adapt to, with so many

versions of reality, each completely and demonstrably plausible to *someone*, education becomes more than just a linear acquisition of facts. It becomes instead a process of discovery. It marks the beginning of a journey which will continue throughout one's life. School is transformed from the place where one is told what to think about everything to a place where questioning everything and thinking for oneself critically and creatively—is encouraged, protected, and made possible; a place where differences are accepted and adjusted to—just as they have to be in any neighbourhood, any village, any country if we are to get anything done.

The point, of course, is the phrase: *Done well*. Inclusion can also be done very badly indeed, as Shefali's story illustrates. Simply herding children in and then ignoring the ones who do not fit the standard definitions except when it is time to do head counts and fill government quotas (*Will all the included children please stand up?*) is worse than useless. It is actually harmful since it reinforces deeply ingrained attitudes about whose opinions matter and whose learning is worth bothering about.

Inclusive education is revolutionary because it is based on equality, on the belief, borne out in an active, lived reality that every single child is as worthy as every other. Respect is the guiding principle of inclusive education: respect for each child's value, each child's potential, each child's right to be there.

One day, most of us will experience discrimination (because we are the wrong age, the wrong size, the wrong colour, or the wrong religion). Most of us will find our reality at odds with the reality of a neighbour, a colleague, or a friend. Most of us will continue to find some things incredibly easy (email!) and some incredibly hard (accounts!). If we live long enough—and you can write this down—*all* of us will be disabled—hard of hearing, fragile, unsteady on our feet, easily confused, rattled by small changes in our routine.

And when those days come, we are going to need people around us who know how to adapt and adjust. We are going to want people nearby who have practised kindness and compassion from an early age and who are not threatened by a little weakness, by a touch of vulnerability.

Inclusion just makes sense. As Martin Luther King said: 'The arc of the moral universe is long, but it bends towards justice.'

The RTE Act has bent that arc closer toward the just, inclusive world we all dream of for our children and our grandchildren. It is up to us to see that the arc extends to every single child in India.

Acknowledgement

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5

Disablement in Higher Education

Mapping Barriers and Access in Indian Universities

Kalpana Kannabiran and Soumya Vinayan

Formal education in India faces its biggest challenge from persons with disabilities from diverse social groups, regions, and locales. Disabling spatial normativities interlock with cultural barriers and curricular assumptions of ability that construct any departure from stringent 'normality' in essentialist terms of 'incapacity' or the need for 'special provisions'. This presents a structural and epistemological exclusion as its opposite, so that the mere overture towards a person with disabilities is presented as 'inclusive policy'—all 'for the benefit of persons with disabilities' entering formal schooling. Higher education is the niche, even within the larger and more complex terrain of formal education, which presents an opportunity (unrealized, for the most part) to set in motion a different sensibility on questions of social justice and representation, displacing encrusted exclusions and barriers through curricular, co-curricular, and spatial interventions/reorderings. This inauguration of a different sensibility is by definition political and transformative—also deeply discomfiting in its displacement of status-quoist normativities of different orders.

The question of identity, and the specific ways in which thought constructs the human body determine quite directly the structures through which persons with different human/social attributes will be accommodated in different social milieus. Most relevant to the present argument is the need to place care *about* the body at the heart of institutional logic: for example, 'the absence of wheelchairs in poor countries, along with inadequate street and public accommodation facilities create a virtually inaccessible world for persons with mobility impairments' (Davis, [1997] 2010: 313). This seemingly simple statement foregrounds for us the fact that Higher Education (HE) while available on paper might well be cordoned off through a series of intersecting obstructions (barriers) in knowledge, technology, and infrastructure, reproducing and deploying segregations within institutional spaces and reinforcing ableist and other hegemonies even while seeming to 'accommodate' them. On this subject, Nussbaum argues persuasively that disability is handed as an afterthought in social contract necessitating 'accommodation' and the 'removal of barriers' (Nussbaum, 2006)—the erection of barriers itself is a matter of foundational exclusions, of inarticulate premises that structure consciousness, and architectural design. How does one get around this problem (See Kannabiran, 2012)?

A preliminary investigation of the challenges faced by persons with disabilities in institutions of higher learning in India (Kannabiran and Vinayan, 2016) pointed to serious gaps in our understanding of the place of disability in imagining the structures (spatial and epistemological) of learning—gaps that only strengthened existing forms of neglect, discrimination, and structural violence in the social order outside the gated university community. We present, in this chapter, our findings from a study that built on these preliminary observations, to explore in greater depth the challenges persons with disabilities pose to the public university system in India—central and state universities.

There has been a fairly animated debate on 'inclusive education', a term which gained global attention as early as 1994 with the Salamanca Statement by the United Nations Educational, Scientific and Cultural Organization (UNESCO), followed by the Education for All (EFA) by UNESCO in 2005 and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006. While the Salamanca Statement provided the framework for the integration of special needs education

into general education, it was the EFA, which broadened the framework to include issues of access, participation and achievement. This is reflected in the definition of inclusion by UNESCO (2005: 13), which states that

> inclusion is seen as *a process* of addressing and responding to the diversity of needs of all learners through increasing participation in learning, cultures and communities, and reducing exclusion within and from education. It involves changes and modifications in content, approaches, structures and strategies, with a common vision which covers all children of the appropriate age range and a conviction that it is the responsibility of the regular system to educate all children.

The UNCRPD 2006 is considered a watershed in the disability rights movement effecting a categorical shift from welfare concerns to a rights framework. Article 9 and Article 24 of the Convention holds relevance to ensuring inclusive education for persons with disabilities (hereafter PWDs). Article 9 is primarily concerned with accessibility; Article 24 recognizes the rights of persons with disabilities to education. It calls for inclusive education to ensure that PWDs 'are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability'. While education is generally regarded as a 'public good', research from across the world has suggested that investment in primary education carries higher returns while higher education, the least.

The entire discussion on higher education today, indeed of formal education itself, centres on planning, policy, budgetary allocations, returns, and 'externalities'—neoliberal frameworks that attempt to measure benefits in relation to cost of providing conditional access to a fixed number of individuals with stable attributes. This fits in with a neoliberal governmental rationality, where 'human beings are conceived as autonomous entrepreneurs of their respective lives: life is regarded as an enterprise, qualified in terms of choice, investment, competencies, and (human) capital, and oriented by highly diverse needs' (Simons and Masschelein, 2008: 216). Schools and institutions of learning (among other public services) become enterprises that demand abilities to communicate and participate from their student-clients who may autonomously contract services of their choice (Simons and Masschelein, 2008: 217). What does inclusion in a 'society of stakeholders,' mean for students and teachers with disabilities? (Gary Thomas cited in Simons and Masschelein, 2008: 218).

We argue, after Roulstone et.al. that these frameworks pre-determine the current and future social possibilities for disabled people' (2014: 1). It is necessary, therefore to place an understanding of the specific ways in which policy spaces construct physical, psycho-social, and ontological spaces provided to persons with disabilities in order to comprehend better the logic of social spaces, and the ways in which a society is enabled or disabled. 'Disability geographies' help us displace the spatial fixity of policy by opening out to view the multitudinous registers along which policy places constraints on the life opportunities of persons with disabilities. Space is critical to the life of a person with disability—where can one enter? How does one enter? How much may one move about? What are the barriers? How does one negotiate them? Is it possible for a disabled person to negotiate barriers, or is the condition of impossibility built into the idea of the barrier itself, making the overture towards negotiation/navigation itself exceptional? Does disability inhere in the space (is it constitutive of the space) or is it a sum of individual attributes that call into account individual 'will power'? In exploring the question of spatial geographies of disability, we would of course need to be mindful of the fact that we are not referring to the structural and the material alone, but importantly to the ways in which ideas of space structure the symbolic, the cultural and the material.

It is with these questions before us that we enter the fields of higher education in an attempt to map its barriers and the travels of persons with disabilities across, around and against these barriers in Indian universities.

Locating Disability in the Context of Higher Education

An OECD study (2011) covering 6 countries (Czech Republic, Denmark, France, Norway, Ireland, the USA) found that 'school for all' and the strategies adopted at the upper secondary school level have contributed to the participation of disabled students in tertiary sector while motivation from primary and secondary school teachers, conducive family environment, and sufficient financial support were also factors that contributed to access to higher education (Tuomi et al., 2015).

Several empirical studies of the problems faced by persons with disabilities in higher education in different countries have pointed to several specific concerns: physical, information, entrance to higher education, assumptions of normality, and levels of awareness (Tinklin and Hall, 1999; Shevlin et al., 2004); choice of university determined by physical access to the university, along with the choice of courses it offered (Hadjikakou et al., 2010); nature of disability was found to determine choice of institution (Hopkins, 2011); exposure to special schools

it was found in some cases, set a standard from past experience that was not met by the present location. Choice of courses, studies have found, are heavily dependent on the type of disability rather than academic credentials; and students with disabilities have also reported inconsistency of behaviour of instructors between departments, within departments or by the same tutor (Hopkins, 2011). The all-pervasive perception of 'normalcy' in higher education discourse was highlighted by the study by Madriaga et al. (2011). Barriers in higher education have been found to result in a relatively higher proportion of drop-outs among students with disabilities when compared to those without (OECD 2011); campus life generally tended to enable greater participation from persons with disabilities when they were included in decision-making (Matshedisho, 2007; Beauchamp-Pryor, 2012).

The abysmally low awareness among faculty regarding disability along with the absence of enabling class environment has been well researched and documented (Cook et al., 2009; Baker et al., 2012; Abu-Hamour, 2013; Gaad, 2013). While most of the faculty was responsive to the requirements of the students with disabilities, they were unaware of institutional mechanisms, legal framework, and were also rigid in changing the course content of methods of evaluation and assessment. In terms of accommodating the requirements of the disabled students, faculty had no training and teaching methods largely followed trial and error methods and were often discriminatory. This of course still does not address the experiences of teachers with disabilities in a classroom, and the ways in which the hierarchies of the classroom shift (if they do); the resultant spatial reorganization and its effect on classroom relationships; and the hermeneutical and curricular shifts that might result in these cases.

Evaluation and assessments typically exhibited complete lack of planning and coordination to understand the needs of the students with disabilities with respect to re-arranging examinations and absence of modularization of assignments. This was compounded by non-availability of study resources in Braille or absence of assistive technologies (Brandt, 2011). In addition, the indifference in the attitude of instructors to make arrangements for 'special needs' also act as one of the major attitudinal barriers. A study by Hanafin et al. (2007) found that multiple-choice questions at the end of the course led to students using surface learning approaches whereas assignment essays prompted deep learning approaches in students especially with learning disabilities (such as dyslexia). Although the motive of excellence in higher education should not be 'how to exclude than how to include' (Willie, 1987, cited by Hanafin et al., 2007: 44), the curriculum, methods of learning, and assessment tend to gravitate towards exclusion.

An examination of course contents of English literature in 79 universities in the United Kingdom did not have any representation of disability while it took cognizance of several forms of identities such as ethnicity, class, gender, and sexuality (Bolt, 2004). Bolt also observes that university websites are most often the first point of contact for those with disabilities desiring to pursue higher education, and such absence of mention of disability would be 'indicative of the notion that disabled people are grotesque, more "them" than "us"' (Bolt, 2004: 5). Similar concerns were also raised by Higbee et al. (2010) in their study on higher education in the USA. It was found that students deeply appreciated the inclusion of disability specifically about language use ('othering' language) in a course on popular culture in the University of Minnesota. The study concludes that inclusion of disability is critical in all spheres of campus community in order to promote diversity.

In India, a study conducted by NCERT (2013) found that only 1/8th of the students with disabilities enrolled in primary school level reached higher secondary level.

Holding up the structures and institutional apparatuses that 'contain' education and providing coherence to it, is the politics of knowledge production, ideologies of embodiment, and construction of spatial geographies through policy. It is not merely a question of diversity and inclusion, but more importantly questions of power, hegemony, and representation that give meaning to the overwhelming presences and significant absences, negations, and invisibilities in higher education (Kannabiran and Vinayan, 2016).

Disability in Higher Education: A Review of Studies in the Indian Context

There are few studies from India that have looked at the challenges that confront persons with disabilities in higher education. In a study of students with disabilities in Delhi University colleges, Jameel (2011) delineates attitudinal barriers, gender, and disability-specific bias. The study shows that non-availability of physical infrastructure leads to exclusion of students with disabilities in some colleges (lack of hostel accommodation). In addition, it was revealed that visually impaired students enjoyed most of the scholarships in these colleges. There was a concentration of students with disabilities in the humanities, with the highest number drawn from those with visual impairment, and a higher proportion of men in co-educational colleges. Another study of colleges under Delhi University (Saksena and

Sharma, 2014) reveals that physical and attitudinal barriers are major obstacles to participation in higher education. There was a lack of awareness among students with disabilities about the establishment of Equal Opportunity Cells in the university and equal opportunity enabling units in colleges as per mandate of the Government of India. The study also pointed to family environment (where family members had accessed higher education) as enabling access and bias against disabled students studying science. In the absence of adequate hostel accommodation, transportation was a major issue for students with disabilities. In terms of physical access and attitudes, the responses were not encouraging. Several other studies also laid emphasis on creating inclusive educational environments through accessible physical spaces, popularization of open and distance mode, inclusiveness in decision-making, and so on.

One of the most important measures, even prior to UNCRPD, have been the constitutional provisions which enable affirmative action in education and employment to bridge the barriers that persons with disabilities face. Irrespective of the constitutional mandate, the third survey on Status of Disability in Higher Education in India conducted by National Centre for Promotion of Employment of Disabled People (NCPEDP) found that only 0.5 per cent of the mandated 3 per cent reservation in educational institutions was made available to persons with disabilities.[1] Moreover, the All India Survey on Higher Education (AISHE) (2014–15) (Provisional) Report indicates that there are 78,449 persons with disability in enrolled across various states in the country. Census of India remains the major source of information though 58th Round of NSSO (2003) dealt with exclusively on disability. The figures of Census of India 2011 illustrates that 54.5 per cent of the total disabled population are literate in contrast to 49.3 per cent in 2001. Men fared better than women in both the Census periods although one can discern improvement in literacy levels in both categories. The literacy levels of men increased from 58 per cent to 62 per cent while that of women too registered increase from 37 per cent to 45 per cent between the Census periods.

Case law on access to education gives us some insights into the problem of exclusion of persons with disabilities in higher education (Kannabiran, 2012). In 1999, the Expert Committee constituted by the Ministry of Social Justice and Empowerment, Government of India, identified posts in Delhi University, set out criteria for the relaxation of standards where candidates with disabilities who met the general standard were unavailable, and observed that the 3 per cent reservation need not limit the inclusion of persons with disabilities, but must only be the minimum below which appointments must not fall. In the year 2001, the Delhi High Court found that with respect to providing employment opportunities to persons with orthopedic and visual disabilities, 'not-withstanding clear, unambiguous and laudable objectives sought to be achieved by a decision [of the University of Delhi],…it remains only on paper because of apathy, lack of will and lackadaisical approach of the authorities who are supposed to implement such decision'.[2] Although the Executive Council of the University of Delhi had discussed the matter and moved a resolution in July 1994, to provide 3 per cent reservation without relaxation of required qualifications to 'blind and orthopedically handicapped candidates', no college in the Delhi University system had actually moved in this regard till 2001. The court found evidence of the availability of suitable candidates who surpassed the general standard, calling into question disablist definitions of merit. Take for instance this observation from the court:

> The petitioner, who is a handicapped person, as she was born with congenital blindness, *has not allowed this disability to disable her*. Even without any vision or proper vision since birth, *the petitioner not only pursued her studies but proved to the world at large that what a normal student could do she could do the same equally well or even better*. This is clearly demonstrated by the testimony of her academic record.[3]

In the decade of the 2000s, courts also imposed sanctions on institutions that neglected to comply with legislation protecting the rights of the disabled.[4] Yet the problem persists as our survey, and observations in institutions of HE have shown (See also Kannabiran and Vinayan, 2016).

Disablement in Higher Education in India: Primary Findings

This section presents the findings of the survey initiated in June 2015 to examine the challenges disability poses to HE in India.[5] The survey was not limited to persons with disabilities and elicited views on disability, disability related information (if disabled), details of education—institution of study, period of study, disclosure, evaluation, and assessment and experience of and encounters with disability. The first phase of the survey was an online version (32). This was then followed by a direct survey in Central Universities and State Universities in two phases: The Central Universities were Central University of Punjab (4), Central University of Orissa (16), Central University of Gujarat (15), Jawaharlal Nehru University (70), University of Hyderabad (22), Maulana Azad National Urdu University (10), Rajiv Gandhi University Arunachal Pradesh (12), Pondicherry University

Table 5.1 Participants with Disabilities by Type

Type of disability	No. of persons
Visual	267 (64.5)
Locomotor	104 (25.1)
Speech & Hearing	5 (1.2)
Intellectual	13 (3.1)
Psycho-social	1 (0.2)
Learning	3 (0.7)
Others	21 (5.1)
Total	414 (100.0)

Source: Field Survey.

(31) and Delhi University (66). State Universities covered include Jammu University (52), Gauhati University (7), Kerala University (40), Kannur University (12), Calicut University (70), M G University (47), Savitribai Phule Pune University (56), Madras University (36), Andhra University (39), Gulbarga University (2), Karnataka State Women's University (13), Rani Chennamma University (7), Karnatak University (1), and BLDE University (2). In addition, the schedule was also canvassed among the participants of a Refresher Course on Disability Studies for university and college teachers from across India conducted by the School of Humanities, University of Hyderabad (30).

PROFILE OF THE PARTICIPANTS

A total of 414 PWDs and 278 persons without disabilities (hereafter ND) participated in the survey. The ND included a parent/family or an intimate partner of PWD, a disability services and rights professional, an administrator in higher educational institution, a teacher in special education and other than special education, among others. Among the PWD participants, persons with visual impairment accounted for majority of the participants (65 per cent), followed by those with locomotor disability (25 per cent), others (5 per cent), intellectual and psycho-social disabilities (4 per cent) and speech and hearing impairments (1 per cent). Three out of 692 participants also reported learning disabilities (Table 5.1). Ninety-one per cent of PWDs reported that they had certification of disability. Of these, only 3 per cent had disability certification at lower than 40 per cent. Fifty-five per cent had 100 per cent disability, followed by 21 per cent in range of 40–59, 13 per cent in the interval of 60–79 (Table 5.2).[6] In terms of cause of disability, the participants

Table 5.2 Incidence of Disability by Certification among Participants

Percentage of disability as per certification	Type of disability							Total
	Visual	Locomotor	Speech & Hearing	Intellectual	Psycho-social	Learning	Others	
Less than 40	5 (41.7) (2.0)	5 (41.7) (5.1)	–	–	–	1 (8.3) (33.3)	1 (8.3) (6.7)	12 (100.0) (3.2)
40–59	16 (20.5) (6.4)	47 (60.3) (48.0)	1 (1.3) (25.0)	2 (2.6) (33.3)	1 (1.3) (100.0)	1 (1.3) (33.3)	10 (12.8) (66.7)	78 (100.0) (20.7)
60–79	17 (30.9) (6.8)	31 (56.4) (31.6)	2 (3.6) (50.0)	2 (3.6) (33.3)	–	1 (1.8) (33.3)	2 (3.6) (13.3)	55 (100.0) (14.6)
80–99	13 (52.0) (5.2)	11 (44.0) (11.2)	–	1 (4.0) (16.7)	–	–	–	25 (100.0) (6.6)
100	199 (96.1) (79.6)	4 (1.9) (4.1)	1 (0.5) (25.0)	1 (0.5) (16.7)	–	–	2 (1.0) (13.3)	207 (100.0) (54.9)
Total	250 (66.3) (100.0)	98 (26.0) (100.0)	4 (1.1) (100.0)	6 (1.6) (100.0)	1 (0.3) (100.0)	3 (0.8) (100.0)	15 (4.0) (100.0)	377 (100.0) (100.0)

Source: Field Survey.

Table 5.3 Participants by Gender and Age Group

Socio-economic variable	Person with disability	Person without disability	Total
Gender			
Male	280 (61.9) (67.6)	172 (38.1) (61.9)	452 (100.0) (65.3)
Female	133 (55.6) (32.1)	106 (44.4) (38.1)	239 (100.0) (34.5)
Transgender	1 (100.0) (0.2)	–	1 (100.0) (0.1)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)
Age Group			
Below 20	61 (60.4) (14.7)	40 (39.6) (14.4)	101 (100.0) (14.6)
20–29	297 (64.8) (71.7)	161 (35.2) (57.9)	458 (100.0) (66.2)
30–39	32 (37.2) (7.7)	54 (62.8) (19.4)	86 (100.0) (12.4)
40–49	17 (45.9) (4.1)	20 (54.1 (7.2)	37 (100.0) (5.3)
50–59	5 (83.3) (1.2)	1 (16.7) (0.4)	6 (100.0) (0.9)
60–69	–	1 (100.0) (0.4)	1 (100.0) (0.1)
Above 70	2 (66.7) (0.5)	1 (33.3) (0.4)	3 (100.0) (0.4)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)

Source: Field Survey.

had the choice not to answer the question—almost half of the PWDs (49 per cent) chose to answer the question. Polio, illnesses related to the eye (retinal complication, micro cornea, cataract, glaucoma), accident, complications at the time of birth, medical negligence at the time of delivery, post-operative and post-illness complications, and genetic and neural disorders were reported.

The distribution across disabilities points to the relatively easy entry granted to persons with visual and locomotor disabilities, and the virtual ousting of those with psycho-social/intellectual disabilities as well as those with speech and hearing impairments within university settings. A politico-cultural setting that only grants sighted 'phonocentric citizenship' and oral/speech driven (even cacophonous) communication constructs space in relation to sound and sight, so that the geographies of disability in universities are mapped in ways that puts the speech and hearing impaired out of its boundaries, permits limited and conditional access to those with intellectual and psycho-social disabilities, and provides access without enabling structures to the visually challenged. In the words of one of our participants, popular perception of disability within accommodative frames is an ableist perception, where physical disability is granted visibility, but psycho-social disability is never alluded to.[7] In general, as Imrie suggests, '[d]isabled people's abilities to express autonomy is constrained and curtailed by socio-political and institutional practices that de-value particular bodily dispositions, capacities and experiences, and, consequentially, may reproduce disabling relations of dominance. This reflects the exercise of bio-power and the reduction of life to biological categories, and the subjugation of those that do not conform to socio-culturally constructed conceptions of the normal, active, body' (Imrie, 2014: 18–19).

Of the total 692 participants, 452 (65 per cent) were males, 239 were females (35 per cent) and 1 transgender (Table 5.3). Among PWDs, of the 414, majority were men (68 per cent). In terms of age group, 66 per cent of the participants were in the age group of 20–29, followed by 15 per cent below 20, 12 per cent in the age group of 40–49 and less than 1 per cent each in 50–59, 60–69, and above 70. Among PWDs, 72 per cent were in age group of 20–29, 15 per cent were below 20, 8 per cent were in 30–39 and rest above 40. In case of ND, while below 20 constituted 15 per cent like among PWDs, the age group of 30–39 accounted for 20 per cent and 7 per cent were in the age group of 40–49 (Table 5.3). This could be attributed to the fact that most of them were faculty.

Nine per cent of the participants reported no religious affiliation, 68 per cent were Hindus, 11 per cent were Muslims, 9 per cent Christians, and rest were Buddhist (2 per cent), Sikhs (1 per cent), Jains, and Others (less than 1 per cent). Forty-three per cent of participants belonged to OBC, followed by Others (35 per cent), SC (13 per cent), Minority (6 per cent), and ST (4 per cent) (Table 5.4).[8] The demographic shift in universities—in our

Table 5.4 Participants by Religious Affiliation and Social Location

Socio-economic variable	Person with disability	Person without disability	Total
Religion			
No religious affiliation	22 (37.3) (5.3)	37 (62.7) (13.3)	59 (100.0) (8.5)
Hindu	281 (59.7) (67.9)	190 (40.3) (68.3)	471 (100.0) (68.1)
Muslim	61 (81.3) (14.7)	14 (18.7) (5.0)	75 (100.0) (10.8)
Christian	39 (62.9) (9.4)	23 (37.1) (8.3)	62 (100.0) (9.0)
Sikh	5 (71.4) (1.2)	2 (28.6) (0.7)	7 (100.0) (1.0)
Buddhist	3 (23.1) (0.7)	10 (76.9) (3.6)	13 (100.0) (1.9)
Jain	1 (50.0) (0.2)	1 (50.0) (0.4)	2 (100.0) (0.3)
Others	2 (66.7) (0.5)	1 (33.3) (0.4)	3 (100.0) (0.4)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)
Social Location			
SC	38 (43.2) (9.2)	50 (56.8) (18.0)	88 (100.0) (12.7)
ST	22 (73.3) (5.3)	8 (26.7) (2.9)	30 (100.0) (4.3)
OBC	188 (63.9) (45.4)	106 (36.1) (38.1)	294 (100.0) (42.5)
Minority	24 (63.2) (5.8)	14 (36.8) (5.0)	38 (100.0) (5.5)
Others	142 (58.7) (34.3)	100 (41.3) (36.0)	242 (100.0) (35.0)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)

Source: Field Survey.

sample, 66 per cent from SC/ST/OBC/minorities, with OBCs the single largest group—is one that has effected far-reaching transformations in the civic, political, and academic lifeworlds of students and teachers in universities, as we have witnessed in the recent student movements across campuses in India. That the shift is also evident in the social composition of students with disabilities is particularly significant as it compels us to examine the intersecting fields of exclusion, discrimination, and articulation of rights on campuses more closely.

In terms of marital status, 53 per cent were currently single while 27 per cent were never married followed by 15 per cent who were currently married, 3 per cent who were in intimate relationship, and others (2 per cent). In case of PWDs, 8 per cent were currently married (25 per cent among ND), while 60 per cent were currently single (41 per cent for ND) followed by never married 29 per cent (25 per cent for ND). These differences in marital status among PWDs and ND may be attributed to PWDs' current status as students in contrast to larger proportion of faculty among ND (Table 5.5).

Given the influence of family environment on access to education (also reported by studies on disability and formal education), the survey explored levels of parental education. Sixty per cent of fathers of PWDs reported formal undergraduate education while the

Table 5.5 Participants by Marital Status

Marital status	Person with disability	Person without disability	Total
Never married	119 (63.3) (28.7)	69 (36.7) (24.8)	188 (100.0) (27.2)
Currently married	35 (31.8) (8.5)	75 (68.2) (27.0)	110 (100.0) (15.0)
In an intimate relationship	6 (30.0) (1.4)	14 (70.0) (5.0)	20 (100.0) (2.9)
Currently single	248 (68.3) (59.9)	115 (31.7) (41.4)	363 (100.0) (52.5)
Others	6 (54.5) (1.4)	5 (45.5) (1.8)	11 (100.0) (1.6)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)

Source: Field Survey.

Table 5.6 Level of Education of Parents of the Participants

Level of education of parents	Person with disability	Person without disability	Total
Father			
Non-literate	91 (64.1) (22.0)	51 (35.9) (18.3)	142 (100.0) (20.5)
Below graduation	250 (68.1) (60.4)	117 (31.9) (42.1)	367 (100.0) (53.0)
Graduation	50 (44.2) (12.1)	63 (55.8) (22.7)	113 (100.0) (16.3)
Postgraduation	17 (36.2) (4.1)	30 (63.8) (10.8)	47 (100.0) (6.8)
Above postgraduation	5 (25.0) (1.2)	15 (75.0) (5.4)	20 (100.0) (2.9)
B. Tech (Technical)	1 (33.3) (0.2)	2 (66.7) (0.7)	3 (100.0) (0.4)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)
Mother			
Non-literate	128 (66.3) (30.9)	65 (33.7) (23.4)	193 (100.0) (27.9)
Below graduation	246 (64.2) (59.4)	137 (35.8) (49.3)	383 (100.0) (55.3)
Graduation	30 (38.5) (7.2)	48 (61.5) (17.3)	78 (100.0) (11.3)
Postgraduation	9 (31.0) (2.2)	20 (69.0) (7.2)	29 (100.0) (4.2)
Above postgraduation	1 (11.1) (0.2)	8 (88.9) (2.9)	9 (100.0) (1.3)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)

Source: Field Survey.

corresponding figure was 42 per cent for NDs. While 23 per cent of fathers of NDs were graduates, it was 12 per cent among PWDs. Twenty-two per cent (18 per cent for NDs) were non-literate among PWDs. Majority of mothers had education below graduation (59 per cent) while 31 per cent of mothers were non-literates among PWDs. Only around 10 per cent had education above graduation. In case of NDs, more than one quarter (27 per cent) of mothers had education above graduation whereas 49 per cent accounted for below graduation and another quarter (23 per cent) were non-literates (Table 5.6).

Among total PWDs, 86 per cent were students, 5 per cent each were faculty and staff/administrator and 4 per cent were independent scholars/professionals. In contrast, among persons without disabilities, 69 per cent were students, 19 per cent were faculty, 7 per cent were independent scholar/professional and 5 per cent were staff/administrator (Table 5.7). It is important for the purposes of this chapter to flag the low proportion of teachers with disabilities—which has immediate implications for our understanding of the place of disability in pedagogy, pedagogic practices, learning outcomes, classroom barriers, communication, knowledge, and classroom relationships.

Out of a total of 692 participants, 82 per cent were pursuing their education while 18 per cent had completed studies. Among PWDs, 14 per cent had completed education while 86 per cent were still studying. Among the latter, 51 per cent were studying graduation, 32 per cent were in postgraduation and 13 per cent were pursuing their doctoral studies. Among those who had completed education around one-third each was doctorates, postgraduates, and graduates. Among those pursuing education among the NDs, 35 per cent were enrolled for predoctoral and doctoral studies, 31 per cent for postgraduation and 35 per cent for graduation. Sixty-two per cent had completed their studies followed by 19 per cent who had finished their postgraduation, followed by graduates (13 per cent) and M.Phil (6 per cent) (Table 5.8).

A majority of the participants (53 per cent) belonged to state universities, while central universities accounted for 28 per cent followed by private colleges (aided and affiliated to recognized universities) at 15 per cent. The rest were spread across private universities, research institutes, private unaided colleges, deemed universities, and international universities abroad (Table 5.9). Ninety-three per cent of those currently enrolled were regular full-time students in their respective years of education. The choice of subjects throws up a telling pattern: social sciences (41 per cent), closely followed by humanities (34 per cent), with extremely low enrollments in science (9 per cent) and 3 per cent each commerce, engineering, and education (Table 5.10). English was the major medium of instruction while speech was the medium of

Table 5.7 Participants by Age and Current Affiliation

Current affiliation	Age group						Total
	Below 20	20–29	30–39	40–49	50–59	Above 70	
Person with disability							
Student	61 (17.2) (100.0)	276 (77.7) (92.9)	15 (4.2) (46.9)	1 (0.3) (5.9)	–	2 (0.6) (100.0)	355 (100.0) (85.7)
Faculty	–	5 (23.8) (1.7)	6 (28.6) (18.8)	8 (38.1) (47.1)	2 (9.5) (40.0)	–	21 (100.0) (5.1)
Staff/Administrator	–	9 (39.1) (3.0)	3 (13.0) (9.4)	8 (34.8) (47.1)	3 (13.0) (60.0)	–	23 (100.0) (5.6)
Independent scholar/ Professional	–	7 (46.7) (2.4)	8 (53.3) (25.0)	–	–	–	15 (100.0) (3.6)
Total	61 (14.7) (100.0)	297 (71.7) (100.0)	32 (7.7) (100.0)	17 (4.1) (100.0)	5 (1.2) (100.0)	2 (0.5) (100.0)	414 (100.0) (100.0)
Person without disability							
Student	39 (20.4) (97.5)	144 (75.4) (89.4)	7 (3.7) (13.0)	1 (0.5) (5.0)	–	–	191 (100.0) (68.7)
Faculty	–	3 (5.7) (1.9)	33 (62.3) (61.1)	15 (28.3) (75.0)	1 (1.9) (100.0)	1 (1.9) (100.0)	53 (100.0) (19.1)
Staff/Administrator	–	4 (28.6) (2.5)	7 (50.0) (13.0)	3 (21.4) (15.0)	–	–	14 (100.0) (5.0)
Independent scholar/ Professional	1 (5.0) (2.5)	10 (50.0) (6.2)	7 (35.0) (13.0)	1 (5.0) (5.0)	–	–	20 (100.0) (7.2)
Total	40 (14.4) (100.0)	161 (57.9) (100.0)	54 (19.4) (100.0)	20 (7.2) (100.0)	1 (0.4) (100.0)	1 (0.4) (100.0)	278 (100.0) (100.0)

Source: Field Survey.

Table 5.8 Educational Level and Status of Education among Participants

Educational Qualification	Status of education		Total
	Completed	Studying	
Person with disability			
Graduation	19 (9.5) (32.2)	180 (90.5) (50.7)	199 (100.0) (48.1)
Postgraduation	18 (13.6) (30.5)	114 (86.4) (32.1)	132 (100.0) (31.9)
Above postgraduation	1 (6.7) (1.7)	14 (93.3) (3.9)	15 (100.0) (3.6)
Ph.D	21 (30.9) (35.6)	47 (69.1) (13.2)	68 (100.0) (16.4)
Total	59 (14.3) (100.0)	355 (85.7) (100.0)	414 (100.0) (100.0)
Person without disability			
Graduation	9 (10.8) (13.2)	74 (89.2) (35.2)	83 (100.0) (29.9)
Postgraduation	13 (16.9) (19.1)	64 (83.1) (30.5)	77 (100.0) (27.7)
Above postgraduation	4 (23.5) (5.9)	13 (76.5) (6.2)	17 (100.0) (6.1)
Ph.D	42 (41.6) (61.8)	59 (58.4) (28.1)	101 (100.0) (36.3)
Total	68 (24.5) (100.0)	210 (75.5) (100.0)	278 (100.0) (100.0)

Source: Field Survey.

Table 5.9 Type of Institution of Study

Type of institution of study	Person with disability	Person without disability	Total
Central University	117 (61.3) (28.3)	74 (38.7) (26.6)	191 (100.0) (27.6)
State University	233 (63.5) (56.3)	134 (36.5) (48.2)	367 (100.0) (53.0)
Private Universities (e.g. AMITY, GITAM)	1 (33.3) (0.2)	2 (66.7) (0.7)	3 (100.0) (0.4)
Research Institute (ICAR, ICSSR, so on)	–	3 (100.0) (1.1)	3 (100.0) (0.4)
Government Colleges (affiliated to recognized Universities)	4 (28.6) (1.0)	10 (71.4) (3.6)	14 (100.0) (2.0)
Private College (aided affiliated to recognized Universities)	55 (52.4) (13.3)	50 (47.6) (18.0)	105 (100.0) (15.2)
Private College (unaided affiliated to recognized Universities)	4 (80.0) (1.0)	1 (20.0) (0.4)	5 (100.0) (0.7)
Deemed University	–	1 (100.0) (0.4)	1 (100.0) (0.1)
International University	–	3 (100.0) (1.1)	3 (100.0) (0.4)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)

Source: Field Survey.

Table 5.10 Subjects of Study of the Participants

Subjects of study	Person with disability	Person without disability	Total
Humanities	143 (61.4) (34.5)	90 (38.6) (32.4)	233 (100.0) (33.7)
Social sciences	176 (62.0) (42.5)	108 (38.0) (38.8)	284 (100.0) (41.0)
Science	31 (50.0) (7.5)	31 (50.0) (11.2)	62 (100.0) (9.0)
Disability studies	4 (50.0) (1.0)	4 (50.0) (1.4)	8 (100.0) (1.2)
Commerce	12 (57.1) (2.9)	9 (42.9) (3.2)	21 (100.0) (3.0)
Education	18 (69.2) (4.3)	8 (30.8) (2.9)	26 (100.0) (3.8)
Engineering	10 (45.5) (2.4)	12 (54.5) (4.3)	22 (100.0) (3.2)
Others	9 (64.3) (2.2)	5 (35.7) (1.8)	14 (100.0) (2.0)
Not mentioned	11 (50.0) (2.7)	11 (50.0) (4.0)	22 (100.0) (3.2)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)

Source: Field Survey.

communication (88 per cent) with 12 per cent reporting Braille, sign language, and assistive technologies.

Financial assistance is an important enabling factor along with family environment and support from teachers, which enables access to higher education. Among PWDs, 72 per cent reported (276 out of 414) that they had financial support to pursue higher education while among the ND the corresponding figure stood at 39 per cent.

Financial assistance, in the form of different types of scholarship, facilitated the access to higher education of the participants. These were: UGC-NET-JRF, university level scholarships, disability scholarships such as NIVH Dehradun scholarship, National Federation of Blind scholarship, Means-cum-merit scholarships, tuition fee waiver, readers' allowance, State government fellowships, escort allowance (Rs 2000/- per month), RGNF, Social welfare scholarships, Chhatrapati Sahu scholarship, Savitribai Phule scholarship, fellowships from Trusts/NGOs such as South Asian Foundation, Ekalavya scholarship from Sahara, Scholarship from Reliance, and so on.

With regard to disclosure of disability, 87 per cent of the PWDs reported that they had disclosed their disability to the institution of study and this was done at the time of application (89 per cent) or at the time of interview/admission. Narratives on issues related to disclosure, however, brought out the stigma and discrimination related to disclosure/non-disclosure.

In this regard, it clearly emerges that certification is deeply rooted in the medical model of disability. It has been documented that the process of certification for benchmark disability involves rigorous medical scrutiny, which is often dehumanizing. The certification is not valid for lifetime and is conducted at regular intervals. In this context, disability movements often call for removal of benchmark disabilities in the realm of education (Council for Social Development, 2014).

The role of social networks in the selection of institution was is clearly evident in the findings of the survey. Majority of the PWDs indicated that friends, peers, family, and teachers played an important role in the selection of the institution of study. It was also pointed out by PWDs that choice of the institution was also influenced inclusive environment, accessible environment including friendly infrastructure at hostels/library, availability of disability support services, among other reasons such as the reputation of the institution, curriculum, subject of study, qualified teachers, nominal fees, peer network, proximity to home or that of relatives were also reported. In stark contrast, for NDs, majority of the responses were related only to the reputation of the institution, quality of teachers, availability of subject of personal interest, peer network, and proximity to home.

DISABLISM IN HIGHER EDUCATION

Studies on the experience of disability in higher education in India have pointed to a complex web of disablism/disablement that is constitutive of the ideological and material contexts of universities and spaces of higher learning (see Imrie, 2014: 15). The most significant expression of this is the 'body-abject' of a conflation of impairment with deficiency, a stigmatizing representation of the individual disabled body: 'In my view, the word disability, or a person with disability is often seen as kind of secondary, less important, unproductive on the very first sight; and a person who is disabled merely exists in non-existence.'[9]

The delineation of images of disability presented by students with disabilities, speaks powerfully of the ways in which *direct* and *indirect psycho-emotional disablism* intertwine with structural disablism—the physicality of disabling environments having a direct bearing on the emotional well-being of a disabled person: According to Reeve (2014), 'psycho-emotional disablism includes internalized oppression which can be considered to arise from the relationship that a disabled person has with themselves; the internalization of the negative messages about disability that are found in the cultural lexicon can lead someone to feel that they are a burden, useless and a second-class citizen' (2014: 103). In the words of a student, 'although "disability" is said to be just a condition and difference by the activists and academicians, it is more often than not perceived in terms of what a person lacks in comparison with majority others. Personally, as a "disabled" person, I would prefer to call it a physical nuisance, for sometimes it disables me to do what others do, or to do things in the ways others do. Culturally, "disability" is seen as a big curse upon the family, deposit of the ancestral sins and punishment of the Gods.'[10]

Figures 5.1 and 5.2 present images of disabilities recalled by persons with disabilities and the non-disabled in the survey.

A more detailed exploration of lifeworlds of disablement pointed to the ways in which the experience of the ordinary every day is denied to persons with disabilities within institutions of learning where the ordinary and normal peaks and troughs in participation and performance that are available to the non-disabled, are denied to students with disabilities: 'Only extraordinary performance evokes praise. What about real life challenges? The so-called mainstream society accepts only a minority group among disabled people…. In Indian scenario…Natya Mayuri Sudha Chandran is never recognized as disabled because she is a great dancer….Mainstream society recognises the value of the disabled once they reach the heights….Can change in images of disabled bring major changes in real lives of disabled?'[11] Or, 'Can change in image trigger change in attitudes?'[12] The problem of stigmatizing representation is one that is deep rooted and reinforces social humiliation on multiple registers: 'When I hear the word disability, the first image which comes to my mind is … how the film directors portray the persons with disabilities in the movies….For instance, if a visually challenged person is shown in a movie, most of the times he is portrayed as a beggar. And especially he is made fun by the comedians. Though the visually challenged persons are working in various posts they are not focused.'[13]

The second set of concerns were focused on naming—is 'disability' a disabling descriptor? 'Being a person with visual disability, I am not quite comfortable to hear the word disability. It sends me a negative connotation of a lack in a person...'[14] This observation derives from experiences of discrimination and mis-treatment in which representation and fact are mutually reinforced, consumed (uncritically?) and witnessed (in complicit silence?): 'When I hear the description of disability, discrimination and ill-treatment of disabled people both

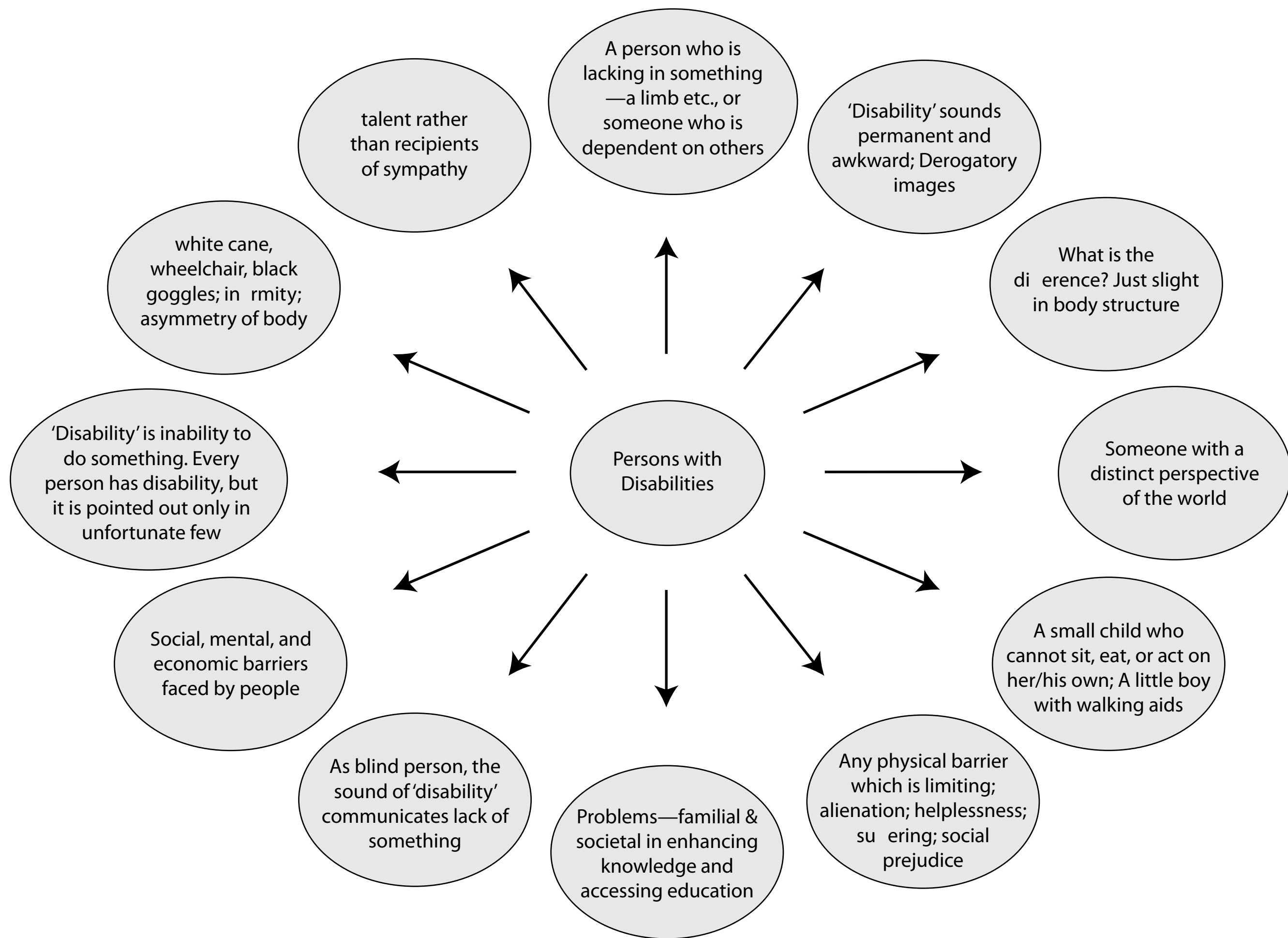

Figure 5.1 Insiders' Recall of Outsider Views
Source: Survey by Authors, 2015.

in the media and in the society come to my mind, as it is increasingly witnessed by all of us.'[15] The fact that 'disability is a social dilemma not an individual problem' (male participant, University of Delhi) is one that is lost in the treatment of persons with disabilities as individuals with impairments by the institutions they enter.

Within the larger space that persons with disabilities occupy the experience of persons with intellectual disabilities merits reiteration: 'My younger brother is differently abled, he has cerebral palsy. From my own experience, I can assert that society by and large is either very indifferent or sometimes quite hostile. In very few instances, people bear normal, equal attitude towards him.'[16]

SPACE, DISABLEMENT, AND BARRIERS: MAPPING DISABILITY IN HE

Attitudes, images, and treatment are tied to spatiality, which are at the core of the experience of students and teachers with disabilities, are reduced completely to the rhetorical assurance to provide 'lifts and ramps' for disabled students within university settings. A close examination of at least two premier central universities in the country has shown that the basic architecture of the campuses cannot even 'accommodate' persons with disabilities. While ramps and lifts (far too few) may be provided at the entrance to constructed structures, the structures themselves are inaccessible in terms of extremely inadequate and ill-equipped hostels, long roads, no signage except visual signs, and no provision of intra campus transport for persons with disabilities to navigate their way across the over hundred-acre campuses that pride themselves on their natural environs, bio-diversity, and/or aesthetic design. Within the buildings as well, at least one university has the office of the vice chancellor on the first floor accessible only through stairs. While washrooms and toilets

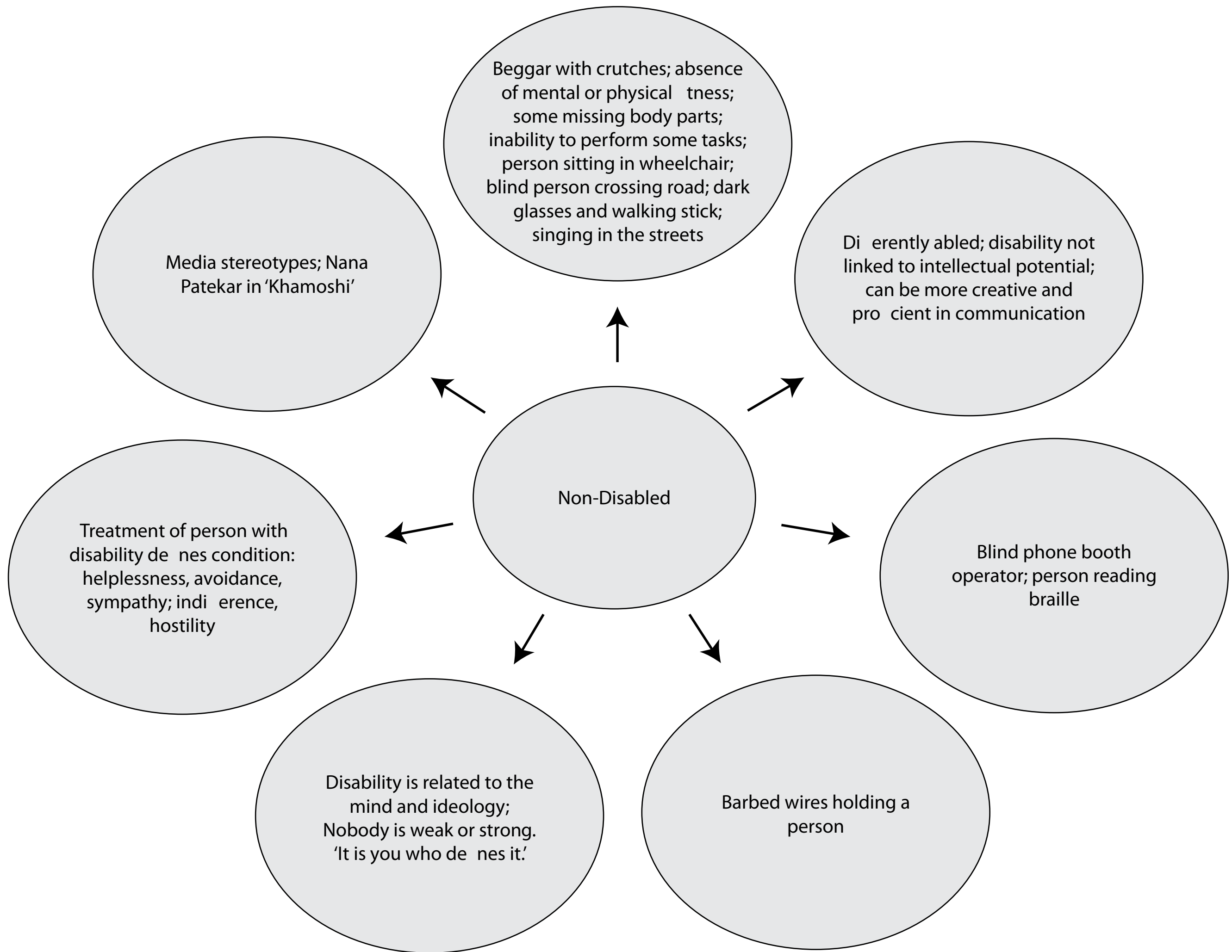

Figure 5.2 Exclusionary Worldviews

Source: Survey by Authors, 2015.

continue to be the bane of Indian built environments, the stated commitment to 'building lifts and ramps for the disabled' does not extend to providing accessible toilets. And yet, even with all of this, we are only speaking of barrier-free access to those with locomotor disabilities—by far the most visible class within the larger community of persons with disabilities.

The understanding of spatiality and access with reference to other kinds of needs of persons with disabilities across the range has not yet entered the reckoning. We could extend Imrie's observations in the context of 'shared space design' to our reading of the geographies of disability within the university, which is purpotedly a shared space, and yet, 'the conception of bodily freedom that underpins shared space design fails to recognise the unequal capacities of bodies. The particular problem of shared space is the disabling nature of its design that conceives of the citizen as an idealized individual defined by, primarily, an ocular culture, or one whereby the primacy of seeing is paramount. This is not dissimilar to Emery's observation about society's perception of deaf people in which social policy is "made in the image of hearing culture"' (Imrie, 2014: 25).

The indispensability of space that may be navigated is at the core of disability access, as is evident from the observations of participants regarding the factors influencing their choice of institutions: 'Main reasons for having chosen the university are barrier free environment throughout the campus, good hostel facilities, assistive technological devices provided by the University Library and so on.'[17] There are others who simply stated that disability support services and a disabled friendly campus

were the deciding factors.[18] But clearly the choice can only be exercised if material resources available to the student permitted such a choice. In most cases, it would be true that the choice of institution is determined not by an enabling environment, but simply because 'I cannot afford another college out of my district.'[19]

Disabling spatialities, to borrow from Imrie, are critical to the absence/conditional presence of persons with disabilities on campuses. Our survey sought responses on degree and extent of accessible physical environment in the institution of study in terms of availability of several provisions such as lifts, ramps, mobility of space, seating and so on (see Table 5.11). The participants were also given the option of ranking the level of use in a scale of 0 to 10 for every indicator. It is evident from the table that while majority reported comfortable access to dining, library, seating arrangements, less than 50 per cent reported assistive devices in public areas, availability of manual assistance including that of availability of lifts and ramps (Table 5.11). Moreover, despite affirmative responses, the mean scores of convenience level were abysmally low across all the physical access indicators ranging from 1.8 to 4.8. Thus, it should be noted that the scores did not even cross 5 in the scale of 0 to 10. This indicates that even when arrangements for removal of physical barriers were put in place, the convenience of use was not anywhere close to desirable levels.

Irrespective of choice, performance, and qualification however, strategies of disablement in selection procedures posit inaccessibility as a norm that must deter the person with disability from daring to enter a space that s/he by definition *cannot* navigate: 'The committee interviewed me related to the subject. After that they asked one question: 'how you are going to come to college and how can you perform experiments in lab?'[20] Or take the instance of a disabled student whose friend with severe disability 'faced problems during stay, travel, attitudinal barriers'.[21] The low presence of students with disabilities in science programmes in Indian universities was validated by the observation of a participant in the survey: 'I think some of the natural science professors are not sensitive to the issues of disability'.[22] Another student was denied admission for PhD in IT Department, and has therefore registered in the Education Department.[23] Yet another was advised to 'take conventional courses'.[24]

Universities are gated communities, which even while delivering a public good like education, sift access along different axes—the performance axis most visible, and the exclusionary axes totally opaque and invisibilized. Admission processes provide a good barometer for

Table 5.11 Physical Access—Availability and Levels of Convenience of PWDs

Particulars of convenience	Number and per cent of affirmative responses	Levels of convenience —mean scores
Availability of lifts	194 (46.9)	2.9
Availability of ramps	212 (51.2)	3.6
Availability of staircase with railings	216 (52.2)	4.8
Space for mobility in the classroom/office/cabin/workspace	268 (64.7)	4.7
Comfortable seating	369 (89.1)	4.4
Availability of manual assistance like drivers, interpreters, and personal assistance	164 (39.6)	2.0
Availability of accessible toilets near classrooms	303 (73.2)	3.8
Availability of accessible toilets at campus residence/hostels	324 (78.3)	4.1
Accessibility to public transport	329 (79.5)	3.4
Availability of waiting areas of public transport	246 (59.4)	3.4
Assistive devices/services in waiting areas	152 (36.7)	1.8
Accessibility to parking slot	183 (44.2)	2.8
Comfortable access to dining space/canteen	308 (74.4)	3.8
Comfortable access to library and other amenities	332 (80.2)	4.3
Comfortable access to campus residence and hostels	334 (80.7)	4.1

Source: Field Survey.

the technologies of gatekeeping where disability is concerned:

As a whole, the admission process was good, but there was no separate arrangement made to facilitate the disabled persons at the time of entrance exam, interview and joining.[25]

As I am physically disabled, I faced a lot of problem during admission; I had to seek help of my friends for admission.[26]

[I] did not face any particular hurdles because of my disability. But I could not grasp the atmosphere and cope up with others because of my disability. Though my experiences during the admission process were not bitter, some help desk for persons with special needs would have made those experiences trouble-free and pleasant.[27]

Frankly speaking, no admission process in Indian institutes is blind-friendly. All institutions require paper work, which was inaccessible to the blind. However, in JNU, there were student volunteers to assist the blind.[28]

I was with my parents so my parents took care of me. In the year 2007 admission process was not that easy, one had to travel from one department to the other either by walk or by using your own transport. But now … the admission process is easy.[29]

Teachers prefer to admit students with disabilities less than 100 percent.[30]

Any marks from a lower course, which are a prerequisite for entry into a higher one ought to be significantly relaxed for anyone who has experienced disability of a serious nature- any nature actually. I got a 52.5 per cent in my masters' and repeat attempts at entry into doctoral program almost a decade and a half later are being rejected, despite me having done a lot of work in research, published in Indian and international peer reviewed publications. Nobody wants to see or acknowledge the work in India, even though it is not in political science, which I did a masters in, but in mental health! My disability experience is of recovery from bipolar over a span of two decades of my life.[31]

Once they enter into the hostile environs of the university, the onus is on persons with disabilities crafting their own solutions—and entering/withdrawing/abstaining from robust participation in the civic life on campus of their own 'free will'—which has already been curtailed by disabling spatialities: 'Since campus is very big, I had problems moving around.'[32]

The visuality of campus cultures—academic and social—present particular sets of difficulties to visually challenged students, who form the largest section of students with disabilities in universities across the country: Completely inaccessible screen reader software; lack of technical facilities to fill out forms; lack of standing rules for use of scribes during examinations; incompetence of scribes especially in spelling and long dictation; and a mismatch between academic background of scribes and students assigned (in this case scribes from fashion design assigned to a social science students).

In spite of having three quarters of participants from the streams of humanities and social sciences, of the 692 participants, only 15 per cent reported that their courses discussed disability (Table 5.12). The discussion on disability was also centred on those who were specifically involved in disability studies either at the doctoral level or had opted for optional course. Moreover, inclusion of disability studies in the curricula were either by those engaged in disability studies or by faculties who had encountered disability. Students of psychology pointed out that inclusive education was part of their course while literature students point out that disability was discussed in class—sometimes through a discussion of barriers to communication,[33] and at other times through creative writing: 'We were introduced to the disability perspective while doing *Beloved* by Toni Morrison by the Professor who herself was disabled.'[34]

In the realm of science, it was discussed as part of genetics or as part of designing buildings in engineering to ensure it is accessible to persons with disabilities, the elderly, and children. Social science students maintained that while social inequalities were discussed, gender

Table 5.12 Participants Who Indicated Disability as Part of Curricula

Disability as a part of curricula	Person with disability	Person without disability	Total
Yes	49 (46.7) (11.8)	56 (53.3) (20.1)	105 (100.0) (15.2)
No	365 (62.2) (88.2)	222 (37.8) (79.9)	587 (100.0) (84.8)
Total	414 (59.8) (100.0)	278 (40.2) (100.0)	692 (100.0) (100.0)

Source: Field Survey.

and disability figured in the discourse of 'structure, processes, and collective action'. Human rights courses too dealt with disability while sociology courses as one of the participants pointed out dealt with 'social stratification', 'marginalized communities', 'social disability'. In other words, neither Disability Studies nor disability as a human social experience was part of mainstream curricula. It appeared, if at all, as part of specialized or optional courses in doctoral studies focused on disability.

With respect to evaluation and assessment, all participants reported the conventional methods of examination, book reviews, presentations, and class seminars. There were several barriers to evaluation and assessment, which were clearly brought out from the experiences of barriers by persons with disabilities. As mentioned earlier, dependence on scribe, ill-qualified scribes (especially with illegible writing and lack of proficiency in language such as misspelling of words) who do not understand the subject matter resulted in low scores for PWDs. Non-provision of extra time during evaluations, problems of inadequacy or lack of infrastructure such as lifts or inaccessible physical environment during fieldwork, lack of study materials in accessible form especially in Braille or through assistive devices, lack of modularizations of assessments (often lengthy terms papers, presentations in power point—hard to gain attention of the audience) were a few chronic barriers.

Classroom cultures predicated on visuality, phonocentric communication, and rigid definitions of mental capacity and mental health and 'sanity', beam ideological messages to disabled people that are embedded in inaccessible environments.

Disablement, as a political ideology and practice towards disabled people, is set in place through everyday manouevres in spatial arrangements, discursive strategies, intellectual engagements, and the various transactions in daily living. The reproduction of disablement in the spatial setting of the university is particularly significant in understanding the entrenchment of disabling worldviews in the social imaginary.

The eugenicist dichotomy of the 'fit' and the 'unfit' is more pervasive than we would imagine. Take for instance the responses from non-disabled participants from the same universities, which are far from exceptional:

> Disability can be stated as the condition in the person (where he/she) is unfit to do certain works done by completely fit person.[35]

> Disability is just the inability to do certain thing with equal efficiency as other people are able to do, it may be by birth or may be occur in duration of life.[36]

> I feel pity…why has god discriminated in making his children?[37]

> I relate disability with a genetic/ or medical or accidental… deformation, loss of functional parts of body.[38]

> When I hear the word disability, blindness comes to first to my mind, *sarvendriyanam nayanam pradhanam*. Such part of our body is very necessary, not only blind also dumb, deaf, lameness all is very sorrowful; cannot imagine as a normal person. I also feel disabled's brain works faster than ordinary persons…[39]

> The image … is physical disability, and the so called abnormal individual …Most often, disabled are described as people [who need] assistance and many occasions, as I heard from the third parties are … a curse of one's/others life and many people viewed them as people could not do any sort of activities, which the normal (an imaginary construction) person thinks and does (means engagement needs a complete body and mind)…My personal experience reveals that, many people think disabled people could not lead a normal life (an opinion generated by many people around me).[40]

The responses of ND participants are set apart from participants with disabilities primarily by the complete absorption of disabling discourse that uncritically reproduces worldviews that feed into disablism, keeping exclusionary structures in place. The images therefore are stark, individualized, and segregatory—beggars with crutches to movies with disabled protagonists or people in need of help to 'catch up'. This is a grim reminder that 'it's the rest of society that should be educated, we [the disabled] should be educating society' (Docherty et al., [1997] 2010: 436).

The constant reiteration of 'abnormality' of 'not belonging' and constantly in need of adjustments that are seen as infringing on the creative impulse of spontaneity in the dominant culture, produces deep effects of circulation within 'landscapes of exclusion' reinforced through cultures of representation and mythic traditions (See Reeve, 2014: 102). Since the visually challenged are the only ones with 'special communication needs' who are even permitted to cross the borders into universities, the incapacity of teachers to communicate appropriately and the ways in which they are challenged by the needs of blind students are the only narratives available through our survey:

Some professors are too…enthusiastic to think about a blind student in their class, and they enjoy conducting what they call *surprise tests*. The blind student is left at the mercy of some immediately available person…for scribing. Most of the faculty members never care about arranging a scribe for the visually impaired students in their class for their internal tests.[41]

Some faculty members are not aware about special needs of visually impaired and they are not willing to accept the term papers by email or printed form.[42]

Since the teachers are aware of the disability, there is a difference in the evaluation pattern. Some give fixed and standard grades and some do recognize the progress. However, one cannot deny the fact that it is extremely difficult for the blind to get the highest possible grade due to the difference in attitudes irrespective of being excellent student.[43]

Sometimes things are explained on black or white boards – not considering the case of visually impaired… they have to be reminded all the time.[44]

In the single instance of intellectual/psycho-social disabilities in the survey, the participant observed poignantly:

Nobody showed any interest in me when I was diagnosed with bipolar disorder, during third year … I practically 'went missing'…. Nobody knew, nor paid heed…My college was one of the key reasons for my alienation from life around and it stayed that forever.[45]

Recalling the continuities and discontinuities between their school education and their experience of universities, students with disabilities reported 'discrimination by teachers, class students, negligence' in school;[46] social stigma;[47] "problems with peer group, teasing and harassment;[48] intersecting, cumulative discrimination: 'I hardly remember people calling me by my name during my school as they used to call me either with the impairment I have or with my caste';[49] non-cooperation from peers: 'most of the times, sighted students did not help me, therefore I struggled to reach my destination';[50] and lack of experience in appropriate physical/social contact in transition from school to university: 'I did not know what was expected of a student in mainstream. Touching people while talking was standard mode of communication in blind school while it was taboo in a mainstream college.'[51]

Issues of transparency, time management, and barriers in language especially those from non-English medium background, proficiency in academic writing, non-serious assessments by evaluators, were the general issues reported by all participants.

Suggestions for inclusive assessment were solicited from all participants. Responses included inclusive classrooms; sensitization of teachers; training for teachers and students in the use of assistive technologies; allotment of extra time during examination and accommodations in the mode of evaluation—oral examinations, discussions, and dialogues—than the conventional modes of assessments; trained staff at department/school level to help PWDs negotiate everyday life situations; establishment of disability committee students and staff from disabled community to create enabling environment—inclusive education in the realm of higher education; disability sensitive budgeting; alternative modes of evaluation and assessment ('from written tests and assignments—prepositional knowledge to discussion and dialogue'), and 'focus on process orientation rather than product'.

One of the major initiatives with regard to institutional support, in India, in the realm of higher education was the Higher Education for Persons with Special needs (HEPSN) programme introduced by University Grants Commission (UGC) under the Ninth Five Year Plan guidelines (UGC, 2008). HEPSN envisaged the establishment of Enabling Units (to provide counselling, facilitate admission, ensure fulfilment of quotas, procurement of assistive devices, and so on). Such enabling units were often called 'Disability Cell' or 'Disability Units' along with student counselling centres, Committee against Sexual Harassment (CASH) and the Equal Opportunity Cell (introduced under Twelfth Five Year Plan). Information about the incidence of these institutional mechanisms in the institutions of higher education was elicited through the survey. Only 137 out of 692 participants (20 per cent) were aware about the establishment of Disability Cell. Among 414 PWDs, only 76 (18 per cent) were aware of the setting up of Disability Cell. The awareness about the establishment of other mandatory committees too was abysmally low—Student Counselling Cell: 195 out of 692; Equal Opportunity Cell: 152 out of 692; and CASH: 238 out of 199 (Table 5.13).

While some students feel that the disability cells serve a useful, if limited, purpose, several recognised the disabilities of the cell itself:

Yes, disability cell helps me but there is no toilet facility in the disability cell.[52]

Yes, needs improvement, materials… are all provided, but not updated technology…[53]

Table 5.13 Participants Who Are Aware about Institutional Support Mechanism

Institutional support	Person with disability	Persons without disability	Total
Student counselling cell	87 (44.6)	108 (55.4)	195 (100.0)
Equal opportunity cell	82 (53.9)	70 (46.1)	152 (100.0)
Disability cell	76 (55.5)	61 (44.5)	137 (100.0)
Committee against sexual Harassment	114 (47.9)	124 (52.1)	238 (100.0)

Source: Field Survey.

Lack of awareness about functioning [of the cell][54]

The disability cell was there in the institution I had studied and I was unaware of it since we were not directed there for any issues and assistance.[55]

In the hands of an inefficient person and it was not functional as it is supposed to be. However, the cell does organise a conference/seminar every year to exhaust funds.[56]

There is no disability cell; EOC looks after SC/ST, disability issues together.[57]

'Disability cells' are specially created spaces that are meant to offer support to persons with disabilities on university campuses. The creation of special cells with a distinct location and spatial attributes raises questions regarding the definitionally restricted scope these spaces have to redefine cultures of disablement. Rather, in full acknowledgement of the entrenchment and pervasiveness of geographies of disability on campuses, disability cells offer minor and fast track solutions to far-reaching, endemic, structural problems. Are these cells, to echo Reeve, part of the problem or part of the solution? We could further ask how far reasonable adjustments may guarantee inclusive access (Reeve, 2014: 99).

* * *

The study on disability in higher education has foregrounded several issues that need to be urgently addressed in order to transform the space of higher education and open it out in the fullest sense to the life experience and worldviews of persons with disabilities in all their diversity.

While students with disabilities do gain limited entry into the portals of universities across the country, the spread of students is extremely uneven across disabilities. An urgent concern is the virtual absence of persons with intellectual and psycho-social disabilities and persons with speech and hearing impairment in universities and mixed environments. In this, it appears, the university system in India reproduces cultures of phonocentric citizenship and segregationist policy that polices large sections of the disabled into confined and controlled spaces, without offering them the full opportunity to engage in civic and collective life on campuses. While the absolute exclusion is undoubtedly a deep injustice to persons so excluded, what is lost in the debate on inclusion is the fact that the entry of persons with disabilities across the range will result in a transformation of campus cultures in unimaginable ways, and by that token, provide a radically new frame within which to locate and understand participatory citizenship and deliberative democracy. Eighty-one per cent of the participants in this study were from public universities, so we are in fact speaking of the derogation of the constitutional mandate for persons with disabilities by state institutions.

The extremely low figures for teachers with disabilities in universities, compounds the problem of shrinking learning opportunities and possibilities for all students in higher education, besides the neglect of the right to public employment on equal terms for persons with disabilities entering the teaching profession. That this is exclusion is part of a consistent strategy of elimination is evident from the responses on teacher attitudes, difficulties in admission procedures and examination protocols and the active discouragement of accessing learning opportunities except in the most stereotyped (and thereby ghettoized) courses. In an irony of ironies, with Stephen Hawking before us, aspiring scientists with disabilities are asked how they will find their way to laboratories. The exceptional must keep the exclusions in place. One very important reminder of the hostility towards disability in environments of higher education is brought home to us by the reasons cited by students with disabilities for choosing particular institutions to study in—family and peer support scores far higher that personal interest in the course opted for or the

reputation of the institution. The opposite is the case with participants without disabilities in this survey. Also particularly stark is the absolute inefficacy of institutional mechanisms in providing equal opportunity, enabling equal access, or redressing chronic problems. The ranking on a scale of 1–10 of physical access indicators where they did exist did not cross 4.8.

These issues, far from being merely 'operational glitches' are embedded in the liminality of disability to university spaces, such that no norms need apply to the space outside the boundaries/margins of this universe, despite a plethora of rules/regulations/guides/guidelines that proliferate through law and policy. In fact the simultaneous proliferation of bureaucratic writing and its routine observation in the breach by universities are part of the same practice of structural violence. Inscription, we argue after Akhil Gupta, is at the core of bureaucracy—the file, registers, memos, notings, reports, complaints, petitions, 'paper work'. The proliferation of writing that is labyrinthine, repetitive, and mundane, far from being a substitute for bureaucratic action, is bureaucratic action in itself and constitutive of institutions of the state (Gupta, 2012: 143). The casual reference to failures in implementation that perpetuate the violence of exclusion—of legislation, policy, schemes, entitlements generally—splice the realm of state action into two parts that never meet. The realm of the proactive state that has everything good and desirable already written into the books of government; and the realm of the implementing agencies (here, public universities, as if this were not also the state) that use every trick from denial to rationalization to subvert the 'good' of the written word.

Immediately relevant to this discussion is a conversation between university researchers and the learning disabled in the UK: 'People have negative attitudes because they don't think we are the same as them, they don't think we can keep up with them…Its about people calling us, we get it when we go on buses, we get it when we go on the streets, in the pubs, cinemas and restaurants, in shops and from work colleagues' (Docherty et al.,[1997] 2010: 436).

Recognizing the continuities between segregation and isolation in the public domain and barriers in HE is extremely important in order to move towards the dismantling of foundational exclusions.

It is apt to conclude in Rob Imrie's words:

> [R]elations (of disablement) may be challenged by the development of a body politics that develops the discourse that everyone, irrespective of corporal form and performance, has the rights to inhabit, or to be emplaced, in ways whereby spaces are facilitative of a person's autonomy or the intrinsic value of the self (Imrie, 2014: 14)

What better place to situate this project than the already churning university system in India?

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Notes

1. 'Disabled gets 0.5% of seats in higher education' (2015, April 5) Available at http://timesofindia.indiatimes.com/home/education/news/Disabled-get-only-0-56-of-seats-in-higher-education/articleshow/46810639.cms?, accessed on 22 May 2015.
2. *Pushkar Singh and Others vs. University of Delhi and Others* 2001 (90) DLT 36.
3. *Smt. Shruti Kalra vs. University of Delhi and Ors* (2001) DLT 262. Emphasis added.
4. *Secretary, Primary and Secondary Education Department, Bangalore and Others vs. Nagaveni M.C. and Another* 2008 (1) Kar LJ 53.
5. The fieldwork was conducted in three phases. In the first phase, an online questionnaire was canvassed (32). In the second phase, the following central universities were covered—Central University of Punjab (4), Central University of Orissa (16), Central University of Gujarat (15), Jawaharlal Nehru University (70), University of Hyderabad (22), Maulana Azad National Urdu University (10) along with the responses from the online survey (32) and the RM course on Disability (30). The India Higher Education Report by NUEPA, New Delhi, presents the findings from the first and second phases (199). This chapter presents combined findings of three phases (including the sample presented in the IHER).
6. It should be noted in this regard that 40 per cent or above is the benchmark disability mandated by the government in order to access affirmative action in education and employment.
7. Rasika, SPPU, non-disabled participant. Names of all participants in the survey have been changed.

8. These figures refer to participants who self-identified as belonging to one or other of these social groups.

9. Palani, OBC student with disability, University of Madras.

10. Chalapathi, OBC student with disability, University of Madras.

11. Manjula, OBC student with disability, University of Hyderabad.

12. Manjula, OBC student with disability, University of Hyderabad.

13. Rajesh, student with disability, Pondicherry University.

14. Jyoti, OBC student with disability, Jawaharlal Nehru University.

15. Srikanth, student with disability, University of Madras.

16. Richard, teacher, North Eastern Hill University.

17. Rajesh, student with disability, Pondicherry University.

18. Ali, student with disability, Jawaharlal Nehru University.

19. Salim, student with disability, Gauhati University.

20. Rajesh, OBC student with disability, Yogi Vemana University.

21. Manjula, OBC student with disability, University of Hyderabad.

22. Manjula, OBC student with disability, University of Hyderabad.

23. Sanjay, OBC student with disability, SPPU.

24. Ahmed, student with disability, University of Madras.

25. Karan Singh, OBC student with disability, Central University of Punjab.

26. Kishwar, student with disability, Jammu University.

27. Chalapathi, OBC student with disability, University of Madras.

28. Jyoti, OBC student with disability, Jawaharlal Nehru University.

29. Manjula, OBC student with disability, University of Hyderabad.

30. Jamal, teacher, Sree Sankara College, Kaladi.

31. Anita, Himachal University.

32. Prakash, SC student with disability, Savitribai Phule Pune University.

33. Vijay, teacher, VSK University, Bellary.

34. Jyoti, OBC student with disability, Jawaharlal Nehru University.

35. Ranjit, student, University of Delhi.

36. Veena, student, University of Delhi.

37. Siddharth, student, University of Delhi.

38. Priyanka, student, University of Delhi.

39. Venkatesh, student, Andhra University.

40. Prashanth, OBC student, University of Hyderabad.

41. Palani, OBC student, University of Madras.

42. Ajay, student, University of Delhi.

43. Jyoti, OBC student, Jawaharlal Nehru University.

44. Keerti, student, Jawaharlal Nehru University.

45. Anita, Himachal University.

46. Kavita, student with disability, Central University of Gujarat.

47. Aslam, student with disability, Maulana Azad National Urdu University.

48. Anil, student with disability, Jawaharlal Nehru University.

49. Lakshman, SC student with disability, University of Hyderabad.

50. Ravi, SC student with disability, Pondicherry University.

51. Raman, teacher with disability, Madras University.

52. Ravi, SC student with disability, Pondicherry University.

53. Preeti, OBC student with disability, University of Delhi.

54. Rakesh, OBC student with disability, Jawaharlal Nehru University.

55. Chalapathi, OBC student with disability, University of Madras.

56. Jyoti, OBC student with disability, Jawaharlal Nehru University.

57. Anil, student with disability, Jawaharlal Nehru University.

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6

Persons with Disabilities in the Labourscape of Tamil Nadu

J. Jeyaranjan and Padmini Swaminathan

Development of a society has to benefit its citizens. However, the developmental process is mediated by its history and the state. The complex interaction results in distortions in the distribution of the fruits of development. Historically, weaker social groups have not benefitted as much from the development process as the stronger social groups in a society. Similarly, regions also have varied experience in benefitting out of the developmental process. Gender inequalities emerge and grow along with the developmental process. Conscious efforts to alter the course of development do not always result in success. Differential benefits persist over a long period of time and even get accentuated. The income, regional, gender, and social inequalities in our country is symptomatic of this process.

Given this context, our attempt in this chapter is to explore the lives of one such marginalized section in our society viz., persons with disabilities. Specifically, we have tried to map the location of persons with disabilities in the labourscape of the economy. The process of development alters the labourscape continuously by altering its size, character and composition which in turn alters the lives of the participants, since 'development' enables participation for some while excluding others. Given the unprecedented growth of the Indian economy and of Tamil Nadu as well, resulting in rapid restructuring of the labourscape, we have attempted to understand the space inhabited by persons with disabilities within the dynamic labourscape of Tamil Nadu.

Tamil Nadu is one of the well-developed states in the country with a strong industrial sector along with an ever growing service sector. It is also one of the highly urbanized states with more than half of its population living in urban areas. Dependence on agriculture for the livelihood is on the decline in rural areas for an increasing number of people with a booming rural non-farm sector absorbing more and more of them. The state has a robust social sector programme aided by the 'competing populism' of the two main political parties that had been governing the state over the past five decades. The safety nets are generous and widespread including free food grains for those who demand it.

This chapter is based on a study of available secondary data (from Census 2001 and 2011, and the 58th Round of the National Sample Survey of the Central Statistical Organization) with field studies in five villages in Tamil Nadu on the status of persons with disabilities.[1] It is organized into three sections; the first section provides a brief synoptic profile of persons with disabilities based on secondary data. The second section is based on primary data from five villages; differential livelihood patterns and options available to residents based largely on the agro-climatic zone in which these villages are located defined the choice of sites for fieldwork. Irrigated agriculture defines the labourscape in one village. Another village is characterized by declining agriculture with very little area under cultivation. The third village is in proximity to an urban centre which defines the livelihood in that village. Rural non-farm labour in manufacturing is the dominant livelihood in the fourth village. Household industry employs large number of women apart from a large non-farm sector in the fifth village. The third section of the paper summarizes and concludes the discussion.

We have identified persons with disabilities in all these villages through a house-listing survey. A detailed survey was undertaken to cover the identified disabled in all these five villages by using a questionnaire.

Extent and Nature of Disability in Tamil Nadu: A Synoptic View

The Census of 2011 used eight categories to enumerate the disabled population. The incidence of disability in 2011 was 1.64 per cent for the entire population. Proportion of disabled among the males was higher (1.82 per cent) as compared to the female population (1.45 per cent). Incidence of disability was the highest among the rural male population of the state (at 1.86%) and was the least among the urban female population (at 1.42 per cent).[2]

Movement disability accounted for nearly one-fourth of the total disability in the state in 2011. Other disabilities, which were not specified, accounted for another one-fifth of the total incidence of disability. Among other disabilities, hearing disability had a high incidence (18.6 per cent), followed by disability in seeing (10.8 per cent). 'Mental retardation,' speech impairment and 'mental illness' (as intellectual and psycho social intellectual disabilities are referred to in official records) accounted for the rest of the disabled population. Importantly, 7.8 per cent of the disabled population were having multiple disabilities in 2011 in Tamil Nadu. There was not much variation across habitations with respect to type of disability in 2011.

The Scheduled Castes (SC) accounted for 21.57 per cent of persons with disabilities and the scheduled tribe accounted for 0.98 per cent of the total disabled population. The non-SC/ST population accounted for about 77.5 per cent of the persons with disabilities in the state.

Incidence of disabilities is lower at younger age groups. With age, the scope for such disabilities may also increase resulting in a higher incidence of disabilities in the older age groups. We find that

(a) Upto 14 years of age, the percentage share of persons with disabilities is lower than the share of this age group in the general population; and
(b) Above 14 years of age, the percentage share of each age group among the disabled population is higher than their respective share of the age group in the general population. For example, while the share of the 30–39 years age group in the general population was 16.2 per cent, the share of this age group in the disabled population was 16.8 per cent. This was true for all higher age groups in 2011 in Tamil Nadu.

Workers and Non-Workers among Persons with Disabilities

As expected, the work participation rate (WPR) among persons with disabilities, at 37 per cent, is lower than the corresponding rate for the general population at 46 per cent, in Tamil Nadu, in 2011. Agriculture labour was the most important occupation for rural persons with disabilities (17.4 per cent) followed by other employment. Household industries had absorbed 1.7 per cent of the disabled population and 7 per cent of them were engaged as cultivators. The occupation pattern among persons with disabilities in the urban habitation was starkly different from the rural habitation. In urban Tamil Nadu, more than four-fifth of those who were working were engaged in miscellaneous occupations classified as 'others'. In general, proportion of the workers among persons with disabilities was higher in the rural areas than in the urban areas in the state in 2011.

Remarkable differences are discernible between genders in the work participation rate of persons with disabilities. The WPR among males with disabilities, at 47 per cent, is far higher than among the females with disabilities, at 25 per cent, a pattern similar to what prevails among the general population.

Nearly about four-fifths of the surveyed disabled in the state had signs of deficit in reaching the developmental milestones in their childhood. Less than 10 per cent had no such visible signs. About 14 per cent could not recall and did not know of such deficits. Most prominent deficit was delay in being able to speak (about 28 per cent) followed by delay in being able to walk (10 per cent) and delay in being able to sit. Such deficit signals were discernible among a large number of persons with intellectual and psycho-social disabilities (68 per cent) followed by number of persons with speech disability (about 50 per cent) and multiple disabilities (about 45 per cent).

Altogether, about one third of persons with disabilities have reported that they were unable to work. Inability to work varied enormously across various types of disabilities. About 62 per cent of those with psycho-social and intellectual disabilities were not able to work followed by about 42 per cent of the visually challenged. Forty-two per cent from among the multiple disabled were not able to work due to their disability. Disability could hamper only about 10 per cent of the hearing disabled and 14 per cent of the speech disabled from participating in work. About 29 per cent of the persons with locomotor disability were not able to work.

We find that about one fourth of persons with disabilities were engaged in some kind of work: as own account worker, employer, unpaid family labour, worked as regular employee, casual worker in public works or in other types of work. Again the proportion of workers among persons with disabilities varies. While the highest

level was reported among the hearing disabled (38 per cent) it was the lowest among those with psycho-social and intellectual disabilities (at around 7 per cent). Nearly about 10 per cent were engaged in other types of work and another 8 per cent were own account workers. Another 5 per cent were working as regular salaried or as wage employees.

Slightly more than one tenth of persons with disabilities attended only domestic duties. The range varied between 4.7 per cent among persons with psycho-social and intellectual disabilities to 20 per cent among the hearing disabled.

EDUCATIONAL LEVEL OF PERSONS WITH DISABILITIES

The educational level among persons with disabilities was very poor with nearly 56 per cent remaining uneducated. The highest level of illiteracy is reported among persons with intellectual and psycho-social disabilities, visually disabled and people with multiple disabilities (70 per cent). Few persons with locomotor disability have completed higher levels of education. Similarly, few persons with speech and hearing disabilities have managed to complete higher education.

Among the uneducated, only 19 per cent were taking up some work. Hardly 2 per cent of persons with disabilities in the state had undergone some sort of vocational training at the time of the survey. Even fewer had undergone vocational training in engineering trade. Few more had benefitted out of non-engineering vocational training.

Vocational training had enhanced the proportion of those who work among persons with disabilities. While only 25 per cent of those who did not receive vocational training were working, the proportion was 33 per cent among those with vocational training in engineering trade and nearly 50 per cent among those were trained in non-engineering trade.

DISABILITIES DUE TO INJURY

Nearly one-tenth of persons with disabilities covered by the NSSO survey have become *disabled due to burn or other types of injury.* Such burns and injuries had resulted in locomotor disabilities in three-fourths of the cases. The single largest reason for the locomotor disability was the transport accident as nearly one-third of persons with such disability have attributed it due to an accident. *Importantly, home is the place where nearly one third of all incidents that had resulted in disabilities due to injuries have happened in the state.*

SEEKING MEDICAL HELP BY PERSONS WITH DISABILITIES

Nearly three-fourths of the persons with locomotor disability have consulted a doctor and undergone treatment. Persons with multiple disabilities also have sought help from doctors to a large extent and a slightly lower proportion of persons with psycho-social and visual disabilities have undergone treatment after consulting doctors.

Seeking help from doctors was poor among the hearing and speech disabled persons. Nearly 40 per cent of them have not consulted the doctors. About 16 per cent of the persons with intellectual and psycho-social disabilities were undergoing treatment at the time of the survey. Insignificant numbers of persons with disabilities attended special schools.

Once they seek medical help, some of the persons with disabilities are advised to have some aid or appliance that would enable them better mobility but many others are not advised such aid or appliances. The NSSO data for the state indicates that slightly more than one-fifth of those who sought medical help were advised to have aid or appliance. Among those who were advised to have aid or appliances, nearly 70 per cent had acquired the advised devices or aid.

Compliance with the advice to have a devise was very high among visually disabled at 78 per cent followed by locomotor disabilities at 73 per cent. Least compliance was among the persons with hearing disabilities as only 44 per cent follow the advice to have an aid.

Acquiring the suggested devise or aid by persons with disabilities was predominantly through purchase (55 per cent) followed by assistance from government (25 per cent). Acquiring with NGO assistance was the lowest (9 per cent).

Nearly three-fourths of whom who have got the appliance or aid did use them regularly. Usage of visual aid was the highest and the hearing aid was the lowest. Majority of the non-users feel uncomfortable in using the appliances or aids. The reason for not acquiring the suggested aid or appliance was predominantly the high cost involved. About one-fifth of those who have not acquired the suggested equipment opined that they were not required for personal independence and another 15 per cent felt that they are not required for their economic independence.

MARITAL STATUS OF PERSONS WITH DISABILITIES

About two-fifth of the surveyed disabled persons remained unmarried at the time of the survey. Incidence of 'never

married' was the highest among persons with intellectual and psycho-social disabilities (70 per cent) followed by speech disability (62 per cent). Nearly 50 per cent of those with multiple disabilities were never married. About 40 per cent of the persons with locomotor disability were never married. Visual and hearing disability had the least incidence of 'never married' among all the categories of disabled in the state. About 38 per cent of all persons with disabilities were currently married. Just about 2 per cent of them were divorced or separated.

Though about 38 per cent of persons with disabilities were married, just about 10 per cent of them were living with spouse only. About 28 per cent of them were living with spouse and other members. Largest number of them (34 per cent) was living with their parents but without spouses. This pattern of living arrangement was the strongest among the persons with psycho-social and intellectual disabilities and was the weakest among the persons with hearing and visual disability. Importantly, about 14 per cent of the visually impaired were living alone and it was the highest proportion among all disabled.

Persons with Disabilities within the Diverse Labourscapes

We have chosen five different villages to map the diverse labour market in the state and surveyed persons with disabilities in those villages to understand their location within the specific labourscapes.

Two agricultural villages (one with canal irrigation and another with tube-well irrigation) provide the synoptic view of the functioning of agricultural labour market. One village in urban proximity was surveyed to understand the dynamics in a labour scape where the rural and urban are closely linked by commuters. One village near the match and fireworks cluster of Sivakasi and another in a beedi rolling heartland of Thirunelveli district were surveyed to map the functioning of the rural non farm labour market.

profiles of the five villages studied

Village Palakurichi: Agricultural Labourscape

The village of Palakurichi is in Nagapattinam district. The total geographical area of the village is 502.72 hectares. The net area sown in the village is 390.82 hectares and 390.19 hectares are irrigated by canals. The canals draw water from the branches of Cauvery River. Paddy is grown during winter, followed by black gram and pulses during summer.

The social organization of production in Palakurichi had transformed phenomenally over a period of time. Palakurichi is in the coastal delta that had witnessed organized movements led by the left parties against the dominance of landlords during the 1950s and 1960s. The movement successfully broke the dominance and it was supported to a certain extent by the state policies in the form of protection laws for labour and tenants. However, the movements have declined since the mid-1970s due to the inroads made by the DMK and subsequently by the AIADMK into the organizations of the peasant and agricultural workers. The Cauvery dispute also led to a decline in the water flow in the river. The crop pattern in the delta changed with the decline in the two paddy crop sequence to a single paddy crop. This is turn had let to a drastic decline in demand for labour over a long period of time. Weakening of the left on the one hand and the prolonged decline in the demand for labour on the other had transformed the very nature of the organization of production in the village.

Confrontation has disappeared and it is more a negotiated relation of production at the present. Wages are periodically negotiated between the land owners and the agricultural workers.

Mechanization has found its way into the production process as the labour unions had realized that without machines, the production process is impossible given the very short time that is available under the changed conditions. Mechanization of farm preparation and harvesting operations has reduced the employment opportunities for male workers. Female workers get just half of the work than earlier as the cultivation has been reduced from two paddy crops to a single crop. Permanent arrangements have given way to contractual arrangement. Palakurichi has 455 households with a population of 1624 (52 per cent male 48 per cent female). About two-thirds are workers and one-third are non workers. Slightly more than 56 per cent of the population belong to Schedule Caste. Nearly one-fourth of the population belong to backward castes and about 17 per cent belong to most backward castes.

Among the working population, only about one-third are main workers and two-thirds are marginal workers. Predominance of agriculture is clearly evident when we look into the composition of the main workers. Just about 10 per cent of the main workers are cultivators and about 77 per cent are agricultural labourers, 'others' account for just 13 per cent of the main workers. The pattern holds good for the marginal workers as well.

Village Thaludali: Agricultural Labourscape

Thaludali village is in a relatively less developed agricultural district of Villupuram. The village does not

have any irrigation source and hence it depends only on rainfall for irrigation. There are few dug wells that provide limited irrigation. With the receding ground water due to water mining, the ayacut of these wells have dwindled over time. This in turn had radically altered the crop pattern in the village.

With no viable alternative, vast tracts of land were converted to Casuarina crop in this village.

When such a vast tract of land is converted to less labour-intensive crops, the local labour cannot depend only on agriculture for their livelihood. Paddy is grown only for self-consumption to a small extent in the village. Thus, the latent potential of the village agriculture to generate employment is very limited.

The total geographical area of the village is 303.66 hectares. Only 60.1 hectares is the net sown area in the village and all this area is irrigated. Wells irrigate about 34.91 hectares and tanks irrigate about 25.91 hectares. Thus, land available for regular cultivation is very limited and a large area is left fallow in the village for lack of irrigation. Also a large area has been cultivated with a perennial tree crop, viz. casuarina.

Thaludali village has 517 households with a population of 2257 (comprising 1153 males and 1104 females). It has total workers of 952 (527 males and 425 females). Total Main workers are 320 (194 males and 126 females). As per the census of 2011, 30 of them were cultivators, 246 were agricultural labourers, one was in household industry and 43 were working as 'other' workers. 632 of the population were marginal workers and 672 were non workers.

Village Vagavasal: Proximity to an Urban Labourscape

Vagavasal village is in Pudukottai district and it adjoins Pudukottai town, the district headquarters. It is located on the main road and there are frequent bus services to the town. The village is connected to the town in many different ways and many people from the village commute to the town for work.

The total area of the village is 793.58 hectares and only 151.82 hectares of land is the net area sown in the village. About 2.7 hectare of land is unirrigated. Tanks in the village irrigate about 100 hectares and remaining 49 hectares is irrigated by wells. Given the scanty and irregular rainfall in the area, tank irrigation frequently fails and the ground water is also not dependable. Thus, even the meagre area that is under cultivation faces enormous uncertainty in terms of cropping. Vagavasal, as per our census, has 686 households. The total population stands at 3060 (males 1550 and female 1570). Total number of workers is 1412 and non-workers 1648. Among the workers, 1044 are main workers and 368 are marginal workers. Cultivators are 174 in number and agricultural labour are 303. Only 14 are in household industry whereas the largest chunk of main workers, numbering 553 are into other works. Other workers thus constitute more than half of the main workers in the village clearly indicating the movement away from agriculture. Most of them are working in Pudukottai and they regularly commute. Our survey indicated that many from the village are working as drivers, workers in hotels, shop assistants, salesmen, petty shop and tea shop owners, mechanics, assistants in mechanical and engineering firms. Nearly about 125 male workers are migrant workers working outside the country and about 180 workers are migrants within the country and both these migrants have left their families behind.

Village Subramaniapuram: Non-farm Intensive Employment

Subramaniapuram is on the state highway that connects Sathur and Sivakani in Virudunagar district. Sathur is known for match industries and Sivakasi is known for fireworks, matches and printing. Sivakasi is 21 km away from Subramaniapuram (henceforth S. Puram).

S. Puram is in the black cotton soil belt in Southern Tamil Nadu. New industries in the belt had attracted large number of workers and agriculture could not compete with the industry in wage payments. Employment was also more regular in those industries compared to the uncertain rain fed agriculture. Lack of sub-surface water for irrigation did not allow pump set irrigation in any large scale. Frequent price crashes of agricultural commodities discouraged any further investment in agriculture. The risk associated with dry land agriculture had discouraged the next generation from agriculture.

Thus, S. Puram has lost most of its agriculture. The total geographical area of the village is 999.49 hectares and only 78.43 hectares are sown in the village. Irrigated area is 33 hectares (21 hectares by wells and 12 hectares by tanks) and unirrigated area is 45 hectares.

S. Puram has 544 households with a population of 1879 (with 914 males and 965 females). Total workers in S. Puram comprised of 91 cultivators 12 agricultural labourers 4 household industry workers and 746 other workers totalling 997. There are only 144 marginal workers. Non-workers in the population are 882.

The labourscape in S. Puram is very active with 86 per cent of the total workers being main workers which means they are employed more regularly. Just 9 per cent

of the main workers are cultivators and 1 per cent of the main workers are agricultural labourers.

Village Mathalamparai: Non-farm Employment of a Different Nature

Mathalamparai is in the foot hills of Western Ghats in Tirunelveli district. The nearest town, Thenkasi, is 9 km away. The village is on the state highway that connects Thenkasi with Papanasam. Tirunelveli district has a very high proportion of its labour in rural non-farm employment next only to Kanyakumari district in the state.

Mathalamparai forms part of a cluster of habitations that has three revenue villages. The village is irrigated both by tanks and canals. However, non-agricultural employment has increased in the village to a very significant level. More importantly, beedi rolling is an important home based work in Mathalamparai. Beedi rolling employs women in large numbers and the work goes on throughout the year. The prevailing wage payment is Rs.150 for rolling 1000 beedies. The women also get an annual bonus based on their output. Provident fund is also provided.

While beedi rolling is the preeminent employment opportunity for women, men commute in large numbers to Thenkasi town to take up various kinds of non-agricultural work.

The total geographical area of the village is 1046 hectares. Only 465 hectares of land is sown and only 296 hectares of land is irrigated. Canals and wells irrigate about 147 hectares of land. Paddy, groundnut, and corn are the main crops grown in the village.

Agriculture is highly mechanized. Field preparation and harvesting are entirely taken up with machines. Transplanting and weeding is a manual work. Since very few women are available for agricultural work, they are brought from outside by paying for their transportation as well.

Mathalamparai has 581 households with a population of 2145 (Male 1061 and Female 1084). There are 1052 total workers and 1093 non-workers. Around 80 per cent of the total workers are main workers. There are only 39 cultivators and 273 agricultural labourers. Household industry employs 300 main workers and 242 main workers are engaged as other labourers. It is pertinent to note here that 96 per cent of the household industry workers are women and 88 per cent of other workers are men in Mathalamparai. These two features indicate the engagement of large number of women in beedi rolling and large number of men commuting to take up non-agricultural work from the village. Our household survey also indicated that 62 per cent of the male workers in Mathalamparai are in non-agricultural employment.

DISTRIBUTION OF PERSONS WITH DISABILITIES AMONG SAMPLE VILLAGES

The survey of persons with disabilities was based on self reporting in three of the five villages, namely Palakurichi, Vagavasal, and Mathalamparai; in other words the approach in these villages was a liberal listing of persons with disabilities. Table 6.1 puts together our data on persons with disabilities collected from the five villages. Whenever the respondent said that either he/she or a member in the household is disabled they have been enumerated as disabled. As a result, our survey in these three villages has captured more kinds of disability, particularly disability associated with aging and prolonged ill health.

In Thaludali and Subramaniapuram, we covered only persons with disabilities in the working age group; in other words, a restricted definition was adopted in these two villages. Time and resource constraint was the reason for this choice.

In three of the villages (Palakurichi, Thaludali, and Mathalamparai), men outnumbered women among disabled. In terms of social composition in four of the five villages, the BCs outnumbered other castes among the disabled population.

AGE DISTRIBUTION OF PERSONS WITH DISABILITIES IN SAMPLE VILLAGES

As indicated earlier, in Palakurichi, Vagavasal, and Mathalamparai, our coverage of persons with disabilities included age-related disability as well. Hence in these villages we find from Table 6.2 a fairly even but high percentage of persons with disabilities among working age (21–60 years) as well as among the elderly (above 60). In Thaludali and Subramaniapuram, the restricted coverage of disabled among working age is starkly reflected in the significantly high percentage of disabled among working age, namely 21–60 years of age.

In terms of gender, we also find a significant number of male disabled in the working age group, 21–60 years, while among women, persons with disabilities are more in the above 60 category.

TYPES OF DISABILITY AND REASONS FOR THE SAME IN SAMPLE VILLAGES

Types and Reasons for Disability: Palakurichi

Nearly 40 per cent of persons with disabilities in Palakurichi village suffer from movement-related

Table 6.1 Distribution of Persons with Disabilities across Gender and Social Groups in Sample Villages, 2015

Sl. No.	Caste	Palakurichi				Thaludali				Vagavasal				Subramaniapuram				Mathalamparai			
		M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P
1	SC	45	24	69	62.7	2	-	2	8.3	19	24	43	35.8	7	6	13	37.1	8	7	15	17.6
2	BC	29	7	36	32.7	14	8	22	92.7	32	45	77	64.2	6	10	16	45.7	33	34	67	78.9
3	OC	4	1	5	4.5	–	–	–	–	–	–	–	–	2	4	6	17.1	3	0	3	3.5
	Total	78	32	110	100.0	16	8	24	100.0	51	69	120	100.0	15	20	35	100.0	44	41	85	100.0

Source: Survey Data. *Note*: M=Male, F=Female, T=Total, P=Percentage.

Table 6.2 Age-wise Distribution of Persons with Disabilities in Sample Villages, 2015

Sl. No.	Age in years	Palakurichi				Thaludali				Vagavasal				Subramaniapuram				Mathalamparai			
		M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P
1	Upto 20	1	1	2	1.8	1	3	4	16.7	6	10	16	13.3	4	3	7	20.0	4	4	8	9.4
2	21–60	39	13	52	47.3	11	3	14	58.3	17	27	44	36.7	9	13	22	62.9	24	14	38	44.7
3	Above 60	38	18	56	50.9	4	2	6	25.0	28	32	60	50.0	2	4	6	17.1	16	23	39	45.9
	Total	78	32	110	100.0	16	8	24	100.0	51	69	120	100.0	15	20	35	100.0	44	41	85	100.0

Source: Survey Data. *Note*: M=Male, F=Female, T=Total, P=Percentage.

disability. About 12 per cent have disability associated with seeing. Psycho-social disability has affected about a tenth of them. More than a quarter are affected by assorted kind of disabilities which could not be categorized. This is mainly because of the problems associated with age where they had responded that they have problems like breathing difficulties, tiredness, blood pressure, etc. When we asked for the reasons for their disability, more than half of them have attributed it to their age.

Another 20 per cent have attributed their disability to accidents. Nearly about 15 per cent have acquired disability due to ill health. Disability since birth is reported by 9 per cent of persons with disabilities in the village.

While a larger number of males have reported disability due to old age, in terms of proportions, it is the women who have reported higher level of disability due to age (at 62 per cent as compared to 50 per cent among men). On the other hand, higher proportion of men had reported disability due to accidents (23 per cent) as compared to women (12.5 per cent).

Types and Reasons for Disability: Thaludali

It is not only that the male disabled predominate in the village; it is the disability associated with movement that predominates the character of disability of men in the village. While there is no one who is disabled due to intellectual disabilities and disability due to seeing, only one had speech disability. Multiple disabilities and psycho-social disabilities, each accounted for one-fifth of the total disability in the village.

More than 70 per cent of the disability in Thaludali village is attributed to congenital reasons by the respondents. This may be due to the predominance of Vanniyar population in the village where endogamous cross-cousin marriages are very widely prevalent. We have not collected any data relating to the marriage patterns and hence this explanation could remain only as a speculation. Since there are many drivers in the village, accident-led disability accounts for one fourth of the causes of disability in the village among males. Ill health had resulted in disability among one eighth of persons with disabilities in the villages.

Types and Reasons for Disability: Vagavasal

Since we have netted a large number of persons with age induced disability, we find nearly half of them had responded with assorted kind of disabilities. Nearly one-fourth of them had disabilities related to movement and about 16 per cent of them had disability associated with seeing.

More men had reported disability associated with seeing as compared to women whereas more women had reported disability due to 'other reason' as compared to men. Both genders had reported the same level of disability associated with movements.

Nearly 42 per cent of the self-declared disabled in Vagavasal had attributed old age as the reason for their disability. About one-fifth of them had claimed that ill health had led to their disability. Slightly more than one-tenth had met with accidents and had suffered disability. About 17 per cent of persons with disabilities in Vagavasal are disabled since their birth.

There are noticeable differences between male and female in the reasons attributed for their disability. While nearly 48 per cent of the male disabled had attributed old age for their disability, it was only 38 per cent among women disabled. While nearly 22 per cent of the male disabled have attributed their birth for their disability only 13 per cent of the women disabled had given that reason for their disability. On the other hand, while only 8 per cent of the male disabled had given ill health as the reason for their disability, nearly 20 per cent of disabled women had given that reason.

Types and Reasons for Disability: Subramaniapuram

Most of the disabilities reported in Subramaniapuram are due to movement associated disabilities. Ocular disability accounts for one-fifth of the persons. Slightly lower number of them has multiple disabilities. Hearing and intellectual disabilities, each account for one-tenth of the disability in the village. One person suffers from psycho-social disabilities.

Thirty-seven per cent of persons with disabilities have attributed their disability to their birth. About one-fifth of them have become disabled due to accidents. Ill health had resulted in disability in another one-fifth of the cases. Since, most of them commute to work and the fireworks are prone to accidents, the incidence of disability due to accidents is about one-fifth of the total disability.

Types and Reasons for Disability: Mathalamparai

Largest number of persons with disabilities have reported movement disability. The second largest type is 'other' disability essentially associated with old age problems like breathing difficulty, joint pain, diabetes, blood pressure, giddiness, general weakness etc. Disability in seeing and multiple disabilities are reported each by 17 per cent of persons with disabilities in the village. No one had hearing disability and only one had speech disability. Psycho-social

and intellectual disabilities together accounted for about 12 per cent of the total disabled in the village.

The disability profile of the women is different from the profile of the men. About one-third of the female disabled reported movement disability followed by 'other' and multiple disabilities. Among men, 'other' disability predominates followed by movement and seeing disabilities. This may be due to the differences in the age composition of persons with disabilities among men and women.

Since we went by the responses of the respondents, we covered the age-related disabled as well in the village. About 45 per cent of the respondents have attributed old age to their disability. About one-fifth of persons with disabilities have attributed their disability to their birth. Thirteen per cent of persons with disabilities have attributed it to accidents. Another one-tenth reported disability due to ill-health. We do not find significant differences between genders in the reasons for disability.

What comes out of clearly from Tables 6.3 and 6.4 is movement-related disability caused largely by accidents followed by ill health which could be age-related and/or by birth.

EDUCATIONAL ATTAINMENT AMONG DISABLED IN SAMPLE VILLAGES

Table 6.5 depicts very starkly the high level of formal illiteracy among persons with disabilities in all the five villages covered by us. That in 2015 more than fifty per cent of persons with disabilities continue to remain formally illiterate speaks very poorly of the environment in which persons with disabilities find themselves in a state otherwise celebrated for its achievements in the social sector. The illiteracy among disabled women is even higher; further, of those who have received some level of education, hardly a handful have managed to move beyond higher secondary.

The severe implications of such poor levels of education for employment prospects of persons with disabilities is discernible from the data relating to occupation captured in Tables 6.6 and 6.7 below.

OCCUPATION OF PERSONS WITH DISABILITIES IN SAMPLE VILLAGES

Acquired disability during the course of a person's life may force them to withdraw from work or change their work. To assess this change in the occupation of persons with disabilities, we have collected data regarding the previous and present occupation of persons with disabilities for all the villages studied by us.

OCCUPATION OF PERSONS WITH DISABILITIES: PALAKURICHI

We find that about 70 per cent of persons with disabilities were wage labourers and 7 per cent were cultivators. About one-tenth worked in government service. Only about 7 per cent of persons with disabilities were not working earlier (Table 6.6).

The percentage of those who are not working has increased from 7.2 per cent prior to disability to 56 per cent after their disability. There is a 60 per cent reduction in wage labour occupation in the post disability occupation pattern. Many of them have taken up cattle rearing after becoming disabled. Few more are into business and some have taken up MGNREGA work in Palakurichi.

Thus, while a substantial number withdraw from work, very few have taken up alternate work. While about 28 disabled persons have taken up alternate occupations, nearly 54 have withdrawn from work in Palakurichi.

We find that 59 males have withdrawn from their earlier work and 24 have found a new occupation (about 40 per cent) whereas among women only 22 per cent who withdraw from earlier occupation could find alternate occupations in Palakurichi.

Occupation of Persons with Disabilities: Thaludali

Since 17 of the 24 were disabled from birth, they had responded that they were not working. Three women were housewives prior to their disability. One each was working as cultivator, wage labour, in government and other services. When we look into the present occupational pattern, we find that only ten were not working and one has taken up a petty shop trade, two of them have started tending cattle, one more has entered the government service, two more have started working in 'other' employment and one more as wage labourer. Thus, there is an improvement in that, there is more participation in work by persons with disabilities in Thaludali.

It is important to note here that the changes in the occupational profile of persons with disabilities is confined entirely to the male and none from the female have changed their occupation indicating the poorer opportunities for females as compared to the male disabled in the labour scape of Thaludali.

Occupation of Persons with Disabilities: Vagavasal

Since we have covered the age-led disability in our survey, we are bound to observe lot of withdrawal from work.

Table 6.3 Distribution of Persons with Disabilities by the Type of Disability in Sample Villages, 2015

Sl. No.	Type of disability	Palakurichi				Thaludali				Vagavasal				Subramaniapuram				Mathalamparai			
		M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P
1	Seeing	9	5	14	12.7	–	–	–	–	11	8	19	15.8	3	4	7	20.0	8	6	14	16.5
2	Hearing	3	1	4	3.6	1	1	2	8.3	–	1	1	0.8	1	3	4	11.4	–	–	–	–
3	Speech	1	0	1	0.9	1	0	1	4.2	–	–	–	–	1	2	3	8.6	1	–	1	1.1
4	Movement	31	14	45	40.9	9	2	11	45.8	12	16	28	23.3	5	5	10	28.6	10	13	23	27.1
5	Intellectual Disabilities	–	–	–	–	–	–	–	–	1	1	2	1.7	2	2	4	11.4	4	1	5	5.9
6	Mental Illness	7	5	12	10.9	3	2	5	20.8	2	–	2	1.7	0	1	1	2.9	3	4	7	8.2
7	Multiple	4	1	5	4.5	2	3	5	20.8	23	39	62	51.7	3	3	6	17.1	6	8	20	23.5
8	Any other	23	6	29	26.4	–	–	–	–	2	4	6	5.0	–	–	–	–	12	8	14	16.5
	Total	78	32	110	100.0	16	8	24	100.0	51	69	120	100.0	15	20	35	100.0	44	41	85	100.0

Source: Survey Data. *Note*: M=Male, F=Female, T=Total, P=Percentage

Table 6.4 Distribution of Persons with Disabilities by the Reasons of the Disability in Sample Villages, 2015

Sl. No.	Reasons	Palakurichi				Thaludali				Vagavasal				Subramaniapuram				Mathalamparai			
		M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P
1	By birth	6	4	10	9.1	11	6	17	70.8	11	9	20	16.7	4	9	13	37.1	8	10	18	21.2
2	Polio	1	0	1	0.9	–	–	–	–	1	1	2	1.7	1	2	3	8.6	1	1	2	2.4
3	Age	39	20	59	53.6	–	–	–	–	24	26	50	41.7	–	–	–	–	18	20	38	44.7
4	Accident	18	4	22	20.0	4	–	4	16.7	6	8	14	11.7	2	6	8	22.9	7	4	11	12.9
5	Ill health	12	4	16	14.5	1	2	3	12.5	4	20	24	20.0	6	2	8	22.9	7	3	10	11.8
6	Other	22	0	2	1.8	–	–	–	–	5	5	10	8.3	2	1	3	8.6	3	3	6	7.0
	Total	78	32	110	100.0	16	8	24	100.0	51	69	120	100.0	15	20	35	100.0	44	41	85	100.0

Source: Survey Data. *Note*: M=Male, F=Female, T=Total, P=Percentage.

Table 6.5 Distribution of Persons with Disabilities by the Educational Level in Sample Villages, 2015

Sl. No.	Education	Palakurichi				Thaludali				Vagavasal				Subramaniapuram				Mathalamparai			
		M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P
1	Non literate	37	28	65	59.1	11	7	18	75.0	25	48	73	60.8	7	15	22	62.8	15	30	45	52.9
2	Primary	16	2	18	16.4	–	–	–	–	7	12	19	15.8	2	1	3	8.6	11	2	13	15.3
3	Middle	12	1	13	11.8	–	–	–	–	8	4	12	10.0	4	1	5	14.3	10	6	16	18.8
4	Secondary	9	1	10	9.1	2	1	3	12.5	9	5	14	16.7	1	2	3	8.6	6	3	9	10.6
5	Higher secondary	4	–	4	3.6	2	–	2	8.3	1	–	1	0.8	–	1	1	2.8	1	–	1	1.2
6	Degree/ Diploma	–	–	–	–	1	–	1	4.2	1	–	1	0.8	1	–	1	2.8	1	–	1	1.2
	Total	78	32	110	100.0	16	8	24	100.0	51	69	120	100.0	15	20	35	100.0	44	41	85	100.0

Source: Survey Data. *Note*: M=Male, F=Female, T=Total, P=Percentage.

Table 6.6 Distribution of Persons with Disabilities by Previous Occupation in Sample Villages, 2015

Sl. No.	Occupation	Palakurichi				Thaludali				Vagavasal				Subramaniapuram				Mathalamparai			
		M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P
1	Wage labourers	54	23	77	70.0	1	–	1	4.2	17	31	48	40.0	8	14	22	62.9	20	8	28	32.9
2	Beedi rolling	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	20	21	24.7
3	Cultivators	5	2	7	6.4	1	–	1	4.2	6	11	17	14.2	1	–	1	2.9	–	–	–	–
4	House wife	–	1	1	0.9	–	3	3	12.5	–	3	3	2.5	–	1	1	2.9	–	1	1	1.2
5	Government service	10	–	10	9.1	1	–	1	4.2	2	–	2	1.7	–	–	–	–	1	–	1	1.2
6	Private service	1	–	1	0.9	–	–	–	–	3	1	4	3.3	–	–	–	–	1	–	1	1.2
7	Cattle rearing	–	1	1	0.9	–	–	–	–	1	1	2	1.7	–	–	–	–	1	–	1	1.2
8	Business	1	–	1	0.9	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
9	Not working	4	4	8	7.3	12	5	17	70.8	14	11	25	20.8	–	–	–	–	11	11	22	25.9
10	Student	–	–	–	–	–	–	–	–	3	7	10	8.3	1	5	6	17.1	–	–	–	–
11	Trade	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2	–	2	2.4
12	Others	3	1	4	3.6	1	–	1	4.2	5	4	9	7.5	5	–	5	14.3	7	1	8	9.4
	Total	78	32	110	100.0	16	8	24	100.0	51	69	120	100.0	15	20	35	100.0	44	41	85	100.0

Source: Survey Data. *Note*: M=Male, F=Female, T=Total, P=Percentage.

Table 6.7 Distribution of Persons with Disabilities by Present Occupation in Sample Villages, 2015

Sl. No.	Occupation	Palakurichi				Thaludali				Vagavasal				Subramaniapuram				Mathalamparai			
		M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P	M	F	T	P
1	Wage labourers	8	3	11	10.0	2	–	2	8.3	7	4	11	9.2	–	–	–	–	9	1	10	11.8
2	Beedi rolling	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	8	9	10.6
3	Cultivators	–	–	–	–	1	–	1	4.2	1	1	2	1.7	–	–	–	–	–	–	–	–
4	House wife	–	1	1	0.9	–	3	3	12.5	–	1	1	0.8	–	–	–	–	–	–	–	–
5	Government service	3	–	3	2.7	2	–	2	8.3	–	–	–	–	–	–	–	–	1	–	1	1.2
6	Private service	–	–	–	–	–	–	–	–	–	1	1	0.8	–	–	–	–	2	–	2	2.4
7	Cattle rearing	14	2	16	14.5	2	–	2	8.3	5	5	10	8.3	–	–	–	–	1	–	1	1.2
8	Business	3	1	4	3.6	1	–	1	4.2	–	–	–	–	–	–	–	–	–	–	–	–
9	NREGA	8	2	10	9.1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
10	Not working	39	23	62	56.4	5	5	10	41.7	34	57	91	75.8	15	20	35	100.0	26	32	58	68.2
11	Trade	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	1	1.2
12	Others	3	–	3	2.7	3	–	3	12.5	4	–	4	3.3	–	–	–	–	3	–	3	3.5
	Total	78	32	110	100.0	16	8	24	100.0	51	69	120	100.0	15	20	35	100.0	44	41	85	100.0

Source: Survey Data. *Note*: M=Male, F=Female, T=Total, P=Percentage.

While many may be returned as not working, some may find new kinds of work which would suit them. Such a pattern is discernible in Vagavasal. About 40 per cent of persons with disabilities were workers earlier. Now, workers account for one-tenth of persons with disabilities in the village. Nearly about 15 per cent of them were cultivators earlier. Only 2 persons (1.7 per cent) remain as cultivators now.

The proportion of disabled who were not working right from the beginning was about one fifth of the total disabled. The proportion of those who are not working after becoming disabled was three-fourths of the total. Cattle tending had witnessed an increase after disability. While only two were tending cattle earlier, the number had gone up to 10.

We also find that women had withdrawn more from work than the men. While 27 per cent of disabled men were not working from the beginning and during the post-disability phase, the proportion had gone up to 60 per cent. On the other hand, only 15 per cent of women were not working from the beginning, whereas after disability, 82 per cent of the women were not working.

Occupation of Persons with Disabilities: Subramaniapuram

S. Puram, as we have noted earlier has moved completely away from agriculture. Most of the workers are into non-agricultural occupation and all the non-agricultural workers commute to work. Let us explore the participation of persons with disabilities in the labour scope of S. Puram.

More than 60 per cent of persons with disabilities were wage workers earlier. One was a cultivator. Five others were working in other occupation. One woman was a housewife. Six of persons with disabilities were not working even earlier.

We find that none of the persons with disabilities is working at present. No work is available in the village as agriculture has completely collapsed. All the workers go outside the village for their work either on their own or by the transportation provided by their employer. No disabled person is employed in the fireworks or in other occupations that have emerged in S. Puram. Most of the work in the fireworks industries is piece rate and the production process goes on like an assembly line. Persons with disability find it impossible to commute and to be part of the work in the fireworks industries and hence no one is working.

The match and firework units bring in labour from far off places apart from hiring some local workers. However, none of the units employ persons with disabilities either from this village or from anywhere.

Thus, while plenty of jobs are available which necessitates labour to be hired from outside (by providing even free housing), the local disabled do not find any work in these units in S. Puram.

Occupation of Persons with Disabilities: Mathalamparai

Mathalamparai has an active labourscape with non-farm employment as well as the home-based beedi rolling activity. While the former employs large numbers of men, the latter employs large numbers of women. Do persons with disabilities find a space in such an active labourscape?

Nearly about one-third of persons with disabilities were working as wage labourer prior to their disability. Another one fourth was rolling beedies. Just one-fourth of persons with disabilities were not working from the beginning.

Nearly two-thirds of persons with disabilities are not working now. Number of wage labourers has declined from 28 to 10 among persons with disabilities. Similar decline is reported in beedi rolling as well, as 12 women had quit rolling beedi with only 8 remaining in the job. Those who were doing ‘other’ kinds of jobs have also withdrawn from work.

This is the broad occupational pattern of persons with disabilities. Participating in work and continuing to work is extremely case specific among persons with disabilities. Old age-led withdrawal and withdrawal by the movement disabled are clear cases of inability to work.

STATE SUPPORT TO PERSONS WITH DISABILITIES IN SAMPLE VILLAGES

Tables 6.8, 6.9, and 6.10 provide information on some of the support services availed by persons with disabilities in the villages studied. These include access to MGNREGA works, pension, and medical care.

Government of Tamil Nadu provides monthly pensions to the vulnerable in the society. It pays a monthly pension of Rs.1000/- which is deposited in the bank account of the beneficiary. Though the government has been increasing the coverage over a period of time, it is not adequate to cover all the eligible persons. A monthly pension gives persons with disabilities a certain level of economic freedom to take care of their requirements. The government also was to provide employment for persons with disabilities on a priority basis under MGNREGA. Disability card is issued

Table 6.8 Access to MGNREGA among Persons with Disabilities in Sample Villages, 2015

Sl. No.	Items	Palakurichi			Thaludali			Vagavasal			Subramaniapuram			Mathalamparai		
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1	Total number of disabled	78	32	110	16	8	24	51	69	120	15	20	35	44	41	85
2	Number with NREGA cards	51	18	69	7	2	9	3	21	24	6	9	15	7	13	20
3	Number of persons worked in NREGA in 2014	39	14	53	6	2	8	1	19	20	3	4	7	2	5	7
4	Average number of days of work under NREGA	41	48	43	31	40	33	10	42	40	53	81	69	100	78	84
5	Average wages received under NREGA (Rs.)	98	93	96	103	105	104	85	90	90	95	80	91	95	112	107

Source: Survey Data. M=Male, F=Female, T=Total.

Table 6.9 Distribution of Pensioners among Persons with Disabilities across Caste in Sample Villages, 2015

Sl. No.	Castes	Palakurichi			Thaludali			Vagavasal			Subramaniapuram			Mathalamparai		
		No.P	T.Dis	A.D.C	No.P	T.Dis	A.D.C	No.P	T.Dis	A.D.C	No.P	T.Dis	A.D.C	No.P	T.Dis	A.D.C
1	SC	17	69	4	2	2	2	11	43	3	6	6	1	3	15	1
2	BC	11	36	5	14	22	17	11	77	4	6	15	3	13	67	10
3	OC	–	5	–	–	–	–	–	–	0	–	14	3	–	3	–
	Total	28	110	9	16	24	19	22	120	7	7	35	7	16	85	11

Source: Survey Data. No.P. = No. of Pensioners, T.Dis.= Total No. of Disabled, A.D.C= Access to Disability Card.

Table 6.10 Access to Medical Care for Persons with Disabilities in Sample Villages, 2015

Sl. No.	Sources	Palakurichi			Thaludali			Vagavasal			Subramaniapuram			Mathalamparai		
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1	Public	54	20	74	3	1	4	22	30	52	8	10	18	15	18	33
2	Private	3	2	5	2	1	3	15	18	33	3	1	4	11	6	17
3	Both	8	3	11	–	–	–	3	11	14	–	–	–	2	3	5
4	Not accessed	13	7	20	11	6	17	11	10	21	4	9	13	16	14	30
	Total	78	32	110	16	8	24	51	69	120	15	20	35	41	45	85

Source: Survey Data. M=Male, F=Female, T=Total.

by the government for them to claim available benefits. Access to all these entitlements is not universal. Let us discuss the level of access to these entitlements for persons with disabilities in each of the villages.

State Support to Persons with Disabilities: Palakurichi

Many persons with disabilities have got MNREGA cards in Palakurichi. However, around 35 per cent of persons with disabilities still do not have these cards. Still fewer have accessed the NREGA work. Even among those who access the MGNREGA work the average number of days worked under the programme was just about 43 in 2014. The wages received on an average was less than Rs.100 a day (at Rs. 96).

The state provides a pension of Rs.1000 for the aged and persons with disabilities. It is not an universal programme. In Palakurichi, slightly more than one-fourth of persons with disabilities are receiving a monthly pension. Among the male disabled, the pensioners are slightly lower than one-fourth of the total number whereas it is slightly higher at 31 per cent among the women. *Disabled from the backward castes are better covered than the ones from the scheduled castes.* While just about one-fourth of the scheduled caste disabled received a pension, nearly about 30 per cent from the backward caste are receiving pension in Palakurichi. None from the other castes are receiving it.

Persons with disabilities require medical assistance and they access both the public health system and the private

doctors. We find that a predominant number (nearly two-thirds) of persons with disabilities in Palakurichi access the public health system. Less than 5 per cent of persons with disabilities access private doctors. About one-tenth of them access both the systems depending on their requirement. There is a primary health centre in the village which is manned by a doctor and the district hospital is about 15 km away in Nagapattinam which is connected by a town bus service with the village. Also, the public health system provides most of the medicines free of cost and that is another reason why so many use it. There is also an efficient ambulance service run by the public health system enabling easy access particularly to persons with disabilities. Compared to the public health care system, the private system is very expensive and hence could deter persons with disabilities from accessing it. There is also a state funded health insurance system that enabled the poor to access the private system when required but involves many out of pocket expenses.

The state has well laid out guidelines to issue disability certificates and cards to persons with disabilities. The procedure estimates the extent of disability and the nature of disability. Special provisions for persons with disabilities are available only to those who are disabled beyond a certain prescribed level and also certain types of disability. Therefore, not every disabled person is recognized as disabled by the system. Getting recognized as disabled is a long and tedious process even if one feels disabled. Age-related disability is not recognised as disability at all. Disability which hampers a person's functioning up to 40 per cent is not recognised as disability. Moreover, there are assigned hospitals which can only vouch for the nature and extent of one's disability.

We find that less than one-tenth of persons with disabilities have the disability card. This is true across all caste and gender. We found in an earlier section that 59 persons with disabilities in Palakurichi have attributed their disability to old age. It we exclude them, then 51 are disabled due to other reasons. If we consider this sub-section of persons with disabilities we find that only about 17 per cent of them have received the disability card which in turn means that only these few disabled can access whatever little is earmarked for persons with disabilities by the State.

Thus Palakuruchi, an agricultural village provides some opportunities to persons with disabilities. While many of the erstwhile agricultural labourers and cultivators have withdrawn from work, some could take up cattle-rearing as an alternate employment opportunity. Employment in the overall context of the village has gone down due to loss of one crop season as well as mechanization. Given this loss, the overall labourscape is not very promising. The employment guarantee scheme was intended to provide a base minimum of opportunities for the workers including persons with disabilities. However, the level of inclusion of disabled is very poor due to insufficient knowledge on the part of both those who implement the programme as well as the beneficiaries. Other state support is also poor except the medical assistance for common ailments.

State Support to Persons with Disabilities: Thaludali

MGNREGA has special provision to accommodate persons with disabilities. However, in practice, the local authorities do not take any initiative to accommodate them. Many disabled are not even given the cards by enrolling them. No special work is assigned nor is any equipment procured to enable the participation of persons with disabilities in the programme. Our enquiries with the local body representatives indicated complete ignorance of such provisions. In Thaludali village, only 9 out of the 24 disabled have enrolled in MGNREGA. One person from the scheduled caste and eight from the backward caste have acquired the card. Thus, just about one third of persons with disabilities have got the cards. While in general women participate in MGNREGA work in large numbers in the state of Tamil Nadu, in Thaludali only 2 out of the 8 women with disabilities in the village have got the cards. However, while men with disabilities have got employment for 31 days on an average, the women have got 40 days of work. The average wage received was Rs.104.

State pension of Rs.1000 for persons with disabilities is available only to 12 out of the 24 disabled persons in the village. Thus, half of them remain uncovered. We find that more proportion of men among persons with disabilities have got the pension as compared to women in Thaludali village. Moreover, even those who are receiving the monthly pension discuss about the erratic disbursal of money by the department. Also, the pension was withdrawn to some on the basis of unsubstantiated complaints about their eligibility. The department, instead of making proper queries, stops the pension. A person with disability has to make enormous efforts to get back his/her name on the rolls again. Many eligible disabled persons complained that despite their eligibility and proper application, their request for pension was not conceded and the sanction of pension is opaque. Who will get and when depends on the discretion of the officials. Each trip to the district office, after several trips to other certifying offices is tedious for persons with

disabilities and requires the help of others to represent their case. Many of these offices remain inaccessible for persons with disabilities.

There is a primary health centre is Mylam and a district hospital in Villupuram. There is Jawaharlal Institute for Post Medical Education and Research centre in Puducherry. All these facilities are easily accessible to the residents of Thaludali by road as they are well connected with frequent buses. However, very few disabled residents access these facilities for medical assistance. Only one-sixth have responded that they have accessed the government medical system. Fewer have accessed the private system. None of them have reported to have used both the systems.

Access to disability card is quite high in Thaludali village. Nineteen out of twenty-four disabled have got the disability card. While most men (14 out of 16) have got their cards, only 5 out of 24 women have got the cards. While 19 out of 24 have got the disability card, only 12 of the 24 are receiving pension. Thus, even after recognizing their disability, the state has not provided the pension for many of them.

State Support to Persons with Disabilities: Vagavasal

Vagavasal has a vast area to take up MGNREGA work to the maximum level possible. However, many of the main workers are employed in disparate kinds of jobs where they earn much more than what MGNREGA can offer. Very few men, thus, turn up for work under MGNREGA in Vagavasal. It was mostly women who took the work but the work did not have even one disabled. When two disabled women tried to participate in the work, other participants stoutly opposed it. The contention of those opposing participation by disabled in MGNREGA work is that since persons with disabilities get a pension, they should keep away from MGNREGA work. The protesters went to the level of threatening the panchayat clerk and the village president of withdrawal from work if persons with disabilities were permitted. For the protesters it was unfair for persons with disabilities to get a pension and also compete with them in the MGNREGA work. They can get only one benefit at a time and they cannot have both. Pension is given to them as they are not able to work. As a result, no disabled was allowed to work in MGNREGA in Vagavasal. It was the same story in many villages. Disabled are turned away and we found that during social audit of the programme, the audit team specifically pointed out this inadequacy in one of the villages. But the local structure is antagonistic towards the participation of persons with disabilities in this work.

We find that in Vagavasal, only 24 persons who have claimed that they were disabled have got the MGNREGA card. Most of them were women. In fact, all of them were aged persons who have claimed they were disabled. Only 20 of them have worked in MGNREGA. They had worked for 41 days on an average last year and have earned at Rs. 90 as average wages.

Less than one-fifth of persons with disabilities in Vagavasal received a pension of Rs.1000 per month. Nearly one-fourth of persons with disabilities among the SCs have got pension whereas only one in seven among persons with disabilities belonging to BCs have received pension. Among men, about one in five have got pension whereas one in six among women have got pension in Vagavasal.

Larger number of disabled persons access the government medical system accounting for about 43 per cent. Another 28 per cent of persons with disabilities have used the private medical assistance and a few others have used both the systems. There is a primary health centre in the village and the district hospital in Pudukottai is accessible by road and this perhaps enables persons with disabilities to access the public system more than the private system.

Nearly half of persons with disabilities from the SCs and 40 per cent of persons with disabilities from the BCs were accessing the government medical assistance.

Access to the disability card is extremely poor in Vagavasal. Only 7 persons have got the card. Many of them have applied for the same and have been repeatedly pleading with the concerned officials for the card but nothing has moved so far. Each time, they need to summon an auto rickshaw to go to the office in Pudukottai. Getting an auto rickshaw is not difficult for them for they have the mobile phone and the phone numbers of the serving auto rickshaws. But the cost of hiring, waiting and returning is very steep. Each trip to Pudukottai costs about Rs. 250/- and many of them need the help of one more person to go to the office. Only one person among them has a motorised three wheeler to commute. All others need to depend on the auto rickshaws. The hamlets are away from the main road from where buses are available to go to the town. Moreover, many with locomotive disabilities find it difficult to climb the footboard of the buses.

State Support to Persons with Disabilities: Subramaniapuram

MGNREGA is implemented in the village with great difficulty as most of the workers are employed in non-

agricultural operations for much higher wages and also more regularly. Moreover, both male and female are employed in such occupations. Labour is available only in small numbers in the village. Unlike in other villages, women also go outside the village for work in large numbers and hence they are also not available for MGNREGA work.

MGNREGA card is available only for 15 persons with disabilities in the villages. Only half of them worked in MGNREGA for 69 days on an average in the year 2015. The average earning per day on those days of MGNREGA work was Rs. 91. No special work was assigned to persons with disabilities under the scheme. Since many of them could not take up any work, they had abstained from this opportunity as well.

Only 7 disabled persons in the village could get the disability card and the pension. Those who get the pension felt that it is a great help provided by the state. We came across a sister and a brother from the same family who are disabled and without pension, it would have been a disastrous starvation as there was no one to support them. The free rice from public distribution system and the monthly pension for one of them is the only source of livelihood for them. There were several others who inquired from us about a sure way of getting a pension after several futile attempts to get it. Since all the family members go out for work, many disabled drink their coffee or tea and a snack from the local shops. Pension money is very useful for this as they need not depend on the financial support of other family members to meet such small daily requirements. But unfortunately, only a few are lucky to have this pension support from the state. But many pensioners did complain that the pension payments are irregular and unpredictable.

There is a primary health centre in S. Puram. But they have to go to Sathur or Sivakasi to consult a private doctor. Both the towns have government hospitals. Persons with disabilities in S. Puram use both the public and private health systems. Nearly half of them use only the public health system. Few of them use the private system.

State Support to Persons with Disabilities: Mathalamparai

Awareness about the eligibility of persons with disabilities to participate in MGNREGA is not there among either persons with disabilities or the panchayat office bearers. Except a few age-led disabled persons, no disabled person in Mathalamparai had the MGNREGA card. Even among the old disabled persons who had the card, few among them had taken up the MGNREGA work. The two men who took up the work had exhausted the maximum number of days of employment in 2015 of 100 days and the women had on an average worked for 78 days. While the men on an average had earned Rs. 95 from the MGNREGA work, the women had reported to have earned an average of Rs. 112 per day during 2015.

Less than one-eighth of persons with disabilities in Mathalamparai has the disability card. Slightly more number of disabled persons is receiving the pension. Since the old age-led disabled are also included in our survey, the number of persons who are getting old age pension are also included and hence the number of pensioners is more than the number of persons with disability card. Proportion of disabled women who are getting pension is better when compared to the proportion of disabled men who get pension.

More than one-third of persons with disabilities do not access any medical assistance. Largest numbers of them (about 40 per cent) access the public medical system for their requirements and about one fifth access the private medical system. About 6 per cent of persons with disabilities use both the systems.

* * *

Our discussion so far about persons with disabilities in the labourscape of Tamil Nadu clearly indicates the very low level of accommodation for them in the overall space. The secondary data indicate that nearly two-thirds among persons with disabilities are non workers with significant variation in the proportion of non workers across disabilities. Non-workers among persons with disabilities comprise of those who are unable to work due to their disability. Data indicate that nearly one third of persons with disabilities were finding it difficult to work due to their disability. The changing labourscpe that we had tried to map throws up very important points for consideration in understanding the location of persons with disabilities within such a laborscape. Considerable research is required to flesh out each of the themes listed below as well as to comprehend how the combination of different factors identified in these themes coalesce to add to the already difficult lives of persons with disabilities.

INCREASINGLY A MIX OF AGRICULTURAL AND NON-AGRICULTURAL OCCUPATION

Almost all the labourscapes have transformed into a mix of both agriculture and non-agricultural occupations and in some cases the non agricultural occupations have

emerged as more important in the overall livelihood strategy of the people in the labourscape. While in terms of standard indicators of development the changeover to non-farm employment signifies progress, for persons with disabilities this changeover has not necessarily translated into more and better opportunities in the absence of enabling factors, such as physical and social infrastructure. To some extent we have captured this scenario through our survey which inquired into their previous and present occupations. What has emerged is that, *once persons with disabilities withdraw from their earlier occupation, they find themselves outside the labourscape* or in the periphery. At one level, the traditional occupations are on the decline; at another level many of the agricultural operations are mechanized and fewer and fewer opportunities are available in such traditional but mechanized occupations. Quite a few of persons with disabilities have moved over to occupations like cattle rearing. The emerging non-farm work very often requires commuting and the new modes of transport like the mechanized two wheelers are not accessible to many disabled. Thus, accessing the emerging labourscape becomes difficult for many. The public transport is also difficult to access for many given the nature of their disabilities.

Changes in the Nature of Work Contract

Work agreements increasingly are based on contracts. This is true even in agriculture. When such works are taken by gangs, persons with disabilities are excluded from such gangs. Even the older workers are left out of such groups and thus many such new contracts are structurally against the differently abled.

Deficits in Formal Education and Professional Skill

Secondary as well data from field corroborate the extremely poor educational attainment among persons with disabilities. Far more research is required to examine why governments at the Centre or state level have been unable to address the issue of education and skill development for this section of the population.

Insufficient Delivery Mechanisms of State-led Schemes

The delivery mechanisms of the state on the ground do not enable a better participation for persons with disabilities in the labourscape. Many persons with disabilities have been unable to procure the disability card. Very few have got pensions and other aids. No vocational or skill training has reached them. While on paper, MGNREGA is designed to provide special opportunities to persons with disabilities, for various reasons (some of which are mentioned in the paper) the implementation of the MGNREGA in the state has failed to support persons with disabilities.

Insensitivity of the General Public

While the state can be faulted for not doing enough for persons with disabilities, what is unpardonable is the behaviour of civil society towards persons with disabilities; the latter are ridiculed and are not treated on par. As our field exploration reveals, legal provisions to give special jobs to persons with disabilities under the MGNREGA are opposed by the abled on the ground that persons with disabilities should be satisfied with their pensions and should not compete for MGNREGA work.

Declining Family Support

With the increasing nucleation of the families and the decline of the joint families the traditional support systems for persons with disabilities are on the decline. On the ground we found many disabled to be supported by their ageing parents; this scenario made us realize how precarious and bleak was the future staring at this section of population in the absence of opportunities for gainful employment and/or other support structures.

Our chapter has merely touched the tip of the disability iceberg. The field study concentrated more on capturing the labour scenario confronting persons with disabilities. While the changing labourscape of the villages studied itself has thrown up several more issues that need in-depth research, the secondary data analysis carried out in the larger report reveal a host of issues, that, to the best of our knowledge, have yet to be explored without which the process of addressing the theme of making the lives of persons with disabilities livable cannot even begin. Today the onus of providing for persons with disabilities is largely the responsibility of the immediate family or on persons with disabilities themselves. Hopefully this chapter and the volume for which it is has been written will open up a dialogue at the societal level.

Acknowledgements

We are grateful to P. Kumar (CSD) for his support in consolidating the presentation of data and tabulations.

Notes

1. This chapter has been extracted from a larger Report that has, among other things, combined available secondary data (from Census 2001 and 2011, and the 58th Round of the National Sample Survey of the Central Statistical Organization) with field studies in five villages to build a picture of the status of persons with disability covering nature, dimension and ground level realities of their life and day to day living. Jeyaranjan, J. 2016. *Report of the Study of Persons With Disability in the Labourscape of Tamil Nadu*. Study sponsored by the Council for Social Development, Hyderabad (mimeo).

2. Census 2001 also recorded data on disability. However, the disability data of 2001 cannot be compared with that collected in Census 2011 because of definitional changes and changes in the categories into which data have been spread. Further, data collected from the sample villages covered in the study could not be strictly matched with the Census categories since perceptions on ground regarding what constitutes disability and what enables/disenables work participation differ drastically from how Census approaches the issue of disability. Census 2011 data nevertheless provide a framework within which our sampled village data can be contextualized and discussed.

7

Urban Employment for Persons with Disabilities

A Study of Telangana

Soumya Vinayan

Context

Discourses on disability in India have for long been based on 'able-normative' approaches, and have foregrounded the medical model of engagement with disability. This is more pronounced in the realm of labour market research, which has long neglected workers with disabilities and pushed them into the category of 'non-labouring' poor (Kannabiran, 2014). The major objectives of this chapter are to sketch the profile of persons with disabilities (hereafter PWDs) and the barriers they face in everyday life. This chapter also looks into the employment status of PWDs in urban areas and attempts to look into the factors that influence their participation in the labour market, drawing on a primary survey conducted in six urban areas in Telangana.

The adoption of United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006 heralded a watershed in disability rights movements across the world. It signalled a marked shift of focus on disability from a welfare concern to that of rights issue. Article 27 addresses employment explicitly: 'to prohibit discrimination in job-related matters, promote self-employment, entrepreneurship and starting one's own business, employ persons with disabilities in the public sector [and] promote their employment in the private sector….'. Employment holds the key to human dignity, self-reliance, and self-determination in the exercise of choice. Needless to say, it is a necessary precondition for PWDs to escape from the vicious circle of marginalization, poverty, discrimination, and social exclusion.

The incidence of disability in India has been difficult to comprehend due to its complex, multifaceted nature as also the lack of standard definitions and availability of data sources (Mitra and Sambamoorthi, 2006a). According to the Census of 2011, there are 26.8 million PWDs in India which accounts for almost 2 per cent of population in India, which was similar to what had been reported in the earlier Census of 2001; in absolute terms, there has been a 22 per cent increase between Census of 2011 and 2001. With respect to the newly formed state of Telangana, as per the Census of 2011, there are 10,46,822 PWDs.[1] Of these 59 per cent were located in rural areas while 41 per cent are in urban areas.

'Disability is complex and the intervention required to overcome disability disadvantage are multiple, systemic and will vary dependent on context' (World Health Organization (WHO), 2011: 261). This statement has to be understood in the context of the interaction between the impairments and other external barriers that restrict the participation of people with disabilities in society, especially labour market participation. Over the years, policies and interventions have focused on provisions for care, incentives in the form of affirmative policies and welfare schemes, some of which such as reservation or quotas in public employment are aimed to bring the persons with disabilities under the ambit of paid work. Nonetheless, these interventions are 'the medium through which tolerance is fostered, and discrimination is left unaddressed in any substantive manner, leaving public morality firmly in place' (Kannabiran, 2012: 54). This places an undue burden of responsibility on the individual with disabilities rather than questioning the social construction of ability which excludes PWDs from full citizenship. It is evident from several studies that the employment rates of PWDs are much lower than of those without disability, while unemployment rates of the

former remain much higher (WHO, 2011). The WHO study also points out that labour market discrimination of PWDs can be attributed to multiplicity of factors: labour market imperfections related to discrimination and prejudice; differences in productivity; and disincentives created by disability benefit system to name a few.

In India, the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 is the legal framework within which there are several provisions for ensuring equal opportunities in employment for PWDs whether through vocational rehabilitation provisions, quotas, anti-discrimination provisions, or employment equity legislation, which is central not only in terms of their economic rights, but also to their broader social and political rights, which are closely and strategically linked to economic empowerment (Kothari, 2012). The quotas and reservations for PWDs are, however, limited to public sector employment. The eschewing of principles of fair labour standards in the private sector, especially in the context of globalization, works disproportionately against the interests of persons with disabilities.

Impediments that arise due to disabling physical or mental conditions can be easily mediated through enabling environments—be it physical infrastructure, attitudinal barriers, or wage structure. Often, such favourable environment does not exist. As a consequence, reservation wage (the lowest wage at which one is willing to work) for PWDs is higher than those without disabilities since there are higher costs involved to secure employment than the latter. On the other hand, if the work place is not conducive or PWDs are perceived as less productive, then they are likely to be paid a lower market wage (Mitra and Sambamoorthi, 2006a). Thus, PWDs are trapped between the high reservation wage and low market wage.

Data Sources on Disability

Census (2001 and 2011) and the NSSO data remain the main source of data on persons with disabilities along with state level enumeration of different levels and scales with respect to India.[2] However, such macro-level data does not reveal much about the ground realities unless adequately qualified with micro-level studies (Jeffrey and Nidhi, 2008). There are very few studies in India which have looked at the status of employment of PWDs using primary survey based data. Most of the studies have been based on secondary data, especially on the NSSO Data of 2002 on Disability (Mitra and Sambamoorthi, 2006a, 2006b; Pal, 2010) and Census of India 2001 (Appunni and Deshpande, 2009; UNDP 2012). The exceptions are the studies conducted by Erb and Harris-White (2001) in three villages of Tamil Nadu and Mitra and Sambamoorthi (2009) which uses 15 Villages Disability Survey data of Uttar Pradesh conducted by the World Bank in 2005.

As far as the present study is concerned, CSD had undertaken an in-depth study of Persons with Disabilities, which examined the barriers to employment for PWDs in selected urban areas of Telangana through a field-based survey. At the time of fieldwork (conducted between October 2013–March 2014), the only statistics available on PWDs at the state level was the Census of 2001. Unit level household data, which would enable sample selection was not available. Hence, for the purpose of sampling, SADAREM (Software for Assessment of Disabled for Access, Rehabilitation, and Empowerment) database was used. At the first stage, six districts with high incidence of PWDs in the age group of 20–50 (active employment-seeking age) were identified. In the second stage, from within these districts, six urban areas/municipalities with high incidence of PWDs in the age group of 20–50 were listed (See Table 7.1).[3] From these, persons (these are persons with government certified and verified disability of 40 per cent and above) who are eligible for disability entitlements of the government were listed from the online database. From this cohort, 500 persons from each urban area/municipality were selected at random across different types of disabilities, namely visual impairment, locomotive impairment, speech and hearing impairment, and intellectual and psycho-social disabilities. It must be noted that the disabilities identified for the study are those recognized officially. This is a limitation in available database. However, given the social stigma attached to disabilities and discrepancies in the information (especially residential address) provided by SADAREM database, convenience sampling had to be employed across the municipalities. Thus, a total of 2571 PWDs from across six municipalities were chosen.

The six urban areas/municipalities, which were selected with the help of SADAREM data were Warangal (Warangal district), Nizamabad (Nizamabad district), Ramagundem (Karimnagar district), L.B. Nagar (Ranga Reddy district), Musheerabad (Hyderabad district), and Khammam (Khammam district). The status of disability, education, health, employment, physical and attitudinal barriers, and socio-economic characteristics, were collected to understand the enabling factors that equip them to seek and undertake employment and disabling factors that inhibit employment.

Table 7.1 Selection of Study Area

Name of the District	No. of PWDs (Urban)* (Age 20–50)	Name of the Municipality	No. of PWDs (Urban)** (Age 20–50)
Ranga Reddy	7132 (26.1)	Ranga Reddy	7132 (100.0)
Hyderabad	7032 (25.7)	Hyderabad	7032 (100.0)
Karimnagar	2022 (7.4)	Ramagundem	666 (32.9)
Warangal	1976 (7.2)	Warangal	1753 (88.7)
Mahbubnagar	1927 (7.0)	Mahbubnagar	765 (39.7)
Khammam	1882 (6.9)	Khammam	616 (32.7)
Adilabad	1540 (5.6)	Nirmal	338 (21.9)
Nalgonda	1513 (5.5)	Nalgonda	531 (35.1)
Nizamabad	1189 (4.3)	Nizamabad	708 (59.5)
Medak	1145 (4.2)	Siddipet	257 (22.4)
Telangana	27358 (100.0)		

Source: SADAREM data as on October 15, 2013 accessed online at www.sadarem.ap.gov.in.
Notes: *Figures in parentheses show column total (% share of districts in state total).
**Figures in parentheses show row total (% share of municipalities in district total).

Analysis

In the field survey, along with the socio-economic characteristics of the respondents (both PWDs), detailed information on status of employment was collected. The status of employment included workers and non-workers. Workers were categorized into self-employed (own account worker), employee (working under an employer) while non-workers included those seeking employment (unemployed), not in labour force, and not working owing to disability (see the section on employment status). In the following analysis, we begin with the socio-economic profile of the respondents, their level of education followed by an analysis of the characteristics of respondents in relation to their employment status highlighting the barriers to employment. This is followed by a detailed analysis of attitudinal and physical barriers faced by PWDs. Table 7.2 summarizes the coverage of respondents in the six municipalities in Telangana.[4]

Socio-economic profile of respondents

Of the total PWDs canvassed, 40 per cent were female and 60 per cent were male (Table 7.3). Majority of the respondents belonged to the age group of 18–59 in both the categories. This was as per the sample selection, since the focus of the study is on labour market barriers.[5]

Among the sampled PWDs, 67.4 per cent were persons with locomotor disability followed by 13 per cent with psycho-social and intellectual disabilities (‘Mental

Table 7.2 Respondents District-wise

Name of the District	No. of respondents
Hyderabad	290 (11.3)
Karimnagar	500 (19.4)
Khammam	458 (17.8)
Nizamabad	524 (20.4)
Ranga Reddy	300 (11.7)
Warangal	499 (19.4)
Total	2571 (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column per cent respectively.

Illness and Retardation'), 10 per cent hearing impaired, eight per cent with visual impairment and one per cent with multiple disabilities. Among the respondents, the proportion of women with disabilities (WWDs) was lower than men across disabilities except in case of hearing impaired (51 per cent). It was lowest among the locomotor disabled (38 per cent) (Table 7.3).

Of the total canvassed, 78 per cent belonged to Hindu religion, closely followed by 20 per cent Muslims, approximately 2 per cent were Christians and less than one per cent others (Sikhs, Parsis, Buddhists, and so on) among persons with disabilities. Across various disabilities too, majority were Hindus though the proportion of Muslims among multiple disabilities and intellectual and psycho-social disabilities were 29 per cent and 23 per cent respectively (Table 7.4). In terms of social category, among PWDs, 62 per cent belonged to OBC, 19 per cent belonged to Others, 15 per cent were SC, and 3 per cent were ST. This trend could be seen across various disabilities as well (Table 7.5).

Of the total canvassed, more than half of the PWDs (56 per cent) were married (Table 7. 6). Within those who were married, the proportion of women stood at 37 per cent. Among total WWDs, the incidence of marriage was stood at 51 per cent and it was lowest among intellectual and psycho-social disabled at 14 per cent. In case of other categories of disabilities too, the proportion of married women among the total ranged from 60 per cent among visually impaired to 57 per cent each among locomotor and multiple disabled while among hearing impaired it stood at 52 per cent. Thus, the incidence of women being married was strikingly low among those with intellectual and psycho-social disabilities. In case of total men with disabilities, the incidence of marriage stood at 60 per cent (higher than women) and like in case of women, the lowest was among men intellectual and psycho-social disabled at 14 per cent. It was highest among visually impaired, 70 per cent of visually impaired men were married in contrast to 60 per cent women, closely followed by locomotor-disabled 67 per cent (men). In case of multiple disabilities, among 14 women, 8 were married, but among 17 men, only 7 were married.

Among the total PWDs canvassed, 40 per cent were unmarried, of these 43 per cent were women while 57 were

Table 7.3 PWDs by Gender and Type of Disability

Type of disability	Number of PWDs		
	Female	Male	Total
Visually impaired	89 (43.0) (8.6)	118 (57.0) (7.7)	207 (100.0) (8.1)
Hearing impaired	135 (50.6) (13.0)	132 (49.4) (8.6)	267 (100.0) (10.4)
Locomotor disability	657 (37.9) (63.4)	1076 (62.1) (70.1)	1733 (100.0) (67.4)
Intellectual and psycho-social disabilities	141 (42.3) (13.6)	192 (57.7) (12.5)	333 (100.0) (12.9)
Multiple disabilities	14 (45.2) (1.4)	17 (54.8) (1.1)	31 (100.0) (1.2)
Total	1036 (40.3) (100.0)	1535 (59.7) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column % respectively.

Table 7.4 PWDs by Religion and Type of Disability

Religion	Visually Impaired	Hearing Impaired	Locomotor disability	Intellectual & psychosocial disability	Multiple disabilities	Total
Hindu	161 (8.1) (77.8)	219 (11.0) (82.0)	1348 (67.4) (77.7)	250 (12.5) (75.1)	21 (1.1) (67.7)	1999 (100.0) (77.8)
Muslim	37 (7.2) (17.9)	46 (9.0) (17.2)	345 (67.3) (19.9)	76 (14.8) (22.8)	9 (1.8) (29.0)	513 (100.0) (19.9)
Christian	4 (9.3) (1.9)	1 (2.3) (0.4)	31 (72.1) (1.8)	6 (14.0) (1.8)	1 (2.3) (3.3)	43 (100.0) (1.7)
Others	5 (31.3) (2.4)	1 (6.2) (0.4)	9 (56.3) (0.6)	1 (6.2) (0.3)	–	16 (100.0) (0.6)
Total	207 (81.1) (100.0)	267 (10.4) (100.0)	1733 (67.4) (100.0)	333 (13.0) (100.0)	31 (1.2) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column % respectively.

Table 7.5 PWDs by Social Group and Type of Disability

Social group	Visually impaired	Hearing impaired	Locomotor disability	Intellectual & psycho-social disability	Multiple disabilities	Total
SC	41 (10.5) (19.8)	43 (11.0) (16.1)	260 (60.3) (15.0)	42 (10.7) (12.6)	6 (1.5) (19.4)	392 (100.0) (15.2)
ST	9 (10.5) (4.3)	4 (4.7) (1.5)	67 (77.9) (3.9)	4 (4.7) (1.2)	2 (2.3) (6.5)	86 (100.0) (3.3)
OBC	121 (7.5) (58.5)	169 (10.5) (63.3)	1090 (67.9) (62.9)	209 (13.0) (62.8)	16 (1.0) (51.6)	1605 (100.0) (62.4)
Others	36 (7.4) (17.4)	51 (10.5) (19.1)	316 (64.8) (18.2)	78 (16.0) (23.4)	7 (1.4) (22.5)	488 (100.0) (19.1)
Total	207 (8.1) (100.0)	267 (10.4) (100.0)	1733 (67.4) (100.0)	333 (13.0) (100.0)	31 (1.2) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column % respectively.

men (Table 7.6). Across various disabilities too, the proportion of men among the unmarried were higher than women except in case of multiple disability. This may be attributed to the non-worker status among unmarried men. Among total unmarried men (587), only 34 per cent were employed, the rest were either seeking employment (4 per cent) or were not in labour force (8 per cent) or were non-workers owing to disability (54 per cent). In case of total men with disabilities, 38 per cent were unmarried, less than 2 per cent each were divorced, separated/deserted, or widowers. Among total disabled women, 43 per cent were unmarried, 1 per cent each was divorced, separated, or deserted while 3 per cent were widows. Thus, the incidence of being unmarried was higher among WWDs (43 per cent) than men (38 per cent). Live in relationship was reported by two disabled among the total 2571 canvassed and both were men with locomotor disability.

The cause for and the onset of disability plays an important role in influencing the lifecycle of PWDs—majority (54 per cent) indicated that they were disabled from birth; 32 per cent reported illness as cause of disability followed by 13 per cent who reported accident, while around 1 per cent reported either harassment or could not explain reasons or causes for disability (Table 7.7). Among men with disabilities, 51 per cent reported disability at birth followed by 31 per cent due to illness, 17 per cent by accident. Among disabled women, 59 per cent of women had disability since birth followed by 33 per cent contracted disability due to illness while only 7 per cent reported accident as cause of disability. Thus, the incidence of accident as a cause of disability was higher among men than women. Two women out of 1,036 women, and four out of 1,535 men with disabilities also reported harassment as reason for disability.

Across disabilities too, highest incidence of disability was since birth—the proportion ranged from 88 per cent among hearing impaired, 82 per cent among intellectual and psycho-social disabled, and 77 per cent among multiple disabled. Among locomotor disabled, incidence of disability since birth was lower than other disabilities, at 43 per cent (higher among women than men—49 per cent and 40 per cent respectively); illness accounted for 40 per cent of disability (42 per cent among women and 38 per cent among men) and 17 per cent reported accident as reason for disability—lower among women (9 per cent) than among men. In case of visually impaired, 56 per cent reported incidence since birth followed by one fourth due to illness and 14 per cent due to accident. Harassment was also reported by 6 out of 2571 disabled canvassed.

LEVEL OF EDUCATION

In most regions of the world, young people with disabilities lack access to formal education, training, and opportunities to develop their skills. The World Health Survey conducted in 51 countries shows that there are significantly lower rates of primary school completion and fewer mean years of education than respondents without disability. For all countries under the analysis, 50.6 per cent of males with disability have completed primary school, compared with 61.3 per cent of males without disability. Females with disability report 41.7 per cent

Table 7.6 PWDs by Marital Status, Gender and Type of Disability

Marital status	Visually impaired			Hearing impaired			Locomotor disability			Intellectual & Psycho-social disability			Multiple disabilities			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
Married	53 (10.0) (59.6)	82 (9.0) (69.5)	135 (9.4) (65.2)	70 (13.3) (51.9)	74 (8.1) (56.1)	144 (10.0) (53.9)	378 (71.6) (57.5)	725 (79.2) (67.4)	1103 (76.4) (63.6)	19 (3.6) (13.5)	27 (3.0) (14.1)	46 (3.2) (13.8)	8 (1.5) (57.1)	7 (0.8) (41.2)	15 (1.0) (48.4)	528 (36.6) (51.0)	915 (63.4) (59.6)	1443 (100.0) (56.1)
Unmarried	27 (6.1) (30.3)	32 (5.5) (27.2)	59 (5.7) (28.5)	54 (12.2) (40.0)	55 (9.4) (41.6)	109 (10.6) (40.9)	239 (53.8) (36.4)	331 (56.4) (30.8)	570 (55.3) (32.9)	118 (26.6) (83.7)	159 (27.1) (82.8)	277 (26.9) (83.1)	6 (1.4) (42.9)	10 (1.7) (58.8)	16 (1.6) (51.6)	444 (43.1) (42.8)	587 (56.9) (38.2)	1031 (100.0) (40.1)
Divorced	1 (10.0) (1.1)	1 (11.1) (0.8)	2 (10.5) (1.0)	1 (10.0) (0.7)	1 (11.1) (0.8)	2 (10.5) (0.7)	6 (60.0) (0.9)	7 (77.8) (0.7)	13 (68.4) (0.8)	2 (20.0) (1.4)	–	2 (10.5) (0.6)	–	–	–	10 (52.6) (1.0)	9 (47.4) (0.6)	19 (100.0) (0.7)
Separated/ Deserted	2 (8.3) (2.3)	3 (16.7) (2.5)	5 (11.9) (2.4)	8 (33.3) (5.9)	2 (11.1) (1.5)	10 (23.8) (3.8))	13 (54.2) (1.9)	8 (44.4) (0.7)	21 (50.0) (1.2)	1 (4.2) (0.7)	5 (27.8) (2.6)	6 (14.3) (1.8)	–	–	–	24 (57.1) (2.3)	18 (42.9) (1.2)	42 (100.0) (1.6)
Widow/er	6 (20.0) (6.7)	–	6 (17.6) (2.9)	2 (6.7) (1.5)	–	2 (5.9) (0.7)	21 (70.0) (3.3)	3 (75.0) (0.2)	24 (70.6) (1.4)	1 (3.3) (0.7)	1 (25.0) (0.5)	2 (5.9) (0.7)	–	–	–	30 (88.2) (2.9)	4 (11.8) (0.3)	34 (100.0) (1.3)
Live-in relationship	–	–	–	–	–	–	–	2 (100) (0.1)	2 (100) (0.1)	–	–	–	–	–	–	–	2 (100.0) (0.1)	2 (100.0) (0.2)
Total	89 (8.6) (100.0)	118 (7.7) (100.0)	207 (8.1) (100.0)	135 (13.0) (100.0)	132 (8.6) (100.0)	267 (10.4) (100.0)	657 (63.4) (100.0)	1076 (70.1) (100.0)	1733 (67.4) (100.0)	141 (13.6) (100.0)	192 (12.5) (100.0)	333 (13.0) (100.0)	14 (1.4) (100.0)	17 (1.1) (100.0)	31 (1.2) (100.0)	1036 (40.3) (100.0)	1535 (59.7) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column % respectively.

Table 7.7 Reasons for Disability by Type of Disability and Gender

Reasons for disability	Visually impaired			Hearing impaired			Locomotor disability			Intellectual & Psycho-social disability			Multiple disabilities			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
By birth	50 (8.1) (56.2)	66 (8.5) (55.9)	116 (8.3) (56.0)	118 (19.2) (87.4)	117 (15.0) (88.6)	235 (16.8) (88.0)	320 (52.0) (48.7)	429 (54.9) (39.9)	749 (53.7) (43.2)	114 (18.5) (80.9)	158 (20.2) (82.3)	272 (19.5) (81.7)	13 (2.1) (92.9)	11 (1.4) (64.7)	24 (1.7) (77.4)	615 (44.1) (59.4)	781 (55.9) (50.9)	1396 (100.0) (54.3)
Due to illness	26 (7.6) (29.2)	27 (5.7) (22.9)	53 (6.5) (25.6)	13 (3.8) (9.6)	9 (1.9) (6.8)	22 (2.7) (8.2)	276 (81.2) (42.0)	411 (86.7) (38.2)	687 (84.4) (39.6)	24 (7.1) (17.0)	24 (5.1) (12.5)	48 (5.9) (14.4)	1 (0.3) (7.1)	3 (0.6) (17.6)	4 (0.5) (12.9)	340 (41.8) (32.8)	474 (58.2) (30.9)	814 (100.0) (31.7)
Accident	9 (13.2) (10.0)	19 (7.2) (16.1)	28 (8.5) (13.5)	1 (1.5) (0.7)	3 (1.1) (2.3)	4 (1.2) (1.5)	58 (85.3) (8.8)	231 (87.8) (21.5)	289 (87.3) (16.7)	–	8 (3.0) (4.2)	8 (2.4) (2.4)	–	2 (0.8) (11.8)	2 (0.6) (6.5)	68 (20.5) (6.6)	263 (79.5) (17.1)	331 (100.0) (12.9)
Harassment	2 (100.0) (2.2)	3 (75.0) (2.5)	5 (83.3) (2.4)	–	–	–	–	–	–	–	–	–	–	1 (25.0) (5.9)	1 (16.7) (3.2)	2 (33.3) (2.2)	4 (66.7) (0.3)	6 (100.0) (0.2)
Cannot explain	–	1 (20.0) (0.8)	1 (10.0) (0.5)	1 (20.0) (0.7)	2 (40.0) (1.5)	3 (30.0) (1.1)	1 (20.0) (0.2)	–	1 (10.0) (0.1)	3 (60.0) (2.1)	2 (40.0) (1.0)	5 (50.0) (1.5)	–	–	–	5 (50.0) (0.5)	5 (50.0) (0.3)	10 (100.0) (0.4)
Others	2 (33.3) (2.2)	2 (25.0) (1.7)	4 (28.6) (1.9)	2 (33.3) (1.5)	1 (12.5) (0.8)	3 (21.4) (1.1)	2 (33.3) (0.3)	5 (62.5) (0.5)	7 (50.0) (0.4)	–	–	–	–	–	–	6 (42.9) (0.6)	8 (57.1) (0.5)	14 (100.0) (0.5)
Total	89 (8.6) (100.0)	118 (7.7) (100.0)	207 (8.1) (100.0)	135 (13.0) (100.0)	132 (8.6) (100.0)	267 (10.4) (100.0)	657 (63.4) (100.0)	1076 (70.1) (100.0)	1733 (67.4) (100.0)	141 (13.6) (100.0)	192 (12.5) (100.0)	333 (13.0) (100.0)	14 (1.4) (100.0)	17 (1.1) (100.0)	31 (1.2) (100.0)	1036 (100.0) (100.0)	1535 (100.0) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column % respectively.

primary school completion compared with 52.9 per cent of females without disability (WHO, 2011: 206).

Rungta elaborates that in India, people with disabilities are 'precluded from accessing or benefiting from mainstream educational (and) vocational training' (2004: 37). As for integrated schools for children with disabilities, Mehrotra reports that in India, they lack 'appropriate facilities for resource teachers, resource rooms and adequate budget provisions for them' (Mehrotra, 2013). The enabling environment for people with disabilities also includes the institutional environment. For instance, anti-discrimination laws may influence earnings and employment differentials across disability status, while assistance programs, depending on how they are designed and put into practice, can 'facilitate, limit, or not affect access to employment for persons with disabilities' (Mizunoya and Sophie, 2013: 29). Given this context, the following analysis focuses on educational status of the sampled PWDs across six districts in Telangana.

Of the total disabled canvassed, 38 per cent were non-literates (Table 7.8). Among disabled women, this proportion was higher (47 per cent) while among men with disabilities only 32 per cent were non-literate. Across disabilities, the incidence of illiteracy was highest among intellectual and psycho-social disabled (82 per cent—higher among women than men) and lowest among locomotor disabled at (26 per cent). In case of other disabilities, incidence of illiteracy ranged from 61 per cent among those with multiple disabilities, 52 per cent among visually impaired and 46 per cent among hearing impaired. In terms of gender, illiteracy among women was high across disabilities too—highest among intellectual and psycho-social disabled (87 per cent), 66 per cent among visually impaired, 58 per cent among hearing impaired, 50 per cent among women with multiple disabilities while it was lowest among locomotor disabled but still accounted for one-third of total locomotor disabled women. This indicates the abysmal levels of educational levels among disabled across disabilities and gender.

Among the literates, 43 per cent were high school educated. Among women, this proportion (40 per cent) was lower than men (45 per cent). Across disabilities too one could observe similar trend except in case of hearing impaired (51 per cent of women and 45 per cent for men). The level of education was lowest among women with intellectual and psycho-social disabled with majority with primary education (42 per cent) followed by secondary (32 per cent) and high school (26 per cent). Of the total literates, 13 per cent each reported secondary and graduation as level of literacy while 11 per cent reported intermediate level of education. Less than one per cent indicated postgraduation and technical while one per cent indicated primary level of education. Interestingly, the proportion of graduates across disabilities was highest among locomotor disabled (14 per cent) while that of primary educated was highest among intellectual and psycho-social disabled (30 per cent) indicative of the low levels of access of education to the latter. Postgraduate and technically qualified candidates were too found in larger proportion among locomotor disabled indicative of their relatively better access to education (Table 7.9).

Seventy-four per cent of the literates were educated in government schools. Private schools accounted for 20 per cent of PWDs. The PWDs who went to special schools (government or private) stood at around one per cent while madrasa and missionary schools accounted for two and one percent respectively (Table 7.10). In addition to educational level, the PWDs were also asked about the medium of instruction as well as reasons for choice of school and medium. Telugu was the major medium of instruction accounting for 75 per cent of the total respondents. In case of PWDs, 10 per cent each reported Urdu and English (Table 7.10). Almost half of the PWDs who were literate (47 per cent) reported that they chose the school out of self-interest while 42 per cent reported that their family decided the choice of the school. Majority (78 per cent) reported mother tongue as the reason for choice of medium of instruction while 8 per cent each also reported IQ and location of school as reasons for choice of medium of instruction (Table 7.11).

Among non-literate PWDs, the major reasons for illiteracy were as follows: 36 per cent reported never enrolled in school while 29 per cent reported financial problems. Around 8–9 per cent also reported absence of special school or schools near place of residence while 5 per cent each reported refusal of admission by school authorities, helping domestic and necessity to earn. In case of drop-outs (those who discontinued education), financial problems (39 per cent), helping in domestic work (23 per cent), and necessity to earn (17 per cent) were indicated by PWDs as reasons for drop-out. This indicates the vulnerability of PWDs (Table 7.12).

EMPLOYMENT STATUS

In the academic and official discourses on labour, persons with disabilities have historically been marginalized in the realm of infirm or disabled.[6] In our sample, 43 per cent

Table 7.8 Educational Status of PWDs by Gender and Type of Disability

Educational level	Visually impaired			Hearing impaired			Locomotor disability			Intellectual & Psycho-social disability			Multiple disabilities			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
Non literates	59 (12.2) (66.3)	49 (10.0) (41.5)	108 (11.1) (52.2)	78 (16.1) (57.8)	45 (9.2) (34.0)	123 (12.7) (46.1)	218 (45.0) (33.2)	232 (47.5) (21.6)	450 (46.3) (25.9)	122 (25.2) (86.5)	150 (30.7) (78.2)	272 (28.0) (81.5)	7 (1.4) (50.0)	12 (2.5) (70.6)	19 (2.0) (61.2)	484 (49.8) (46.7)	488 (50.2) (31.8)	972 (100.0) (37.8)
Literates	30 (5.5) (33.8)	69 (6.6) (58.5)	99 (6.2) (47.8)	57 (10.4) (42.2)	87 (8.4) (69.9)	144 (9.1) (53.9)	439 (7.9) (66.9)	844 (80.7) (78.5)	1283 (80.3) (74.0)	19 (3.4) (13.5)	42 (4.1) (21.8)	61 (3.9) (18.4)	7 (1.2) (0.5)	5 (0.5) (29.5)	12 (0.8) (38.8)	552 (34.5) (53.3)	1047 (65.5) (68.3)	1599 (100.0) (62.2)
Total	89 (8.6) (100.0)	118 (7.7) (100.0)	207 (8.1) (100.0)	135 (13.0) (100.0)	132 (8.6) (100.0)	267 (10.4) (100.0)	657 (63.4) (100.0)	1076 (70.1) (100.0)	1733 (67.4) (100.0)	141 (13.6) (100.0)	192 (12.5) (100.0)	333 (13.0) (100.0)	14 (1.4) (100.0)	17 (1.1) (100.0)	31 (1.2) (100.0)	1036 (40.3) (100.0)	1535 (59.7) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column per cent respectively.

Table 7.9 Literacy Levels of PWDs by Gender and Type of Disability

Literacy level	Visually impaired			Hearing impaired			Locomotor disability			Intellectual & Psycho-social disability			Multiple disabilities			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
Primary	8 (7.9) (26.7)	10 (8.2) (14.5)	18 (8.1) (18.2)	11 (10.9) (19.3)	8 (6.6) (9.2)	19 (8.5) (13.2)	72 (71.3) (16.4)	93 (76.2) (11.0)	165 (74.0) (12.9)	8 (7.9) (42.1)	10 (8.2) (23.8)	18 (8.1) (29.5)	2 (2.0) (28.6)	1 (0.8) (20.0)	3 (1.3) (25.0)	101 (45.3) (18.3)	122 (54.7) (11.7)	223 (100.0) (13.9)
Secondary	6 (8.3) (20.0)	6 (4.4) (8.7)	12 (5.7) (12.2)	8 (11.1) (14.0)	14 (10.2) (16.1)	22 (10.5) (15.3)	52 (72.2) (11.9)	106 (77.4) (12.6)	158 (75.6) (12.3)	6 (8.3) (31.6)	9 (6.6) (21.4)	15 (7.2) (24.6)	–	2 (1.5) (40.0)	2 (1.0) (16.7)	72 (34.5) (13.0)	137 (65.5) (13.1)	209 (100.0) (13.1)
High School	12 (5.4) (40.0)	34 (7.2) (49.3)	46 (6.7) (46.5)	29 (13.1) (50.9)	39 (8.3) (44.8)	68 (9.8) (47.2)	170 (76.9) (38.7)	379 (80.6) (44.9)	549 (79.5) (42.8)	5 (2.3) (26.3)	17 (3.6) (40.5)	22 (3.2) (36.1)	5 (2.3) (71.4)	1 (0.2) (20.0)	6 (0.9) (50.0)	221 (31.9) (40.1)	470 (68.1) (44.9)	691 (100.0) (43.2)
Intermediate	4 (6.9) (13.3)	10 (9.8) (14.5)	14 (8.8) (14.1)	5 (8.6) (8.8)	13 (12.7) (14.9)	18 (11.3) (12.5)	49 (84.5) (11.2)	77 (75.5) (9.1)	126 (78.8) (9.8)	–	1 (1.0) (2.4)	1 (0.6) (1.6)	–	1 (1.0) (20.0)	1 (0.6) (8.3)	58 (36.3) (10.5)	102 (63.7) (9.7)	160 (100.0) (10.0)
Graduation	–	4 (3.1) (5.8)	4 (2.0) (4.0)	4 (5.8) (7.0)	9 (6.9) (10.3)	13 (6.5) (9.0)	65 (94.2) (14.8)	115 (87.8) (13.6)	180 (90.0) (14.0)	–	3 (2.3) (7.1)	3 (1.5) (4.9)	–	–	–	69 (34.5) (12.5)	131 (65.5) (12.5)	200 (100.0) (12.5)
Post-Graduation	–	3 (6.3) (4.3)	3 (4.1) (3.0)	–	1 (2.1) (1.2)	1 (1.4) (0.7)	25 (100) (5.7)	44 (91.7) (5.2)	69 (94.5) (5.4)	–	0	0	–	–	–	25 (34.3) (4.5)	48 (65.7) (4.6)	73 (100.0) (4.6)
Technical	–	2 (5.4) (2.9)	2 (4.7) (2.0)	–	3 (8.1) (3.5)	3 (7.0) (4.2)	6 (100) (1.4)	30 (81.1) (3.6)	36 (83.7) (2.8)	–	2 (4.8) (0.5)	2 (4.7) (3.3)	–	–	–	6 (13.9) (1.1)	37 (86.1) (3.5)	43 (100.0) (2.7)
Total	30 (5.4) (100.0)	69 (6.6) (100.0)	99 (6.2) (100.0)	57 (10.4) (100.0)	87 (8.3) (100.0)	144 (9.0) (100.0)	439 (79.5) (100.0)	844 (80.6) (100.0)	1283 (80.3) (100.0)	19 (3.4) (100.0)	42 (4.0) (100.0)	61 (3.8) (100.0)	7 (1.3) (100.0)	5 (0.5) (100.0)	12 (0.7) (100.0)	552 (34.5) (100.0)	1047 (65.5) (100.0)	1599 (100.0) (100.0)

Source: Field Survey.

Table 7.10 Type of School and Medium of Instruction by Literate Respondents

Particulars of the Variable	PWD					
	Visually impaired	Hearing impaired	Locomotor disability	Intellectual & Psycho-social disability	Multiple disabilities	Total
Type of school						
Government	78 (6.5) (78.8)	92 (7.7) (63.9)	975 (81.5) (76.0)	40 (3.3) (65.6)	11 (0.9) (91.7)	1196 (100.0) (74.8)
Private	16 (5.0) (16.2)	34 (10.7) (23.6)	254 (80.1) (19.8)	13 (4.1) (21.3)	–	317 (100.0) (19.8)
Govt. special	3 (15.8) (3.0)	9 (47.4) (6.3)	6 (31.6) (0.5)	1 (5.3) (1.6)	–	19 (100.0) (1.2)
Private/NGO special	–	3 (27.3) (2.1)	5 (45.5) (0.4)	3 (27.3) (4.9)	–	11 (100.0) (0.7)
Madrasa	1 (2.7) (1.0)	4 (10.8) (2.8)	29 (78.4) (2.3)	3 (8.1) (4.9)		37 (100.0) (2.3)
Missionary	1 (6.3) (1.0)	1 (6.3) (0.7)	12 (75.0) (0.9)	1 (6.3) (1.6)	1 (6.3) (8.3)	16 (100.0) (1.0)
Others	–	1 (33.3) (0.7)	2 (66.7) (0.2)	–	–	3 (100.0) (0.2)
Total	99 (6.2) (100.0)	144 (9.0) (100.0)	1283 (80.2) (100.0)	61 (3.8) (100.0)	12 (0.8)	1599 (100.0) (100.0)
Medium of Instruction						
Not indicated	8 (13.8) (8.1)	5 (8.6) (3.5)	39 (67.2) (3.0)	4 (6.9) (6.6)	2 (3.4) (16.7)	58 (100.0) (3.6)
Urdu	10 (6.2) (10.1)	6 (3.7) (4.2)	138 (85.2) (10.8)	7 (4.3) (11.5)	1 (0.6) (8.3)	162 (100.0) (10.1)
English	5 (3.2) (5.1)	9 (5.8) (6.3)	136 (87.2) (10.6)	4 (2.6) (6.6)	2 (1.3) (16.7)	156 (100.0) (9.8)
Telugu	71 (6.0) (71.7)	112 (9.4) (77.8)	955 (80.3) (74.4)	45 (3.8) (73.8)	7 (0.6) (58.3)	1190 (100.0) (74.4)
Hindi	–	3 (18.8) (2.1)	13 (81.3) (1.0)	–	–	16 (100.0) (1.0)
Braille	5 (100.0) (5.1)	–	–	–	–	5 (100.0) (0.3)
Sign language	–	9 (75.0) (6.3)	2 (16.7) (0.2)	1 (8.3) (1.6)	–	12 (100.0) (0.8)
Others	–	–	–	–	–	–
Total	99 (6.2) (100.)	144 (9.0) (100.0)	1283 (80.2) (100.0)	61 (3.8) (100.0)	12 (0.8) (100.0)	1599 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column per cent respectively.

of PWDs reported that they were employed—23 per cent were self-employed while 20 per cent were employees. Four per cent reported that they were seeking employment (SE) while the rest indicated they were not engaged in any economic activity.[7] However, a close look at the data collected indicated that 282 PWDs (11 per cent) were not in labour force (NLF) as per conventional employment definition, that is, who were too young to work, students, engaged in domestic work while 1093 (43 per cent) reported that they were not working due

Table 7.11 Reasons for Choice of School and Medium of Instruction by Literate Respondents

Particulars of the variable	PWDs					Total
	Visually impaired	Hearing impaired	Locomotor disability	Intellectual & Psycho-social disability	Multiple disabilities	
Reasons for selecting the School						
Self interested	51 (6.8) (51.5)	65 (8.6) (45.1)	608 (80.7) (47.4)	24 (3.2) (39.3)	5 (0.7) (41.7)	753 (100.0) (47.1)
Family	35 (5.2) (35.4)	61 (9.1) (42.4)	541 (81.1) (42.2)	25 (3.7) (41.0)	5 (0.7) (41.7)	667 (100.0) (41.7)
Nearby	4 (5.9) (4.0)	1 (1.5) (0.7)	59 (86.8) (4.6)	4 (5.9) (6.6)	–	68 (100.0) (4.3)
Due to special school	1 (5.9) (1.0)	7 (41.2) (4.9)	7 (41.2) (0.5)	2 (11.8) (3.3)	–	17 (100.0) (1.1)
Rejected in other school	–	–	2 (100.0) (0.2)	–	–	2 (100.0) (0.1)
Others	8 (8.7) (8.1)	10 (10.9) (6.9)	66 (71.7) (5.1)	6 (6.5) (9.8)	2 (2.2) (16.7)	92 (100.0) (5.8)
Total	99 (6.2) (100.0)	144 (9.0) (100.0)	1283 (80.2) (100.0)	61 (3.8) (100.0)	12 (0.8) (100.0)	1599 (100.0) (100.0)
Reasons for selecting the medium of instruction						
No response	10 (11.5) (10.1)	6 (6.9) (4.2)	64 (73.6) (5.0)	5 (5.7) (8.2)	2 (2.3) (16.7)	87 (100.0) (5.4)
Mother tongue	77 (6.2) (77.8)	114 (9.1) (79.2)	1007 (80.8) (78.5)	43 (3.4) (70.5)	6 (0.5) (50.0)	1247 (100.0) (78.0)
IQ	7 (5.4) (7.1)	13 (10.1) (9.0)	101 (78.3) (7.9)	8 (6.2) (13.1)	–	129 (100.0) (8.1)
School is nearby	4 (3.7) (4.0)	9 (8.4) (6.3)	87 (81.3) (6.8)	3 (2.8) (4.9)	4 (3.7) (33.3)	107 (100.0) (6.7)
Others	1 (3.4) (1.0)	2 (6.9) (1.4)	24 (82.8) (1.9)	2 (6.9) (3.3)	–	29 (100.0) (1.8)
Total	99 (6.2) (100.0)	144 (9.0) (100.0)	1283 (80.2) (100.0)	61 (3.8) (100.0)	12 (0.8) (100.0)	1599 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column % respectively.

Table 7.12 Reasons for Illiteracy and Drop-Outs

Particulars of variable	PWDs					
	Visually impaired	Hearing impaired	Locomotor disability	Intellectual & Psycho-social disability	Multiple disabilities	Total
Reasons for illiteracy						
Never gone to school	70 (12.1) (37.4)	82 (14.2) (39.4)	272 (47.0) (33.0)	146 (25.2) (40.4)	9 (1.6) (40.9)	579 (100.0) (36.1)
Not given admission	10 (13.5) (5.3)	4 (5.4) (1.9)	22 (29.7) (2.7)	38 (51.4) (10.5)	–	74 (100.0) (4.6)
School is not nearby residence	11 (9.0) (5.9)	11 (9.0) (5.3)	72 (59.0) (8.7)	25 (20.5) (6.9)	3 (2.5) (13.6)	122 (100.0) (7.6)
No special school nearby residence	22 (15.4) (11.8)	27 (18.9) (13.0)	39 (27.3) (4.7)	54 (37.8) (15.0)	1 (0.7) (4.5)	143 (100.0) (8.9)
Financial problem	59 (12.8) (31.6)	61 (13.3) (29.3)	261 (56.7) (31.6)	73 (15.9) (20.2)	6 (1.3) (27.3)	460 (100.0) (28.7)
Need to earn	6 (7.0) (3.2)	8 (9.3) (3.8)	63 (73.3) (7.6)	8 (9.3) (2.2)	1 (1.2) (4.5)	86 (100.0) (5.4)
Helping in domestic work	9 (8.8) (4.8)	7 (6.9) (3.4)	78 (76.5) (9.5)	6 (5.9) (1.7)	2 (2.0) (9.1)	102 (100.0) (6.4)
Others	–	8 (21.6) (3.8)	18 (48.6) (2.2)	11 (29.7) (3.0)	–	37 (100.0) (2.3)
Total	187 (11.7) (100.0)	208 (13.0) (100.0)	825 (51.5) (100.0)	361 (22.5) (100.0)	22 (1.4) (100.0)	1603 (100.0) (100.0)
Reasons for dropouts						
Due to no infrastructure	5 (11.1) (6.8)	5 (11.1) (4.7)	33 (73.3) (3.0)	2 (4.4) (4.1)	–	45 (100.0) (3.3)
Financial problems	34 (6.5) (46.6)	48 (9.1) (45.3)	420 (79.8) (38.0)	18 (3.4) (36.7)	6 (1.1) (35.3)	526 (100.0) (39.0)
Helping in domestic work	16 (5.1) (21.9)	20 (6.4) (18.9)	265 (84.7) (24.0)	8 (2.6) (16.3)	4 (1.3) (23.5)	313 (100.0) (23.2)
Misbehavior by co students	1 (2.6) (1.4)	7 (18.4) (6.6)	28 (73.7) (2.5)	1 (2.6) (2.0)	1 (2.6) (5.9)	38 (100.0) (2.8)
Misbehavior of teachers	1 (3.8) (1.4)	2 (7.7) (1.9)	22 (84.6) (2.0)	1 (3.8) (2.0)	–	26 (100.0) (1.9)
Need to earn	6 (2.6) (8.2)	10 (4.4) (9.4)	200 (87.7) (18.1)	8 (3.5) (16.3)	4 (1.8) (23.5)	228 (100.0) (16.9)
No transport facility	4 (4.5) (5.5)	8 (9.0) (7.5)	69 (77.5) (6.2)	6 (6.7) (12.2)	2 (2.2) (11.8)	89 (100.0) (6.6)
Others	4 (6.3) (5.5)	6 (9.5) (5.7)	49 (77.8) (4.4)	4 (6.3) (8.2)	–	63 (100.0) (4.7)
School management rejected admission	2 (9.1) (2.7)	–	19 (86.4) (1.7)	1 (4.5) (2.0)	–	22 (100.0) (1.6)
Total	73 (5.4) (100.0)	106 (7.9) (100.0)	1105 (81.9) (100.0)	49 (3.6) (10.0)	17 (1.3) (100.0)	1350 (100.0) (100.0)

Source: Field Survey.
Note: Figures in parentheses indicate row and column per cent respectively.

to disability. As per conventional definition, the infirm or disabled are also clubbed under 'not in labour force'; however in order to examine socio-economic indicators other than disability which lead them to be not in labour force, we treat them as a separate category 'Not working owing to disability' (NWOD) in the present analysis. This is in conformity with the critique of 'disablement as 'presenced' through the removal of "disability" as a *pre-existing condition* in the labour market' (Kannabiran, 2014).

In the ensuing sections, we try to map the different characteristics of workers and non-workers in terms of demographic characteristics (gender, marital status), disability characteristics (type of disability), social status (caste/tribe/religion), human capital characteristics (education), and occupational profile.

a. Demographic Characteristics

It is clear from Table 7.13 that the proportion of WWDs who were employed were significantly lower (30 per cent) than men with disabilities (52 per cent). Among workers, 55 per cent were self-employed and 45 per cent were employees. Among WWDs, 54 per cent were self-employed while among men it was marginally higher at 55 per cent. However, among both categories of employment, the proportion of women was lower than men (Table 7.13). Among the non-working disabled, 6 per cent were seeking employment, 19 per cent were not in labour force and 75 per cent reported disability as a cause for their non-worker status. Among the non-worker owing to disability (NWOD), majority were men (58 per cent). Among those seeking employment too majority were men (57 per cent) while among NLF, 81 per cent were women. In other words, among the disabled non-worker men, majority were NWOD (86 per cent) and 7 per cent each were seeking employment or were not in labour force. In case of disabled non-worker women, NWOD accounted for 63 per cent while 31 per cent were not in labour force and only 6 per cent were actively seeking employment (Table 7.13).

b. Marital Status

High incidence of marriage among the employed and high levels of being unmarried across categories of non-workers except among NLF and SE is evident from the field data. Incidence of divorce, separation/desertion, and widow(er)hood were negligible and but were more pronounced among non-workers especially NWOD (Table 7.14).

Among workers, 70 per cent of them were married. Of these 54 per cent were self-employed and rest were employees. Within self-employed WWDs, 60 per cent were married while the incidence of marriage for men was higher at 74 per cent. In case of employees too, the corresponding figures were 67 per cent and 73 per cent respectively. This indicates that incidence of WWDs being married was marginally more when they were employees than self-employed while for men it did not show any significant change. In other words, the incidence of being unmarried was higher under self-employed for disabled women in comparison with men—32 per cent for women vs. 24 per cent for men among self-employed; while the corresponding figures were 27 per cent and 26 per cent for employees. The incidence of divorce, separation/desertion, and widow(er)hood was lower among both categories of employment and though the incidence was higher among women than men in both categories of employment (7.2 per cent of disabled women vs. 2 per cent of men with disabilities among self-employed; 6.3 and 1.4 per cent among men with disabilities) (Table 7.14).

Table 7.13 Status of Workers and Non-Workers by Gender

Status of employment	Female	Male	Total
Self employed	167 (27.8) (53.7)	434 (72.2) (54.8)	601 (100.0) (54.5)
Employee	144 (28.7) (46.3)	358 (71.3) (45.2)	502 (100.0) (45.5)
Sub Total-workers	311 (28.2) (30.0)	792 (71.8) (51.6)	1103 (100.0) (43.0)
Seeking employment	40 (43.0) (5.5)	53 (57.0) (7.1)	93 (100.0) (6.3)
Non-worker owing to disability	457 (41.8) (63.0)	636 (58.2) (85.6)	1093 (100.0) (74.5)
Not in labour force	228 (80.9) (31.4)	54 (19.1) (7.3)	282 (100.0) (19.2)
Sub Total Non-workers	725 (49.4) (70.0)	743 (50.6) (48.4)	1468 (100.0) (57.0)
Grand total	1036 (40.3) (100.0)	1535 (59.7) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in first parentheses indicate row % and second parenthesis indicate column % of totals in sub-total/grand total respectively.

Table 7.14 Gender-wise Marital Status among Workers and Non-Workers

Status of employment	Gender	Marital	Un Married	Divorced	Separated/ Deserted	Widow	Live-in relationship	Total
Self employed	Female	100 (59.9) (51.0)	55 (32.9) (58.5)	1 (0.6) (33.3)	6 (3.6) (85.7)	5 (3.0) (45.5)	–	167 (100.0) (53.7)
	Male	319 (73.5) (55.0)	106 (24.4) (53.5)	3 (0.7) (50.0)	4 (0.9) (80.0)	1 (0.2) (50.0)	1 (0.2) (100.0)	434 (100.0) (54.8)
	Total	419 (69.7) (54.0)	161(26.8) (55.1)	4 (0.7) (44.4)	10 (1.7) (83.3)	6 (1.0) (46.2)	1 (0.2) (100.0)	601 (100.0) (54.5)
Employee	Female	96 (66.7) (49.0)	39 (27.1) (41.5)	2 (1.4) (66.7)	1 (0.7) (14.3)	6 (4.2) (54.5)	–	144 (100.0) (46.3)
	Male	261 (72.9) (45.0)	92 (25.7) (46.5)	3 (0.8) (50.0)	1 (0.3) (20.0)	1 (0.3) (50.0)	–	358 (100.0) (45.2)
	Total	357 (71.1) (46.0)	131 (26.1) (44.9)	5 (1.0) (55.6)	2 (0.4) (16.7)	7 (1.4) (53.8)	–	502 (100.0) (45.5)
Sub Total-workers	Female	196 (63.0) (25.3)	94 (30.2) (32.2)	3 (1.0) (33.3)	7 (2.3) (58.3)	11 (3.5) (84.6)	–	311 (100.0) (28.2)
	Male	580 (73.2) (74.7)	198 (25.0) (67.8)	6 (0.8) (66.7)	5 (0.6) (41.7)	2 (0.3) (15.4)	1 (0.1) (100.0)	792 (100.0) (71.8)
	Total	776 (70.4) (53.8)	292 (26.5) (28.3)	9 (0.8) (47.4)	12 (1.1) (28.6)	13 (1.2) (38.2)	1 (0.1) (50.0)	1103 (100.0) (42.9)
Seeking employment	Female	20 (50.0) (6.0)	18 (45.0) (5.1)	1 (2.5) (14.3)	–	1 (2.5) (5.3)	–	40 (100.0) (5.5)
	Male	28 (52.8) (8.4)	24 (45.3) (6.2)	–	–	–	1 (1.9) (100.0)	53 (100.0) (7.1)
	Total	48 (51.6) (7.2)	42 (45.2) (5.7)	1 (1.1) (10.0)	–	1 (1.1) (4.8)	1 (1.1) (100.0)	93 (100.0) (6.3)
Non-worker owing to disability	Female	149 (32.6) (44.9)	279 (61.1) (79.7)	6 (1.3) (85.7)	14 (3.1) (82.4)	9 (2.0) (47.4)	–	457 (100.0) (63.0)
	Male	302 (47.5) (90.1)	317 (49.8) (81.5)	2 (0.3) (66.7)	13 (2.0) (100.0)	2 (0.3) (100.0)	–	636 (100.0) (85.6)
	Total	451 (41.3) (67.6)	596 (54.5) (80.6)	8 (0.7) (80.0)	27 (2.5) (90.0)	11 (1.0) (52.4)	–	1093 (100.0) (74.5)
Not in labour force	Female	163 (71.5) (49.1)	53 (23.2) (15.1)	–	3 (1.3) (17.6)	9 (3.9) (47.4)	–	228 (100.0) (31.4)
	Male	5 (9.3) (1.5)	48 (88.9) (12.3)	1 (1.9) (33.3)	–	–	–	54 (100.0) (7.3)
	Total	168 (59.6) (25.2)	101 (35.8) (13.7)	1 (0.4) (10.0)	3 (1.1) (10.0)	9 (3.2) (42.9)	–	282 (100.0) (19.2)
Sub Total–Non-workers	Female	332 (45.8) (49.8)	350 (48.3) (47.4)	7 (1.0) (70.0)	17 (2.3) (56.7)	19 (2.6) (90.5)	–	725 (100.0) (49.4)
	Male	335 (45.1) (50.2)	389 (52.4) (52.6)	3 (0.4) (30.0)	13 (1.7) (43.3)	2 (0.3) (9.5)	1 (0.1) (100.0)	743 (100.0) (50.6)
	Total	667 (45.4) (46.2)	739 (50.3) (71.7)	10 (0.7) (52.6)	30 (2.0) (71.4)	21 (1.4) (61.8)	1 (0.1) (50.0)	1468 (100.0) (57.1)
Grand total	Female	528 (51.0) (36.6)	444 (42.9) (43.1)	10 (1.0) (52.6)	24 (2.3) (57.1)	30 (2.9) (88.2)	–	1036 (100.0) (40.3)
	Male	915 (59.6) (63.4)	587 (38.2) (56.9)	9 (0.6) (47.4)	18 (1.2) (42.9)	4 (0.3) (11.8)	2 (0.1) (100.0)	1535 (100.0) (59.7)
	Total	1443 (56.1) (100.0)	1031 (40.1) (100.0)	19 (0.7) (100.0)	42 (1.6) (100.0)	34 (1.3) (100.0)	2 (0.1) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.

Note: Figures in first parentheses indicate row % and second parenthesis indicate column % of totals in sub-total/grand total respectively.

Among non-workers, the figures on marital status throw light on interesting facts. Among non-working disabled, 45 per cent were married, 50 per cent were unmarried and rest were divorced, separated/deserted, widow/er, or in live-in relationship. Among the NWOD, only 41 per cent were married while 55 per cent were unmarried. Within NWOD, however, the incidence of being unmarried was higher for women (61 per cent) than men (50 per cent). Overall, however, the incidence of being not married was higher for men (52 per cent) than women (48 per cent). Among those seeking employment too higher proportion were married (52 per cent) than unmarried (45 per cent). In addition, among married NLF, 97 per cent were females, while in case of seeking employment there was no significant difference in terms of gender. The incidence of divorce, separation/desertion was higher among females than males (Table 7.14).

c. Disability characteristics

Literature indicates that nature of disability may lead to differences in status of employment. It was evident from the data that the proportion of workers was lower than non-workers across disabilities, though it was marginally high among those with locomotor disability (51 per cent). It was lowest among those with intellectual and psycho-social disabilities (13 per cent) (Table 7.15).

Among workers, across disabilities, the proportion of self-employment was higher except in case of visual impaired wherein 56 per cent were employees. Among non-workers, the incidence of NWOD was lowest among locomotor disability in comparison with other disabilities (highest among intellectual and psycho-social disabilities and multiple disabled). In case of seeking employment, it was highest among locomotor disabled. In case of NLF, the incidence was highest among hearing impaired (24 per cent) and was closely followed by locomotor disabled at 23 per cent. Incidence of NWOD was also high among men than women across disabilities (except in case of intellectual and psycho-social disability and multiple disabilities—no difference) while among NLF the incidence was high among women (could be attributed to larger proportion of women who are homemakers) (Table 7.15). Thus, it is evident that in terms of non-worker status, the incidence was lower among locomotor disabled (except in case of seeking employment) indicative of their mobility in labour market.

d. Social Status

One can observe that there exist higher levels of non-worker status among SCs (60.5 per cent) and STs (69 per cent) than among OBCs and Others (56 per cent) (Table 7.16). Among workers, one can observe higher incidence of being self-employed across social groups. The proportion was highest among ST, 19 out of 27 employed were self-employed while it ranged from 53 per cent among SCs and OBCs to 56 per cent among others. High incidence of women in self-employment was also evident across social groups too (lowest among OBCs) (Table 7.16).

Among disabled non-workers, the incidence of NWOD was high, around 70 per cent across social groups; 77 per cent in Others being the highest and 70 per cent among SCs. This is indicative of barriers owing to disability. Incidence of not being in labour force (NLF) was marginally higher among SCs and STs (22 and 20 per cent respectively) in comparison with 19 per cent and 17 per cent among OBC and Others. Proportion of women was lower than men among NWOD (lower among SC/ST than OBC/Others) while it was higher among those NLF. This could be attributed to the proportion of homemakers among NLF. The proportion of seeking employment was marginally higher among SCs and STs (approximately 8–9 per cent) than OBCs and Others (6 per cent). In terms of gender too, the proportion of women seeking employment was marginally higher among SC and ST while it was lower among OBCs and Others (Table 7.16).

The proportion of workers was lower across religious groups though the incidence was lowest among Muslims (41 per cent) closely followed by Hindus and Christians (44 per cent) and Others (50 per cent). The incidence of self-employment was higher among Muslims (59 per cent) in comparison with Hindus (54 per cent). This was also true of women among the religious groups—71 per cent of Muslim women were self-employed compared to 50 per cent of Hindu women. Among employees, the proportion of employees was lowest among Muslims (41 per cent) while the corresponding proportion was 53 per cent (10 out of 19) and 47 per cent for Christians and Hindus respectively (Table 7.17).

Among non-workers, the proportion of NWOD stood at 73 per cent among Hindus, while the corresponding figures were higher for Muslims (81 per cent) and Christians (83 per cent—20 out of 24). This is true of minority women too—70 per cent of Muslim women and 86 per cent of Christian women were NWOD in comparison with 61 per cent of Hindu women. This is indicative of increased vulnerability of minority who are disabled. However, the incidence of NLF among minority women were lower (28 per cent and among Muslims and

Table 7.15 Disability-wise Status of Workers and Non-Workers

Status of employment	Gender	Visual impaired	Hearing impaired	Locomotor disability	Intellectual Psycho-social disability	Multiple disabilities	Total
Self employed	Female	9 (5.4) (37.5)	21 (12.6) (61.8)	130 (77.8) (54.6)	4 (2.4) (36.4)	3 (1.8) (75.0)	167 (100.0) (53.7)
	Male	26 (6.0) (47.3)	27 (6.2) (45.8)	358 (82.5) (55.9)	18 (4.1) (58.1)	5 (1.2) (83.3)	434 (100.0) (54.8)
	Total	35 (5.8) (44.3)	48 (8.0) (51.6)	488 (81.2) (55.5)	22 (3.7) (52.4)	8 (1.3) (80.0)	601 (100.0) (54.5)
Employee	Female	15 (10.4) (62.5)	13 (9.0) (38.2)	108 (75.0) (45.4)	7 (4.9) (63.6)	1 (0.7) (25.0)	144 (100.0) (46.3)
	Male	29 (8.1) (52.7)	32 (8.9) (54.2)	283 (79.1) (44.1)	13 (3.6) (41.9)	1 (0.3) (16.7)	358 (100.0) (45.2)
	Total	44 (8.8) (55.7)	45 (9.0) (48.4)	391 (77.9) (44.5)	20 (4.0) (47.6)	2 (0.4) (20.0)	502 (100.0) (45.5)
Sub Total-workers	Female	24 (7.7) (30.4)	34 (10.9) (36.6)	238 (76.5) (27.1)	11 (3.5) (26.2)	4 (1.3) (40.0)	311 (100.0) (28.2)
	Male	55 (6.9) (69.6)	59 (7.4) (63.4)	641 (80.9) (72.9)	31 (3.9) (73.8)	6 (0.8) (60.0)	792 (100.0) (71.8)
	Total	79 (7.2) (38.2)	93 (8.4) (34.8)	879 (79.7) (50.7)	42 (3.8) (12.6)	10 (0.9) (32.3)	1103 (100.0) (42.9)
Seeking employment	Female	2 (5.0) (3.1)	5 (12.5) (5.0)	33 (82.5) (7.9)	–	–	40 (100.0) (5.5)
	Male	–	4 (7.5) (5.5)	46 (86.8) (10.6)	3 (5.7) (1.9)	–	53 (100.0) (7.1)
	Total	2 (2.2) (1.6)	9 (9.7) (5.2)	79 (84.9) (9.3)	3 (3.2) (1.0)	–	93 (100.0) (6.3)
Non-worker owing to disability	Female	41 (9.0) (63.1)	61 (13.3) (60.4)	226 (49.5) (53.9)	120 (26.3) (92.3)	9 (2.0) (90.0)	457 (100.0) (63.0)
	Male	61 (9.6) (96.8)	62 (9.7) (84.9)	355 (55.8) (81.6)	148 (23.3) (91.9)	10 (1.6) (90.9)	636 (100.0) (85.6)
	Total	102 (9.3) (79.7)	123 (11.3) (70.7)	581 (53.2) (68.0)	268 (24.5) (92.1)	19 (1.7) (90.5)	1093 (100.0) (74.5)
Not in labour force	Female	22 (9.6) (33.8)	35 (15.4) (34.7)	160 (70.2) (38.2)	10 (4.4) (7.7)	1 (0.4) (10.0)	228 (100.0) (31.4)
	Male	2 (3.7) (3.2)	7 (13.0) (9.6)	34 (63.0) (7.8)	10 (18.5) (6.2)	1 (1.9) (9.1)	54 (100.0) (7.3)
	Total	24 (8.5) (18.8)	42 (14.9) (24.1)	194 (68.8) (22.7)	20 (7.1) (6.9)	2 (0.7) (9.5)	282 (100.0) (19.2)
Sub Total–Non-workers	Female	65 (9.0) (50.8)	101 (13.9) (58.0)	419 (57.8) (49.1)	130 (17.9) (44.7)	10 (1.4) (47.6)	725 (100.0) (49.4)
	Male	63 (8.5) (49.2)	73 (9.8) (42.0)	435 (58.5) (50.9)	161 (21.7) (55.3)	11 (1.5) (52.4)	743 (100.0) (50.6)
	Total	128 (8.7) (61.8)	174 (11.9) (65.2)	854 (58.2) (49.3)	291 (19.8) (87.4)	21 (1.4) (67.7)	1468 (100.0) (57.1)
Grand total	Female	89 (8.6) (43.0)	135 (13.0) (50.6)	657 (63.4) (37.9)	141 (13.6) (42.3)	14 (1.4) (45.2)	1036 (100.0) (40.3)
	Male	118 (7.7) (57.0)	132 (8.6) (49.4)	1076 (70.1) (62.1)	192 (12.5) (57.7)	17 (1.1) (54.8)	1535 (100.0) (59.7)
	Total	207 (8.1) (100.0)	267 (10.4) (100.0)	1733 (67.4) (100.0)	333 (13.0) (100.0)	31 (1.2) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in first parentheses indicate row % and second parenthesis indicate column % of totals in sub-total/grand total respectively.

Table 7.16 Social Group-wise Status of Workers and Non-Workers

Status of employment	Gender	SC	ST	OBC	Others	Total
Self employed	Female	24 (14.4) (55.8)	5 (3.0) (71.4)	100 (59.9) (49.5)	38 (22.8) (64.4)	167 (100.0) (53.7)
	Male	58 (13.4) (51.8)	14 (3.2) (70.0)	279 (64.3) (55.4)	83 (19.1) (53.2)	434 (100.0) (54.8)
	Total	82 (13.6) (52.9)	19 (3.2) (70.4)	379 (63.1) (53.7)	121 (20.1) (56.3)	601 (100.0) (54.5)
Employee	Female	19 (13.2) (44.2)	2 (1.4) (28.6)	102 (70.8) (50.5)	21 (14.6) (35.6)	144 (100.0) (46.3)
	Male	54 (15.1) (48.2)	6 (1.7) (30.0)	225 (62.8) (44.6)	73 (20.4) (46.8)	358 (100.0) (45.2)
	Total	73 (14.5) (47.1)	8 (1.6) (29.6)	327 (65.1) (46.3)	94 (18.7) (43.7)	502 (100.0) (45.5)
Sub Total-workers	Female	43 (13.8) (27.7)	7 (2.3) (25.9)	202 (65.0) (28.6)	59 (19.0) (27.4)	311 (100.0) (28.2)
	Male	112 (14.1) (72.3)	20 (2.5) (74.1)	504 (63.6) (71.4)	156 (19.7) (72.6)	792 (100.0) (71.8)
	Total	155 (14.1) (39.5)	27 (2.4) (31.4)	706 (64.0) (44.0)	215 (19.5) (44.1)	1103 (100.0) (42.9)
Seeking employment	Female	10 (25.0) (7.8)	3 (7.5) (11.1)	22 (55.0) (5.0)	5 (12.5) (3.9)	40 (100.0) (5.5)
	Male	8 (15.1) (7.3)	2 (3.8) (6.3)	33 (62.3) (7.2)	10 (18.9) (6.9)	53 (100.0) (7.1)
	Total	18 (19.4) (7.6)	5 (5.4) (8.5)	55 (59.1) (6.1)	15 (16.1) (5.5)	93 (100.0) (6.3)
Non-worker owing to disability	Female	72 (15.8) (56.3)	15 (3.3) (55.6)	285 (62.4) (64.6)	85 (18.6) (65.9)	457 (100.0) (63.0)
	Male	94 (14.8) (86.2)	27 (4.2) (84.4)	389 (61.2) (84.9)	126 (19.8) (87.5)	636 (100.0) (85.6)
	Total	166 (15.2) (70.0)	42 (3.8) (71.2)	674 (61.7) (75.0)	211 (19.3) (77.3)	1093 (100.0) (74.5)
Not in labour force	Female	46 (20.2) (35.9)	9 (3.9) (33.3)	134 (58.8) (30.4)	39 (17.1) (30.2)	228 (100.0) (31.4)
	Male	7 (13.0) (6.4)	3 (5.6) (9.4)	36 (66.7) (7.9)	8 (14.8) (5.6)	54 (100.0) (7.3)
	Total	53 (18.8) (22.4)	12 (4.3) (20.3)	170 (60.3) (18.9)	47 (16.7) (17.2)	282 (100.0) (19.2)
Sub Total– Non-workers	Female	128 (17.7) (54.0)	27 (3.7) (45.8)	441 (60.8) (49.1)	129 (17.8) (47.3)	725 (100.0) (49.4)
	Male	109 (14.7) (46.0)	32 (4.3) (54.2)	458 (61.6) (50.9)	144 (19.4) (52.7)	743 (100.0) (50.6)
	Total	237 (16.1) (60.5)	59 (4.0) (68.6)	899 (61.2) (56.0)	273 (18.6) (55.9)	1468 (100.0) (57.1)
Grand total	Female	171 (16.5) (43.6)	34 (3.3) (39.5)	643 (62.1) (40.1)	188 (18.1) (38.5)	1036 (100.0) (40.3)
	Male	221 (14.4) (56.4)	52 (3.4) (60.5)	962 (62.7) (59.9)	300 (19.5) (61.5)	1535 (100.0) (59.7)
	Total	392 (15.2) (100.0)	86 (3.3) (100.0)	1605 (62.4) (100.0)	488 (19.0) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in first parentheses indicate row % and second parentheses indicate column per cent of totals in sub-total/grand total respectively.

14% per cent i.e. 2 out of 14 among Christians) than Hindu women (33 per cent) (Table 7.17).

e. Literacy and Level of Education

The data reveals that only 28 per cent of non-literates were workers while 48 per cent of literates were non-workers indicative of the vulnerability of the disabled in the labour market (Table 7.18). However, among workers, majority were literates (75 per cent). This trend could be observed across categories of employment. Among women workers, the proportion of non-literates stood at 36 per cent while it was significantly lower among men (21 per cent). Similarly, in both categories of employment, there was higher incidence of illiteracy among women than men though lower among employees (Table 7.18). The incidence of illiteracy among NWOD was highest at 55 per cent, lower among NLF (35 per cent) and lowest among SE (4 per cent). This is clearly indicative of the vulnerable position of NWOD in the labour market. The incidence of illiteracy among non-working disabled women was also high (51 per cent). Among NWOD, the incidence of female illiteracy was 62 per cent (higher than men at 50 per cent) and among NLF it stood at 40 per cent (higher than men at per cent of NLF were literates. This is clearly indicative of the barriers persons with disabilities face in the realm of the labour market.

Among literates in the total disabled, one could discern high incidence of education above high school among category of workers. The proportion of graduates was also higher among the worker category. Nonetheless, the incidence of both graduates and postgraduates

Table 7.17 Religion-wise Status of Workers and Non-Workers

Status of Employment	Gender	Hindu	Muslim	Christian	Others	Total
Self employed	Female	121 (72.5) (49.6)	40 (24.0) (71.4)	3 (1.8) (37.5)	3 (1.8) (100.0)	167 (100.0) (53.7)
	Male	344 (79.3) (55.0)	82 (18.9) (54.3)	6 (1.4) (54.5)	2 (0.5) (40.0)	434 (100.0) (54.8)
	Total	465 (77.4) (53.5)	122 (20.3) (58.9)	9 (1.5) (47.4)	5 (0.8) (62.5)	601 (100.0) (54.5)
Employee	Female	123 (85.4) (50.4)	16 (11.1) (28.6)	5 (3.5) (62.5)	–	144 (100.0) (46.3)
	Male	281 (78.5) (45.0)	69 (19.3) (45.7)	5 (1.4) (45.5)	3 (0.8) (60.0)	358 (100.0) (45.2)
	Total	404 (80.5) (46.5)	85 (16.9) (41.1)	10 (2.0) (52.6)	3 (0.6) (37.5)	502 (100.0) (45.5)
Sub Total-workers	Female	244 (78.5) (28.1)	56 (18.0) (27.1)	8 (2.6) (42.1)	3 (1.0) (37.5)	311 (100.0) (28.2)
	Male	625 (78.9) (71.9)	151 (19.1) (72.9)	11 (1.4) (57.9)	5 (0.6) (62.5)	792 (100.0) (71.8)
	Total	869 (78.8) (43.5)	207 (18.8) (40.4)	199 (1.7) (44.2)	8 (0.7) (50.0)	1103 (100.0) (42.9)
Seeking employment	Female	37 (92.5) (6.3)	3 (7.5) (2.4)	–	–	40 (100.0) (5.5)
	Male	40 (75.5) (7.3)	11 (20.8) (6.1)	1 (1.9) (10.0)	1 (1.9) (14.3)	53 (100.0) (7.1)
	Total	77 (82.8) (6.8)	14 (15.1) (4.6)	1 (1.1) (4.2)	1 (1.1) (12.5)	93 (100.0) (6.3)
Non-worker owing to disability	Female	355 (77.7) (60.9)	89 (19.5) (70.1)	12 (2.6) (85.7)	1 (0.2) (100.0)	457 (100.0) (63.0)
	Male	464 (73.0) (84.8)	158 (24.8) (88.3)	8 (1.4) (80.0)	6 (0.9) (85.7)	636 (100.0) (85.6)
	Total	819 (74.9) (72.5)	247 (22.6) (80.7)	20 (1.8) (83.3)	7 (0.6) (87.5)	1093 (100.0) (74.5)
Not in labour force	Female	191 (83.8) (32.8)	35 (15.4) (27.6)	2 (0.9) (14.3)	–	228 (100.0) (31.4)
	Male	43 (79.6) (7.9)	10 (18.5) (5.6)	1 (1.9) (10.0)	–	54 (100.0) (7.3)
	Total	234 (83.0) (20.7)	45 (16.0) (14.7)	3 (1.1) (12.5)	–	282 (100.0) (19.2)
Sub Total–Non-workers	Female	583 (80.4) (51.6)	127 (17.5) (41.5)	14 (1.9) (58.3)	1 (0.1) (12.5)	725 (100.0) (49.4)
	Male	547 (73.6) (48.4)	179 (24.1) (58.5)	10 (1.3) (41.7)	7 (0.9) (87.5)	743 (100.0) (50.6)
	Total	1130 (77.0) (56.5)	306 (20.8) (59.6)	24 (1.6) (55.8)	8 (0.5) (50.0)	1468 (100.0) (57.1)
Grand Total	Female	827 (79.8) (41.4)	183 (17.7) (35.7)	22 (2.1) (51.2)	4 (0.4) (25.0)	1036 (100.0) (40.3)
	Male	1172 (76.4) (58.6)	330 (21.5) (64.3)	21 (1.4) (48.8)	12 (0.8) (75.0)	1535 (100.0) (59.7)
	Total	1999 (77.8) (100.0)	513 (20.0) (100.0)	43 (1.7) (100.0)	16 (0.6) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in first parentheses indicate row % and second parentheses indicate column per cent of totals in sub-total/grand total respectively.

among non-worker category raises serious concern about the access to labour market for the disabled (Table 7.19). Among NWOD, there were 8 per cent and 5 per cent graduates and post graduates respectively while among NLF, the proportion stood at 21 per cent and 5 per cent respectively.

Among the workers who were literates 47 per cent had high school level education, 13 per cent each had secondary and graduation, 12 per cent were primary educated, 10 per cent were intermediate and 3 per cent each held postgraduation and technical level education. Among employees, one could observe that the incidence of graduates, postgraduates and with technical education was higher than self-employed, indicating better labour market outcomes with higher levels of education (Table 7.19).

Among the literate non-working, 40 per cent had high school education while 20 per cent (with graduation/postgraduation/technical qualification) were also non-working. Forty-three per cent each of total graduates and post graduates, 54 per cent of intermediate educated, 29 per cent of technical qualified among non-workers were NWOD. High incidence of highly educated among non-workers that too among those who report disability as a reason for non-participation in labour market is reflective of the absence of enabling environment which is evident from the attitudinal barriers they face as discussed in the ensuing section (Table 7.19).

f. Type of Employment

Among the self-employed, almost 60 per cent (357 out of 601) were involved in service sector engaged as tailors,

Table 7.18 Literacy Level among Workers and Non-Workers

Status of Employment	Gender	Non literate	Literate	Total
Self-employed	Female	55 (32.9) (49.5)	112 (67.1) (56.0)	167 (100.0) (53.7)
	Male	83 (19.1) (51.2)	351 (80.9) (55.7)	434 (100.0) (54.8)
	Total	138 (23.0) (50.5)	463 (77.0) (55.8)	601 (100.0) (54.5)
Employee	Female	56 (38.9) (50.5)	88 (61.1) (44.0)	144 (100.0) (46.3)
	Male	79 (22.1) (48.8)	279 (77.9) (44.3)	358 (100.0) (45.2)
	Total	135 (26.9) (49.5)	367 (73.1) (44.2)	502 (100.0) (45.5)
Sub Total-workers	Female	111 (35.7) (40.7)	200 (64.3) (24.1)	311 (100.0) (28.2)
	Male	162 (20.5) (59.3)	630 (79.5) (75.9)	792 (100.0) (71.8)
	Total	273 (24.7) (28.1)	830 (75.3) (51.9)	1103 (100.0) (42.9)
Seeking employment	Female	1 (2.5) (0.3)	39 (97.5) (11.1)	40 (100.0) (5.5)
	Male	3 (5.7) (0.9)	50 (94.3) (12.0)	53 (100.0) (7.1)
	Total	4 (4.3) (0.6)	89 (95.7) (11.6)	93 (100.0) (6.3)
Non-worker owing to disability	Female	281 (61.5) (75.3)	176 (38.5) (50.0)	457 (100.0) (63.0)
	Male	315 (49.5) (96.6)	321 (50.5) (77.0)	636 (100.0) (85.6)
	Total	596 (54.5) (85.3)	497 (45.5) (64.6)	1093 (100.0) (74.5)
Not in labour force	Female	91 (39.9) (24.4)	137 (60.1) (38.9)	228 (100.0) (31.4)
	Male	8 (14.8) (2.5)	46 (85.2) (11.0)	54 (100.0) (7.3)
	Total	99 (35.1) (14.2)	183 (64.9) (23.8)	282 (100.0) (19.2)
Sub Total–Non-workers	Female	373 (51.4 (53.4)	352 (48.6) (45.8)	725 (100.0) (49.4)
	Male	326 (43.9) (46.6)	417 (56.1) (54.2)	743 (100.0) (50.6)
	Total	699 (47.6) (71.9)	769 (52.4) (48.1)	1468 (100.0) (57.1)
Grand total	Female	484 (46.7) (49.8)	552 (53.3) (34.5)	1036 (100.0) (40.3)
	Male	488 (31.8) (50.2)	1047 (68.2) (65.5)	1535 (100.0) (59.7)
	Total	972 (37.8) (100.0)	1599 (62.2) (100.0)	2571 (100.0) (100.0)

Source: Field Survey.
Note: Figures in first parentheses indicate row % and second parentheses indicate column percentage of totals in sub-total/grand total respectively.

painters, auto rickshaw/cycle rickshaw pullers, street vendors, and running hotel/catering/bakery; while around 20 per cent were engaged in manufacturing (carpentry, stitching and handicrafts, auto mechanic works, etc.). Around 4 per cent were also engaged in agriculture and petty animal rearing while around 17 per cent reported being engaged in other activities (Figure 7.1). In case of those who reported that they were employees too, service sector accounted for the majority of the employed (71 per cent) (Figure 7.1). Interestingly, the kind of employment engaged in differed from—casual labour (almost half of those in service sector) followed by domestic worker, security services, office work, computer operator, as well as engaged in anganwadi, health centre and State/Central Government jobs (12 out of 356). Around one-fourth reported being employed in sectors Other than service and manufacturing. Those engaged in manufacturing accounted for only 4 per cent of the total employees whereas none reported being engaged in agriculture though casual labourers may be engaged in any of these sectors.

ATTITUDINAL BARRIERS

Attitudinal barriers are those that discriminate against people with disabilities. Negative attitudes can produce barriers in all domains leading to stigmatization and stereotyping which in turn lead to discrimination and exclusion. Stereotypes about people with disabilities arise from negative attitudes in society 'that devalue and limit the potential of PWDs. People with disabilities are assumed to be less worthy of respect and consideration, less able to contribute and take part, and of less value than others' (Ontario Human Rights Commission, 2013). Familial environment also provides a context

Table 7.19 Level of Education among Workers and Non-Workers

Status of employment	Gender	Primary	Secondary	High school	Intermediate	Graduation	PG	Technical	Total
Self employed	Female	17 (15.2) (53.1)	15 (13.4) (68.2)	60 (53.6) (68.2)	10 (8.9) (50.0)	8 (7.1) (29.6)	2 (1.8) (20.0)	–	112 (100.0) (56.0)
	Male	42 (12.0) (63.6)	55 (15.7) (61.8)	169 (48.1) (56.5)	30 (8.5) (50.0)	41 (11.7) (52.6)	5 (1.4) (29.4)	9 (2.6) (42.9)	351 (100.0) (55.7)
	Total	59 (12.7) (60.2)	70 (15.1) (63.1)	229 (49.5) (59.2)	40 (8.6) (50.0)	49 (10.6) (46.7)	7 (1.5) (25.9)	9 (1.9) (40.9)	463 (100.0) (55.8)
Employee	Female	15 (17.0) (46.9)	7 (8.0) (31.8)	28 (31.8) (31.8)	10 (11.4) (50.0)	19 (21.6) (70.4)	8 (9.1) (80.0)	1 (1.1) (100.0)	88 (100.0) (44.0)
	Male	24 (8.6) (36.4)	34 (12.2) (38.2)	130 (46.6) (43.5)	30 (10.8) (50.0)	37 (13.3) (47.4)	12 (4.3) (70.6)	12 (4.) (57.1)	279 (100.0) (44.3)
	Total	39 (10.6) (39.8)	41 (11.2) (36.9)	158 (43.1) (40.8)	40 (10.9) (50.0)	56 (15.3) (53.3)	20 (5.4) (74.1)	13 (3.5) (59.1)	367 (100.0) (44.2)
Sub Total-Workers	Female	32 (16.0) (32.7)	22 (11.0) (19.8)	88 (44.0) (22.7)	20 (10.0) (25.0)	27 (13.5) (25.7)	10 (5.0) (37.0)	1(0.5) (4.5)	200 (100.0) (24.1)
	Male	66 (10.5) (67.3)	89 (14.1) (80.2)	299 (47.5) (77.3)	60 (9.5) (75.0)	78 (12.4) (74.3)	17 (2.7) (63.0)	21 (3.3) (95.5)	630 (100.0) (75.9)
	Total	98 (11.8) (44.0)	111 (13.4) (53.1)	387 (46.6) (56.0)	80 (9.6) (50.0)	105 (12.7) (52.5)	27 (3.3) (37.0)	22 (2.7) (51.2)	830 (100.0) (51.9)
Seeking employment	Female	2 (5.1) (2.9)	1 (2.6) (2.0)	10 (25.6) (7.5)	10 (25.6) (26.3)	10 (25.6) (23.8)	5 (12.8) (33.3)	1 (2.6) (20.0)	39 (100.0) (11.1)
	Male	2 (4.0) (3.6)	2 (4.0) (4.2)	15 (30.0) (8.8)	9 (18.0) (21.4)	6 (12.0) (11.3)	12 (24.0) (38.7)	4 (8.0) (25.0)	50 (100.0) (12.0)
	Total	4 (4.5) (3.2)	3 (3.4) (3.1)	25 (28.1) (8.2)	19 (21.3) (23.8)	16 (18.0) (16.8)	17 (19.1) (37.0)	5 (5.6) (23.8)	89 (100.0) (11.6)
Non-worker owing to disability	Female	46 (26.1) (66.7)	27 (15.3) (54.0)	70 (39.8) (52.6)	12 (6.8) (31.6)	14 (8.0) (33.3)	5 (2.8) (33.3)	2 (1.1) (40.0)	176 (100.0) (50.0)
	Male	49 (15.3) (87.5)	44(13.7) (91.7)	151 (47.0) (88.3)	31 (9.7) (73.8)	27 (8.4) (50.9)	15 (4.7) (48.4)	4 (1.2) (25.0)	321 (100.0) (77.0)
	Total	95 (19.1) (76.0)	71 (14.3) (72.4)	221 (44.5) (72.7)	43 (8.7) (53.8)	41 (8.2) (43.2)	20 (4.0) (43.5)	6 (1.2) (28.6)	497 (100.0) (64.6)

Not in labour force	Female	21 (15.3) (30.4)	22 (16.1) (44.0)	53 (38.7) (39.8)	16 (11.7) (42.1)	18 (13.1) (42.9)	5 (3.6) (33.3)	2 (1.5) (40.0)	137 (100.0) (38.9)
	Male	5 (10.9) (8.9)	2 (4.3) (4.2)	5 (10.9) (2.9)	2 (4.3) (4.8)	20 (43.5) (37.7)	4 (8.7) (12.9)	8 (17.4) (50.0)	46 (100.0) (11.0)
	Total	26 (14.2) (20.8)	24 (13.1) (24.5)	58 (31.7) (19.1)	18 (9.8) (22.5)	38 (20.8) (40.0)	9 (4.9) (19.6)	10 (5.5) (47.6)	183 (100.0) (23.8)
Sub Total–Non-workers	Female	69 (19.6) (55.2)	50 (14.2) (51.0)	133 (37.8) (43.8)	38 (10.8) (47.5)	42 (11.9) (44.2)	15 (4.3) (32.6)	5 (1.4) (23.8)	352 (100.0) (45.8)
	Male	56 (13.4) (44.8)	48 (11.5) (49.0)	171 (41.0) (56.3)	42 (10.1) (52.5)	53 (12.7) (55.8)	31 (7.4) (67.4)	16 (3.8) (76.2)	417 (100.0) (54.2)
	Total	125 (16.3) (56.0)	98 (12.7) (46.9)	304 (39.5) (44.0)	80 (10.4) (50.0)	95 (12.4) (47.5)	46 (6.0) (63.0)	21 (2.7) (48.9)	769 (100.0) (48.1)
Grand Total	Female	101 (18.3) (45.3)	72 (13.0) (34.4)	221 (40.0) (32.0)	58 (10.5) (36.3)	69 (12.5) (34.5)	25 (4.5) (34.2)	6 (1.1) (14.0)	552 (100.0) (34.5)
	Male	122 (11.7) (54.7)	137 (13.1) (65.6)	470 (44.9) (68.0)	102 (9.7) (63.8)	131 (12.5) (65.5)	48 (4.6) (65.8)	37 (3.5) (86.0)	1047 (100.0) (65.5)
	Total	223 (13.9) (100.0)	209 (13.1) (100.0)	691 (43.2) (100.0)	160 (10.0) (100.0)	200 (12.5) (100.0)	73 (4.6) (100.0)	43 (2.7) (100.0)	1599 (100.0) (100.0)

Source: Field Survey.
Note: Figures in first parenthesis indicate row % and second parentheses indicate column per cent of totals in sub-total/grand total respectively.

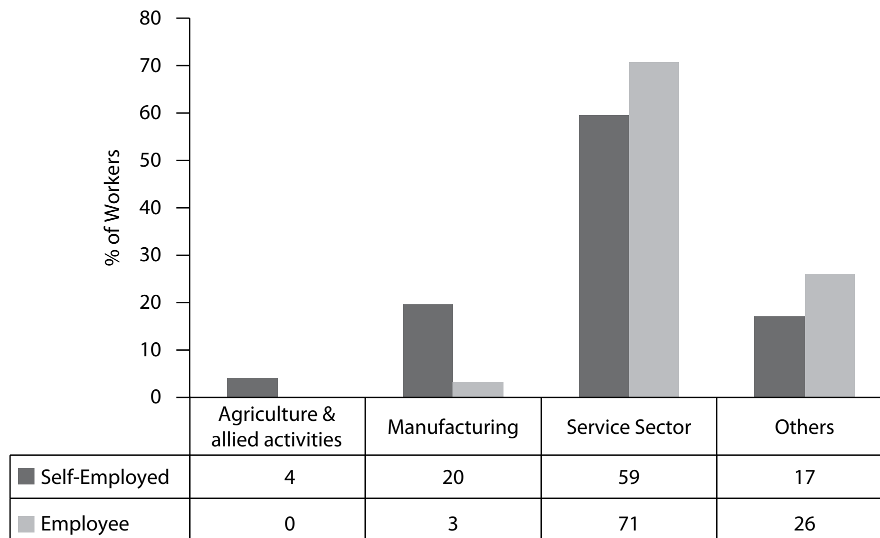

Figure 7.1 Type of Employment by Category of Workers
Source: Field Survey.

that is not conducive to a person with disability's entry into the labour force (Mizunoya and Sophie, 2013). On this subject, Mitra and Sambamoorthi have observed in their study that for 36 per cent of their participants, household heads have negative attitudes towards people with disabilities ability to be successfully employed (Mitra and Sambamoorthi, 2009: 1397). Rungta (2004) and Siperstein et al.'s (2013) study in the Indian context stresses that persons with disabilities often face unequal treatment by other family members, because they are seen as a burden and as 'cursed' in some cases. This can lead at times to 'the neglect and rejection of the child' (Siperstein et al., 2013: 2). According to Siperstein, the fear that persons with disabilities might be rejected by the community can also lead to their seclusion by their family. Titumir et al.'s (2005) study amongst Bangladeshi families indicates that most of the population view disability as embarrassment for family. Thomas and Thomas's studies stress the fact that families of women with disabilities tend to prevent them from going out of the house, 'for fear that they may be exploited in some way because of their disability' (2002: 4).

In this context, the present study focused on the incidence, location and perpetrators of such events and the course of action or preventive measures they undertook to overcome tackle such issues. It is evident from Table 7.20 that the incidence of peer and stare (45 per cent), verbal abuse (41 per cent), laugh at (38 per cent) and being pushed (32 per cent) are the most common attitudinal barriers the PWDs face. Of these, most of these occur outside home though almost one-third report verbal abuse and being pushed occurring at home as well. Physical abuse has been reported by 8 per cent of the total PWDs, the incidence equal both at home and outside home. Similarly, sexual abuse has also been reported by 4 per cent of the total respondents, and the incidence is higher outside home (59 per cent). Being implicated in wrongful acts and lack of assistance to undertake personal tasks are also reported by 10 per cent each of the respondents. In these too, the incidence is highest outside home. One could also infer seclusion from the fact that being barred from taking part in family and public events was also reported. There have also been instances of not being given adequate food reported and it is reportedly higher within home than outside. Data revealed that across most of the abuses, the perpetrators were the immediate family members of the PWD—father, mother, or spouse. Across these, the course of action has been to either ignore or suffer in silence while some of them reported complaining about it within the family or sorting it out with community elders/leaders.[8]

Data on incidence of attitudinal barriers suffered outside home revealed that around 40 per cent of the PWDs reported use of objectionable language, being implicated in wrongful acts, being laughed at, or pushed by men and people in public places. Similarly around one third of them also reported the same in case of peer and stare and not being given adequate food; while around 20–8 per cent reported being forced to work, physical abuse, being barred from participation in public events,

Table 7.20 PWDs Reporting Attitudinal Barrier by Location

S. No	Attitudinal barriers	Response (N = 2571)	Location	
			At home	Outside home
1	Use of Objectionable language/abuses	1061 (41.3)*	417 (39.3)**	644 (60.7)**
2	Peer and Stare	1150 (44.7)	133 (11.6)	1017 (88.4)
3	Push	812 (31.6)	261 (32.1)	551 (67.9)
4	Being Laughed at	988 (38.4)	134 (13.6)	854 (86.4)
5	Physical abuse	203 (7.9)	99 (48.8)	104 (51.2)
6	Sexual abuse	93 (3.6)	38 (40.9)	55 (59.1)
7	Implicated in wrongful acts	253 (9.8)	94 (37.1)	159 (62.8)
8	Not given adequate food	137 (5.3)	75 (54.7)	62 (45.3)
9	Forced to work	153 (5.9)	48 (31.3)	105 (68.7)
10	Not allowed to participate in family events	122 (4.7)	52 (42.6)	70 (57.4)
11	Not allowed to participate in public events	192 (7.5)	68 (35.4)	124 (64.6)
12	Not assisted to undertake personal tasks	276 (10.7)	110 (39.8)	166 (60.1)
13	Secluded	185 (7.2)	121 (65.4)	64 (34.6)

Source: Field Survey.
Note: *Denotes column percentage, **Denotes row percentage.

and being refused assistance to undertake personal tasks. In case of inadequate food, 25 per cent reported employers as perpetrators; while sexual and physical abuse was by others (other than those mentioned). Even in these, the PWDs mostly suffered in silence or ignored the abuse; while some of them tried to sort it out through mediation by family or elders/leaders.[9]

Out of 2571 PWDs canvassed, 2234 reported having participated in ceremonies and functions during the last year. Of these 44 per cent indicated marriage whereas 31 per cent indicated religious festivals at home as the functions they participated in. Around 6 per cent each also reported birthdays, village festivals, and other festivals/functions, while 4 per cent each participated in religious festivals (outside home) and also in death-related ceremonies.[10]

From the data it was evident that PWDs encountered several physical barriers. The frequency of occurrence and level of difficulty with respect to lack of bus shelter and seating arrangements were high. This was also reported for delay of buses/not stopping at the bus stop, overcrowded public/shared transport, ill treatment of co-passengers/drivers/conductors, inconvenient entry/exit, unavailability of reserved seats, long waiting hours at renewal of travel passes, different location of arrival and departures of bus/train, absence of announcements about arrivals/departures and for crossing the road. Similar views were also expressed about the frequency of occurrence for—overcharging by auto drivers, lack of signals/sign boards, absence of demarcation on roads/bridges for bicyclers/tricyclers, and lack of special toilets in public places.[11]

* * *

Participation of people with disabilities in all walks of life—social, economic, political, and cultural—is crucial in realizing their full citizenship through promoting human dignity and social dignity. The very mode of engaging with PWDs has been deeply rooted in the 'normalcy' paradigm based on medical computation and quantification of terms and conditions. This leads to erecting barriers in the labour market and impeding entry into it for PWDs through inaccessible physical, systemic, and social set-ups. Barriers to accessibility are obstacles that make it difficult and sometimes impossible for people with disabilities to negotiate everyday lives the things most of us take for granted like taking a public transport, attending daily chores, etc. Barriers to accessibility are generally taken as limited to physical barriers like a person who uses a wheelchair not being able to enter a public building because there is no ramp. But they are not limited to physical barriers alone. Attitudes and perceptions toward PWDs are equally important in limiting their labour market participation.

It is evident from the above discussion that in various facets of life of PWDs faces barriers. Their status as

non-literates and school dropouts can be directly correlated to barriers (such as never enrolled in schools, lack of financial resources, and refusal of admission). The proportion of women with disabilities and from the marginalized groups engaged in employment has been low while low levels of employment were also evident among those persons with intellectual, psycho-social, and multiple disabilities. In case of educational status, irrespective of level, incidence of non-worker status was high indicative of the fact that barrier other than human capital was at play. This is evident from the incidence of attitudinal (at home and outside home) as well as physical barriers that PWDs face. In case of attitudinal barriers, the perpetrators at home were close family members while outside home the perpetrators took different faces and forms to inflict various types of physical and mental abuse. Physical barriers —the frequency and level of difficulty—have been clearly articulated by PWDs with respect to access to transport, public places, streets, and roads.

Given the specific accounts that emerge from the study, one needs to review the pre-conceived notion of categorizing the disabled in the realm of 'non-labouring' poor as referred to in the beginning of this chapter. It is important to draw attention, given this context, that the segregation of the disabled especially into institutional settings can be 'attributed to transition from agriculture and cottage-based industries to large-scale factory-type system' (Barnes [1997] 2010: 23). The capitalist mode of production embedded in its construction of the able-bodied have always relegated the disabled into the sphere of those with impaired labour mobility. The occupational profile of the workers under this study (concentrated in service sector both among self-employed and employees category) also reiterate the importance of flexibility in methods of work which allow their integration into labour market as the key in contrast to the factory mode of production reflective of rigorous discipline, time bound production process. This alongside attitudinal barriers both in the public and private spheres hinders their labour market participation as reflected in the incidence of educated among non-workers in the study. At the level of employers too, irrespective of private or public sector employment (irrespective of affirmative action in the latter), the perception of inclusivity has not yet permeated the spaces of work especially in the context of India where seeking and keeping employment is a corporeal experience and negation of human capital (Upadhyay, 2013). It is therefore necessary that disability is recognized as an identity 'not necessarily a medicalized identity—it could simply be an identity that is based on identifying someone who navigates the world in atypical ways, facing many attitudinal and physical barriers' (Sherry [1997] (2010): 95). This can be achieved with the recognition of persons with disabilities as workers, through enabling conditions and reasonable accommodation, which has deep outcomes for the development of social identity of persons and their well-being.

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Notes

1. Census of India 2011 does not mention the State of Telangana since the reorganization of the states of Andhra Pradesh and Telangana took place only in 2014. However, from the district-wise data, the total for Telangana is calculated. This includes data for those seven mandals in the district of Khammam which was transferred to Andhra Pradesh under the AP State Reorganisation (Amendment) Act 2014.

2. For a detailed discussion on Census 2001 and 2011 see Vinayan (2016).

3. As per data, high incidence of disability in urban areas in the age group of 20–50 was in the districts of Hyderabad, Ranga Reddy, Warangal, Karimnagar, Mahbubnagar, and Khammam. However, in case of Nizamabad, though the incidence of disability was lower than Mahbubnagar at district level in the urban areas, among municipalities in Nizamabad and Mahbubnagar, the former had approximately similar level of incidence as in the former. Hence, Nizamabad was selected over Mahbubnagar in the final selection of sample district/ municipality.

4. In case of Hyderabad and Ranga Reddy, though the secondary data indicates highest concentration of PWDs, during the fieldwork, the research team encountered difficulties in locating the PWDs given the vast geographic spread of the municipality. In fact, in certain instances, due to lack of clarity over the addresses procured and/or due to unwillingness of the PWD or family to respond, the team had to canvass the respondents from the site of Municipal Corporation when the

PWDs arrived in person to collect the pension at the beginning of the month.

5. Though at the stage of sample selection, from SADAREM data base we had listed PWDs in the age group of 20–50, due to time lag in the SADAREM data, we have persons above 50 included in the sample as well.

6. Refer Kannabiran (2014) for a detailed discussion on disability and labour.

7. The reference period of work was 180 days preceding the date of survey.

8. For details see Vinayan (2016, Table 36: 72, Annexure 3: 82).

9. For details see Vinayan (2016, Table 37: 73, Annexure 4: 82).

10. For details see Vinayan (2016, Table 38: 73).

11. For details see Vinayan (2016, Annexure 6: 84).

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8

MGNREGA

Unexpected Bonanza for Persons with Disability?

Satish B. Agnihotri and Shruti Singh

It was certainly a sight to behold. We were visiting a Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) work site in Thiruvallur district in Tamil Nadu. The work, one of the typical works undertaken under MGNREGA, was digging of a pond. But there was a difference. In one corner of the pond, one could see a number of disabled persons engaged in work. Their mate, as the group leader is called, was himself a disabled person. While interacting with the workers, one found that they had MGNREGA job cards and were getting their wages as regularly, sometimes as irregularly as other 'normal' workers. There was empathy, not sympathy, for the work done by them. Certain easier jobs had been identified for the more disabled workers, tasks like watering the plants, clearing bushes, etc. More importantly, Government of Tamil Nadu had codified the empathy through a formal circular equating half the work done by a worker with disability to the full work done by a regular worker as far as payment of wages was concerned (Appendix I).[1]

Was it not easier to just give them a dole? The pride on the faces of these workers answered that question in negative. They would take their 'wages' home with head held high, not the dole!

Tamil Nadu is not alone in this endeavour. A few weeks earlier, one of us had visited Nizamabad district in Telangana to see the works taken up under MGNREGA. One could see among the MGNREGA workers, persons with disability (PWDs henceforth). The district magistrate who accompanied us, was very proud of the wage employment opportunity provided under MGNREGA, to the PWDs. Tasks that could be carried out by them were identified proactively, they were provided with transportation allowance. But a chance observation by the district magistrate set a deeper analysis process rolling. 'Livelihood opportunities offered to the persons with disability are far more than those provided than their Department itself' she observed, 'especially in the rural areas'.

This was likely to be correct, for, anyone having dealt with the problem of providing livelihood to persons with disability, particularly in rural areas, would know how difficult the task could be. The difficulty gets compounded while dealing with disabled women.

Departments dealing with welfare of persons with disability are typically lower in power hierarchy and have low budget compared to 'mainstream' departments. If one takes out the salary, pensions, and the scholarship component, the outlay for the schemes with focus on livelihood is low indeed. This focus again is on self-employment schemes which are implemented considerably indifferently. Besides, the per capita investment in asset creation is not adequate as brought out below. Providing wage employment opportunity to persons with disability is a far cry indeed.

It is against this backdrop that MGNREGA's contribution to the welfare of the persons with disability needs to be seen. Was the situation seen in two of our field visits a happenstance or is the trend more robust? We explore and analyse the available evidence.

The discussion below is organized as follows. The next section analyses the funding available for the PWDs in the concerned line Department and compares it with the potential of wage transfer under MGNREGA assuming that 3 per cent of the stipulated wages should go to the PWDs as per the norm prescribed in

the PWD Act. The third section examines the actual engagements of the PWDs under MGNREGA in different states and compares it with the prescribed norm. The fourth section looks at the ways in which the support to the PWDs under MGNREGA could be made sustainable.

Budgetary Allocations for Persons with Disabilities

Providing livelihood opportunities to persons with disability is a difficult task, and certainly so in the rural areas. Jobs in the formal sector, where provisions of reservations could be applied are themselves shrinking. Besides, these are mostly available in urban areas.

Table 8.1 shows the 2001 census data for persons with disabilities. The unemployment situation is clear, more so among women than that among men. Creating livelihood opportunity for them is a daunting task.

One micro survey carried out at Kolar district in Karnataka (Basavaraju et al., 2014) bears this pattern out. The sample study of 454 PWDs show that nearly 70 per cent of the PWDs in the productive age group earn less than Rs 1200/- per month. A likely percentage was without any immovable property and over 90 per cent had no movable assets. Only 34 per cent of the PWDs in the 18–60 age groups were employed. The employment among females (19 per cent) was predictably lower compared to that among males (43 per cent). Major entitlement reaching them was the disability pension.

If we analyse the budget allocation for disability welfare, both at the Central[2] and the State[3] level these would show a preponderance of schemes aimed at charity—pensions, 'free' distribution of aids and appliances, and unemployment allowance to PWDs registered at the employment exchanges. The schemes for self-employment have a very meagre allocation. In these schemes too, the investment made per individual asset is not very high or adequate, a point to which we return later. It may however, be noted that the PWD Act, 1995[4] does make a provision for reserving certain percentage of jobs for PWDs in the formal public sector thereby creating opportunities for employment. However, this is again confined to the educated and mostly urban PWDs and does not benefit the rural unskilled PWDs.

Based on analysis of budgetary allocation of various State and the Central government for the FY 2013–14, 14–15, and 15–16, EQUALS — a Centre for Promotion of Social Justice (Specific Expenditure Related to Persons with Disabilities—India 2016) has brought out three features of the budgetary provisions for the PWDs.

(1) First, the allocation is highly skewed between the states. Typically 4–5 states account for more than 60 per cent of the allocation. These are TN, Karnataka, UP, Haryna, and Delhi. The Union budget is about 15–20 per cent . Rest of the states account for the residual allocation (See Figures 8.1 and 8.2).

(2) When we look at the per capita spending its inadequacy becomes clear. While in states like Karnataka, Tamil nadu, Haryana, and Delhi, this amount is in the range of Rs. 3000–Rs. 5000 per capita, the figure comes down to Rs. 1000–Rs. 1200 for UP. States like Uttarakhand, Mizoram, and Kerala are in the intermediate range. Puducherry has been an outlier with the per capita allocation of about Rs. 11,000 (Figure 8.3).

(3) The predominnce of the charity mode is clear from the pattern of expenditure. Over half the budget is spent on pension, allowances, assistive devices, etc. The allocation for work, employment and vocational training has hovered between Rs. 50–70 crore. One could add the institutional finance, yet the figure will not come close, to, say, Rs. 200 crore or so. How much of this amount goes to rural areas is anybody's guess (Figure 8.4).

MGNREGA, in contrast, has a budgetary allocation is around Rs. 32,000 crore per annum. It is one of the most ambitious wage employment programmes attempted anywhere in the world[5] (Shah 2012). It aims to provide any rural household that demands work, wage employment up to 100 days at specified wage rates. The programme in its first decade has managed to create 2,060.83 crore person days, giving wage employment to over 27.79 crore persons, transferring over Rs. 3,27,674,87 crore as

Table 8.1 Persons with Disabilities, Census 2001

	Total disabled population			Worker % (main + marginal)		
T/R/U	Persons	Male	Female	Persons	Male	Female
Rural	1,86,36,358	1,04,10,559	82,25,799	37.6	47.2	25.4
Urban	81,78,636	45,78,034	36,00,602	33.5	47.2	16.1
Total	2,68,14,994	1,49,88,593	1,18,26,401	36.3	47.2	22.6

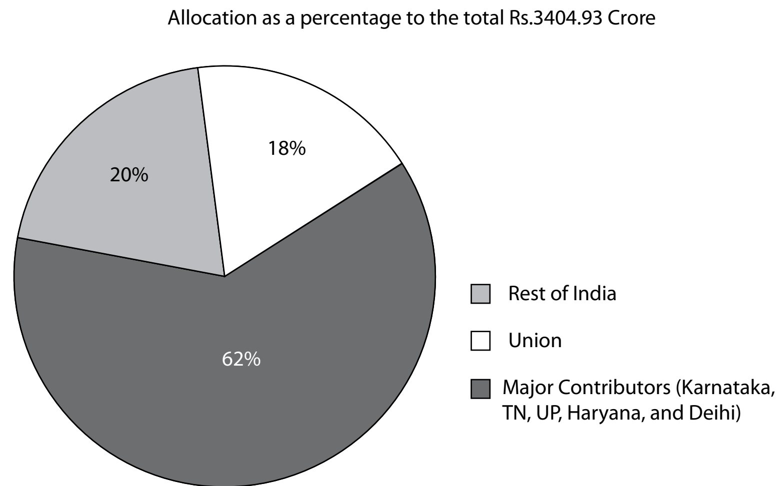

Figure 8.1 Skewed Allocations at All India Level for FY 2015–16

Source: EQUALS.

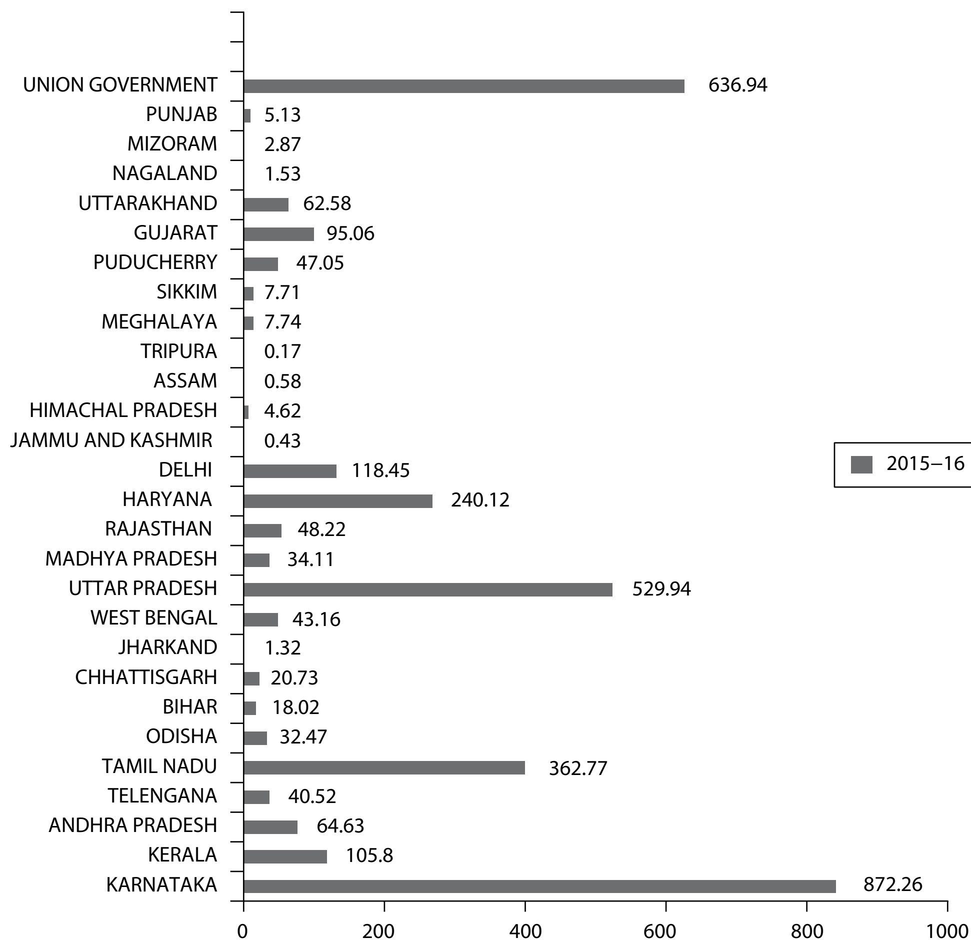

Figure 8.2 Allocation (Rs. in Crores) towards Specific Expenditure towards Persons with Disabilities

Source: EQUALS.

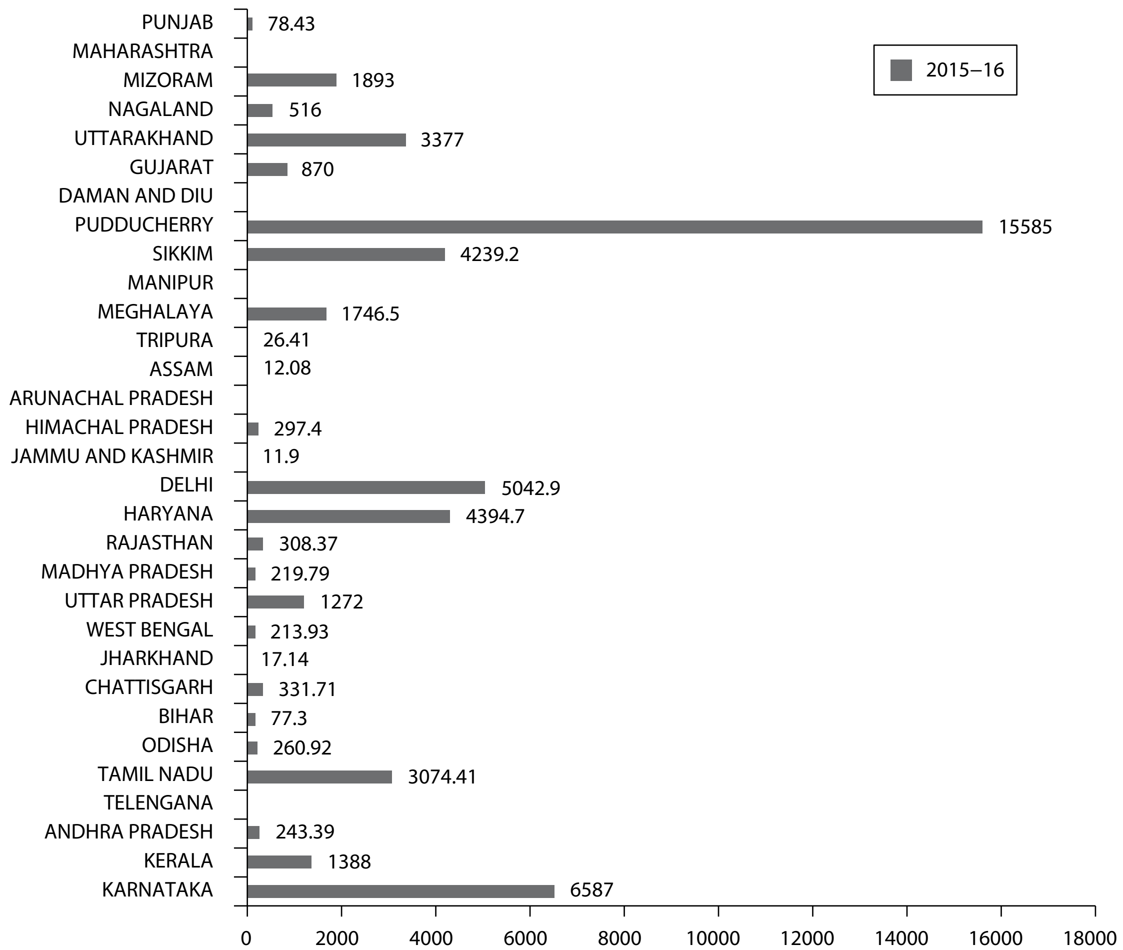

Figure 8.3 The Per Capita Spending, Calculated as a Ratio between Allocation for Spending on Persons with Disabilities for that Particular Year by the State and the Population of the State
Source: EQUALS.

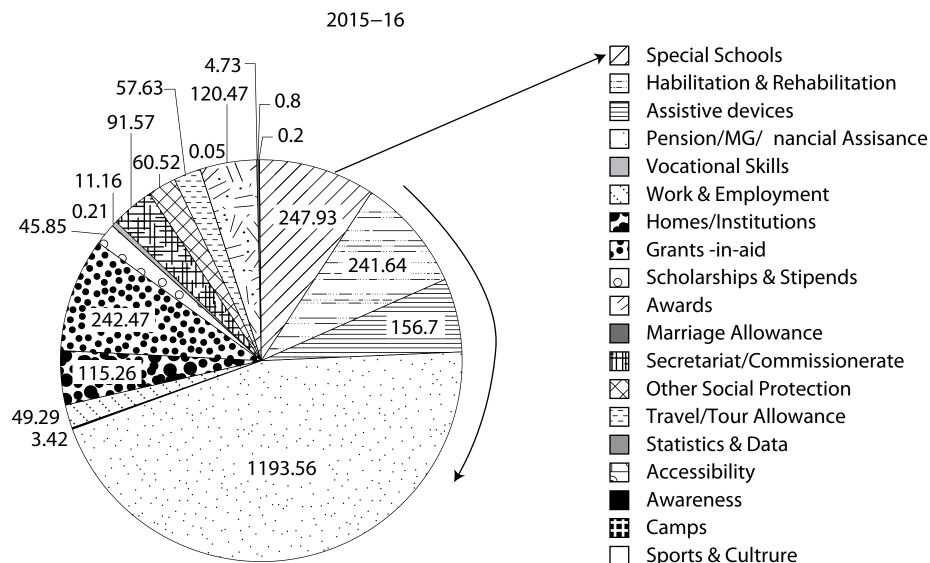

Figure 8.4 The Proportion of Spending on Pension/Allowance/Grant to Individuals
Source: EQUALS.

wages. The programme has a wide coverage, beginning from 200 districts in its first phase, with 130 districts added in the second and 295 districts in the third phase. It has a statutory backing. The work can be demanded and has to be provided. There is a financial penalty in terms of unemployment allowance that is required to be paid, if wage work is not provided within a stipulated time—15 days.

It stands to reason that participation of the PWDs in MGNREGA could benefit a large number of them through the wage programme. The PWD Act 1995 does in fact stipulate 3 per cent of the public expenditure on poverty alleviation programmes to be earmarked for persons with disability. MGNREGA guidelines themselves stipulate that the participation of the PWDs will be in accordance with the provisions of the PWD Act, 1995. If we take their participation to be at 3 per cent of the MGNREGA wage payment, the wage transfer to the PWDs could be of the order of Rs 680 crore (3 per cent of the 60 per cent of Rs 38,000 Cr.). Does that happen? It is certainly worth finding out. Does the MGNREGA data allow one to decipher this aspect?

Given the sheer diversity of coverage under MGNREGA, it was imperative that MoRD, the administrative Ministry of this programme puts in place an effective IT base and a MIS system tracking different aspects and milestones of the scheme. MoRD has carried out this task remarkably well and its web site is accessible in the public domain. As a result, one can today access data related to MGNREGA works, benefits, projects and payments with considerable ease and the data are fairly up to date.

It is this feature of MGNREGA that allows us to find out the wages transferred to persons with disability in a given year and the person-days of wage employment provided and to see whether the examples we saw in the field represented a flash in the pan or whether it represented a trend.

MGNREGA Support – How Significant?

Tables 8.2a and b provide a state-wise breakup of persons with disability in rural areas who registered under MGNREGA, the number that were engaged for some wage work under MGNREGA, the person-days generated for the year 2014–15 and the wages transferred to such persons thereof. The wages paid have been calculated on the basis of the average wage rate in that state for 2014–15.

On an all India basis, about 17 lakh persons with disability have registered under MGNREGA, of which more than 4 lakh have got work and about 1.2 crore person-days have been generated resulting in transfer of about Rs. 167 crore. This roughly translates to 26 days of wage work in a year. Data from 2013–14 and 15–16 provides comparable figures (data not presented). In fact in 2013–14 about 5 lakh persons participated in MGNREGA, 1.6 crore person-days were generated at an average of 33 person-days, and about Rs. 206 crore was the wage transfer to PWDs. For 2015–16, the figures are provisional but comparable. The amount of wages paid has been estimated on the basis of the average wage paid under MGNREGA in the respective state for the given year.

The amount of Rs. 206 crore may be small compared to the annual MGNREGA budget of about Rs. 35,000 crore and the wage component of about Rs. 21,000 crore assuming a wage material ratio of 60:40. But it is quite comparable to the amount spent for the livelihood options of the PWDs by concerned Departments in the Centre and the States. This amount, that is, wages given to the PWDs under MNREGA would go up substantially if the participation of the PWDs in MGNREGA in other states matches the performance of Tamil Nadu, Tripura, Telangana, or Andhra Pradesh. One can see however, that the pattern of participation of PWDs under MGNREGA is not uniform across the States. As Table 8.2a reveals, Tamil Nadu, West Bengal, Tripura, Andhra Pradesh, Telangana, MP, and Chhattisgarh account for nearly two-thirds of the MGNREGA participants. In many of the states, even if the number of persons registered under MGNREGA is larger, the participation rates are poorer.

The sample study at Kolar, Karnataka (Basavaraju, et al., 2014) reveals that while 79 per cent of the sample households reported a need for a MGNREGA job, only 34 per cent received a job card. It further shows that 38 per cent of these job card holders did not apply for the MGNREGA work. But out of the 68 per cent who did apply, nearly all (86 out of 91) got the wage job. This does contradict the reported perception of the officials and the PRI members about the ability of the PWDs to do MGNREGA works (Basavaraju, et al., 2014). The point remains however, that institutional rather than ad hoc arrangements need to be in place for inclusion of the PWDs in the MGNREGA works.

Moreover, if one compares this wage transfer against the stipulated norm of 3 per cent , it falls well short of the norm of 3 per cent stipulated under the PWD Act and the MGNREGA guidelines. Table 8.2b below compares the wage component of the overall MGNREGA programme in a given state in the year 2014–15, the normative wage

Table 8.2a State-wise Breakup of PWDs Registered in MGNREGA, Provided Employment in MGNREGA Shown Here as a Percentage of Total PWD Population

State (Only major states)	Total disabled persons in rural areas in the age group of '15–59' and 'Age not stated' (Source-Census 2011)	No. of disabled persons registered in MGNREGA (source-MGNREGA website)	No. of disabled persons worked in NREGA in FY 2013–2014 (source-MGNREGA website)	Person days generated in FY 2013–14 (source-MGNREGA website)	Average wage Rate (Calculated by averaging the average no of days of each month, Source-MGNREGA website)	Expenditure in FY 2014–15 at avg wage rate	Average number of days per person (column E/ column D)	Percentage of beneficiaries registered in MGNREGA with respect to the rural population	Percentage of beneficiaries worked in MGNREGA with respect to the rural population
TRIPURA	27,127	21,710	12,716	5,47,946	₹150	₹8,22,83,224	43	80%	47%
WEST BENGAL	8,43,377	4,12,695	78,763	17,49,327	₹164	₹28,70,35,405	22	49%	9%
GUJARAT	3,37,057	1,48,419	7,792	1,41,729	₹151	₹2,13,65,647	18	44%	2%
CHHATTISGARH	2,65,847	1,11,098	15,160	2,59,073	₹154	₹3,98,75,653	17	42%	6%
TAMIL NADU	4,09,771	1,27,408	65,383	29,43,481	₹125	₹36,89,16,285	45	31%	16%
TELANGANA	6,21,767	1,79,225	61,798	18,97,288	₹121	₹23,00,46,170	31	29%	10%
MADHYA PRADESH	6,06,939	1,74,614	38,609	7,15,826	₹150	₹10,74,93,204	19	29%	6%
ANDHRA PRADESH	8,90,156	2,30,464	75,168	30,14,510	₹121	₹36,55,09,338	40	26%	8%
MAHARASHTRA	9,84,503	1,12,622	19,313	5,31,377	₹167	₹8,85,62,833	28	11%	2%
HIMACHAL PRADESH	76,865	6,714	1,234	41,529	₹153	₹63,67,780	34	9%	2%
KARNATAKA	4,77,533	41,280	5,285	72,845	₹190	₹1,38,64,832	14	9%	1%
JAMMU AND KASHMIR	1,49,622	12,303	1,832	36,566	₹156	₹56,92,107	20	8%	1%
JHARKHAND	3,22,304	25,918	5,458	1,79,895	₹158	₹2,84,23,410	33	8%	2%
ASSAM	2,34,021	17,674	1,466	22,019	₹167	₹36,77,173	15	8%	1%
MANIPUR	24,946	1,762	890	15,795	₹174	₹27,53,595	18	7%	4%
ODISHA	5,72,110	31,885	3,352	78,667	₹162	₹1,27,37,498	23	6%	1%
MIZORAM	5,304	284	108	1,852	₹99	₹1,83,657	17	5%	2%
ARUNACHAL PRADESH	12,912	690	69	1,010	₹152	₹1,53,015	15	5%	1%
RAJASTHAN	5,48,211	24,934	4,071	1,19,259	₹115	₹1,37,24,723	29	5%	1%
SIKKIM	9,950	389	97	4,133	₹156	₹6,43,026	43	4%	1%
MEGHALAYA	21,448	752	238	9,280	₹153	₹14,17,520	39	4%	1%
UTTARAKHAND	72,855	2,218	591	18,110	₹156	₹28,19,123	31	3%	1%
UTTAR PRADESH	17,75,607	51,113	9,146	2,48,181	₹155	₹3,85,09,419	27	3%	1%
KERALA	2,45,882	6,706	1,753	67,212	₹214	₹1,43,72,166	38	3%	1%
BIHAR	11,12,847	27,768	2,497	69,774	₹171	₹1,19,13,911	28	2%	0%
NAGALAND	13,328	159	108	2,242	₹155	₹3,46,576	21	1%	1%
HARYANA	2,03,399	2,316	238	4,176	₹239	₹9,95,976	18	1%	0%
PUNJAB	2,66,701	2,295	408	7,286	₹198	₹14,43,235	18	1%	0%
Total	1,11,05,262	17,53,705	4,00,827	1,22,52,442	₹158	₹ 1,66,88,43,277	26	16%	4

Table 8.2b State-wise Data on Person-Days Generated for the PWDs as per cent of the Total Person Days

State	No. of disabled persons registered in NREGA	No. of disabled persons worked in NREGA in FY 2014–2015	Persondays generated for PwDs in FY 2014–2015	Total persondays generated in FY 2014–15	Calculated disabled-persondays as per norms (3% of the total persondays)	Percentage of disabled-persondays of the total persondays generated
LAKSHADWEEP	38	10	253	12,527	376	2.02%
ANDHRA PRADESH	2,30,464	75,168	30,14,510	15,59,04,465	46,77,134	1.93%
TELANGANA	1,79,225	61,798	18,97,288	10,32,06,500	30,96,195	1.84%
TAMIL NADU	1,27,408	65,383	29,43,481	26,79,65,154	80,38,955	1.10%
TRIPURA	21,710	12,716	5,47,946	5,11,75,744	15,35,272	1.07%
WEST BENGAL	4,12,695	78,763	17,49,327	16,97,07,843	50,91,235	1.03%
MAHARASHTRA	1,12,622	19,313	5,31,377	6,13,86,797	18,41,604	0.87%
GUJARAT	1,48,419	7,792	1,41,729	1,81,53,449	5,44,603	0.78%
MADHYA PRADESH	1,74,614	38,609	7,15,826	11,75,44,380	35,26,331	0.61%
CHHATTISGARH	1,11,098	15,160	2,59,073	5,55,90,352	16,67,711	0.47%
JHARKHAND	25,918	5,458	1,79,895	4,53,42,210	13,60,266	0.40%
ANDAMAN AND NICOBAR	142	44	1,595	5,17,169	15,515	0.31%
JAMMU AND KASHMIR	12,303	1,832	36,566	1,21,09,013	3,63,270	0.30%
HIMACHAL PRADESH	6,714	1,234	41,529	1,90,80,255	5,72,408	0.22%
BIHAR	27,768	2,497	69,774	3,52,60,430	10,57,813	0.20%
UTTAR PRADESH	51,113	9,146	2,48,181	13,12,11,945	39,36,358	0.19%
SIKKIM	389	97	4,133	24,12,513	72,375	0.17%
KARNATAKA	41,280	5,285	72,845	4,33,28,089	12,99,843	0.17%
MANIPUR	1,762	890	15,795	1,01,17,209	3,03,516	0.16%
ODISHA	31,885	3,352	78,667	5,35,40,272	16,06,208	0.15%
PUDUCHERRY	199	61	484	3,77,619	11,329	0.13%
UTTARAKHAND	2,218	591	18,110	1,47,34,073	4,42,022	0.12%
KERALA	6,706	1,753	67,212	5,88,71,927	17,66,158	0.11%
PUNJAB	2,295	408	7,286	64,57,222	1,93,717	0.11%
ASSAM	17,674	1,466	22,019	2,10,94,622	6,32,839	0.10%
RAJASTHAN	24,934	4,071	1,19,259	16,86,18,702	50,58,561	0.07%
HARYANA	2,316	238	4,176	61,64,674	1,84,940	0.07%
MEGHALAYA	752	238	9,280	1,67,35,268	5,02,058	0.06%
ARUNACHAL PRADESH	690	69	1,010	19,38,440	58,153	0.05%
MIZORAM	284	108	1,852	43,59,635	1,30,789	0.04%
GOA	20	2	59	1,72,459	5,174	0.03%
NAGALAND	159	108	2,242	89,98,458	2,69,954	0.02%
DADRA & NAGAR HAVELI	2,688	–	–	–	–	0.00%
DAMAN & DIU	–	–	–	–	–	0.00%
	17,78,502	4,13,660	1,28,02,779	1,66,20,89,415	4,98,62,682	0.77%

transfer @ 3 per cent of this amount, the wages actually transferred and the gap. Idea here is not to run down the effort done by the MNREGA implementers, but to show the gap that could be bridged.

It can be seen that none of the states have been able to reach the stipulated norm of 3 per cent; the best case scenario being just under 2 per cent. It is therefore necessary that steps are taken to ensure a higher participation of the PWDs under MGNREGA.

We thus see that the allocation of funds under MGNREGA for creation of wage employment opportunity for persons with disability is significant, and can in many cases exceed the budgetary provision of the Central and State Governments towards livelihood programmes in the concerned departments dealing with welfare of persons with disability. This is provided, the coverage of PWDs under MGNREGA is followed up in right earnest, creating an enabling environment as done in states like Tamil Nadu, Telangana, and Andhra Pradesh. This nevertheless falls short of the stipulated 3 per cent wage, but at least it represents a correct beginning.

CREATING AN ENABLING ENVIRONMENT

Charity approach for the welfare of the disabled is not new. Traditionally, the outlay of the concerned departments has been geared towards pensions, provision of aids and appliances under various 'free distribution' programmes, and scholarships to the students with disability. Self-employment schemes are inadequate in their reach and the financial investment in creation of an individual asset is meagre; it cannot pull the person above the poverty levels significantly.

Wage work under MGNREGA, may not solve all the problems of persons with disability, but it certainly gives them livelihood with a sense of dignity. Everybody understands that they cannot be as productive as the other 'able- bodied' workers, but the fact still remains that they earn their wages. The Government of Tamil Nadu has formally recognized through a circular that stipulates payment of full wages for half the work done (Appendix I). In Andhra Pradesh and Telangana the PWDs are given transport allowance to reach their work sites and suitable tasks are identified for them. Other states, that is, Tripura may not have come up with such formal enabling mechanism, but the field support given to the PWDs is considerable and reflects in the data itself both in terms of registration and participation in MGNREGA and, in terms of average work days annually.

The supportive environment does a lot of good to the self-esteem of the PWDs. In Telangana, for example, a number of enabling provisions are in place.

(i) A robust process for Certification with a 3 Member team at the GP to identify left out persons.
(ii) Group strength of 2 or more disabled workers. They can also be part of a regular group if they so wish.
(iii) Identification of suitable tasks—watering plants, bush clearance, nursery, watch and ward, etc.
(iv) Mates are selected from among disabled persons as far as possible.
(v) The disabled workers receive wages plus allowance for travel.

Why are such 'best practices' not picked up by other states? While one could expect the MoRD to document and disseminate these, it is really the task of the Department of Empowerment of Persons with Disabilities (erstwhile Department of Disability Affairs) to note the support the PWDs are getting under MGNREGA, study the process of institutionalization done in states like Tamil Nadu, Telangana, or Andhra Pradesh and impress on other state governments to adopt these efforts. To the best of our knowledge, there is no structured inter-ministerial exchange between the two Ministries at the Central Government level. A relatively marginal skill development scheme is run by the Department of Empowerment of Persons with Disabilities through its own training Institute but that is insignificant compared to the benefits the PWDs could draw from MGNREGA. It is time that the Department for the welfare of the PWDs sets up a structured mechanism to ensure appropriate coverage to PWDs under the MGNREGA.

SUSTAINABILITY OF THE MGNREGA EFFORTS

While the livelihood opportunity created under MGNREGA for persons with disability through wage work may be laudable, its sustainability is doubtful. As work ceases in a given area, the wage work opportunity will also reduce if not disappear altogether. This is where the importance of creating individual productive assets for the MGNREGA beneficiary comes in. It is possible to identify rural poor among the PWDs and give them land based assets schemes e.g. dug well, farm pond, goat-shed, horticulture, or fisheries which could reduce their dependence on wage work under MGNREGA. This can be done on the same lines as done for the STs/ SCs and marginal farmers. Unlike various loan linked

self-employment schemes in vogue, the investment in creation of individual assets under MGNREGA is sizeable and not anemic in quantum. Further it is free from any loan linkage or collaterals. This is an important issue, for, the process of obtaining bank loans for a small purpose, however viable it may be, is fraught with a host of procedural paraphernalia. In the MGNREGA scheme, the poor is not being appraised, not asked to give a collateral for creation of assets on his own land and the level of investment can be significant, e.g,. 1.2 lakh for a farm pond or Rs 35,000 for a goat shed, making her livelihood viable.

In a separate study, an interesting, but not so comprehensive result was observed. The study involved an analysis of the pattern of participation of those households who had benefitted with an individual asset under MGNREGA. FY 2013–14 was taken as the base year for creation of the asset. Correspondingly, data depicting the 'number of days worked' under MGNREGA from FY 2010–11 to FY 2015–16, was also collected. A total of 45,000 odd beneficiaries from the state of Madhya Pradesh was analysed, out of which 113 were PWD beneficiaries.

It was noticed that the outcome in a few of these cases tend to support our central idea of 'living with dignity'.[6] Seven out of these 113, which accounts for nearly 6 per cent of the recorded data, showed trends of decreasing participation under MGNREGA. While 21 of the beneficiaries (19 per cent) showed increase in the number of days worked in MGNREGA, the rest approximately 70 per cent showed no particular trend.

The numbers might not seem to be very promising, but in hindsight these indicate a way forward. If more and more marginal asset owning PWDs are covered under the individual asset creation programme while MGNREGA funds and procedures permit it, we can look forward for a progressive change. This will also be a big financial support to the Department of disability welfare.

CONSOLIDATING THE UNEXPECTED GAINS

The unintended consequence, that is, significant benefit to the PWDs of the intended intervention, that is, MGNREGA is not a new phenomenon in development literature (Merton, 1936). However, there is a clear need to consolidate this gain. It is time that the Department of Empowerment of Persons with Disabilities sets up a co-ordination mechanism to reap the synergy that exists between the two sectors. Only then *Sabka Vikas* will become a reality for persons with disability living in rural India. Such a mechanism needs to be established both at the central and the state level and the Department of Disability Welfare needs to monitor its spread, effectiveness and sustainability in the field and incentivize adoption of the best practices in the field. An indicative list of the milestones to be monitored through such a mechanism is given below:

(1) Per cent of job-card holders out of the disabled population
(2) Per cent of active job-card holders
(3) Per cent seeking work and the per cent getting the work
(4) Adoption of the 'best practices' among different states or districts by others
(5) Identification of jobs suitable for different PWDs
(6) Person days generated for the PWDs
(7) Wage transfer to the PWDs
(8) Timeliness or the delay in payment of the MNREGA wages
(9) Inclusion of the concerns about the PWDs in the social audit

THE GENDER DIMENSION

One of the concerns in this context is the gender dimension of the problem. As indicated above vide (Basavaraju, et al. 2014) there is considerable gender gap in the person-days generated. We tried to ascertain the position on an all India basis through MGNREGA web site. However, the genderwise break-up for the PWDs is not available. The only exception is Telangana and Andhra where the web site provides data by gender. It does substantiate the concern about the gender aspect; lower representation of women with disability in the MGNREGA workforce even in relatively progressive states like Andhra Pradesh and Telangana (Table 8.3). It is imperative that the MoRD and the state governments pay attention to this aspect. Clearly, the two fault lines, disability and gender aggravate each other.

* * *

We thus see that MGNREGA has provided a substantial amount to the PWDs by way of wage transfer. In some cases, the amount may even be larger than the budget of the concerned government departments. However, the coverage of the PWDs is short of the stipulated norm of 3 per cent wage transfer to the PWDs. Even the current coverage is uneven across the states and there is a need for the Department for Welfare of the PWDs to co-ordinate with the MoRD and the state government to take remedial measures. MoRD should also take steps

Table 8.3 Gender-wise Breakup of Job – Cards Issued and Employment Provided under MGNREGA

	Telangana	Andhra Pradesh
Total No of Districts under EGS	9	13
Total No of Job Cards Issued for PWDs so far	1,29,031	1,68,442
Total No of Individual PWD Labour in the Issued PWD Job Cards		
a. Male:	94,362	1,21,308
b. Female:	59,248	72,836
Wage employment provided to PwD labourers (Financial Year 2014-15)		
a. No. of House Holds	58,100	1,18,224
b. Individuals	62,455	1,24,536
c. Men (No.s)	38,961	83,749
d. Women (No.s)	24,775	45,738
e. SC Individuals (No.s)	16,011	30,441
f. ST Individuals (No.s)	7,164	6,780

to see that the best practices adopted by the front ranking states are adopted by other states. There should be structured inter- departmental meeting between the two departments to monitor different performance indicators indicated above. A similar mechanism needs to be created at the state level and monitored.

Among the PWDs, the gender gap needs the attention next. First, the MoRD needs to disaggregate the data by gender among the PWDs and then take follow up actions to bridge the gender gap.

Third, MGNREGA needs to move in the direction of creating individual productive assets for the PWD workers. These could either be land based or otherwise; but should aim at reducing the dependence of the PWDs on MGNREGA. That will be a measure of the success of MGNREGA and the efforts for welfare of persons with disabilities.

Postscript

During our visit to Thiruvallur, the DM mentioned about the scheme to provide petro scooters to the PWDs. Earlier in the day, from our discussions on mobility of the banking correspondents in the villages, it emerged that women BCs typically face difficulty related to mobility. In their case they only go to the places where public transport goes and the MGNREGA beneficiaries are expected to come to her camping place to receive their wages. It was suggested to the district magistrate to consider requesting the concerned bank to appoint a qualified women with disability, a banking correspondent and provide her a petro-scooter. This will send a good signal in the field both to persons with disabilities as well as women workers under MGNREGA. We are reproducing below the SMS received from the DM within a fortnight: 'Sir, I will like to share the Good News that…we have appointed Ms. Rajalaxmi, (MA Bed, 60% LD) as Banking Correspondent for Kandapuram village in Thiruvallur district today. Also we have scheduled to give her free petrol scooter to facilitate her to go for work without any difficulty' (message dated 14th January 2016).

Where there is a will there is a way. The District Magistrate Thiruvallur has demonstrated this. When will others follow suit?

Appendix I: MGNREGS Works for Disabled Persons—Government Orders

Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS)
Guidelines on MNREGS Works for Disabled Persons–Approved – Orders issued

Rural Development and Panchayat Raj (CGS.1) Department

G.O. Ms. No. 52 **Dated: 25.06.2012**

Read:

Commissioner of Rural Development and Panchayati Raj, Chennai–15 Roc. Letter No. 73975/2011/MGNREGS-2.1. dated 07.05.2012

******

ORDER:

(1) In the letter read above, the Commissioner of Rural Development and Panchayat Raj has stated that in para 5.5.10 of operational guidelines of Mahatma Gandhi National Rural Employment Guarantee Scheme it is indicated that 'if a rural disabled person applies for work, work suitable to his/her ability and qualifications will have to be given. This may also be in the form of services that are identified as integral part to the Programme. Provisions of the persons with Disabilities (Equal opportunities, protection of rights and full participation) Act 1995 will be kept in view and implemented'.

(2) The Commissioner of Rural Development and Panchayat Raj has also stated that as a measure to identify the suitable works to the disabled persons and to assess the quantum of work that can be done by them and also assess the duration of continuous work done by them without fatigue, a comprehensive time motion study was undertaken in 4 districts in 4 regions viz. Coimbatore, Madurai, Tirunelveli, and Kancheepuram. Since the time motion study involves the disabled persons including persons with mental illness, the study was conducted in coordination with reputed NGOs like Ramakrishna Mission (Coimbatore), M.S. Chellamuthu Trust (Madurai), Amar Seva Sangam (Tirunelveli), and Banyan (Kancheepuram).

(3) The Commissioner of Rural Development and Panchayat Raj has further stated that based on the inference arrived out of the study some special activities have been identified for the disabled persons in Mahatma Gandhi National Rural Employment Guarantee Scheme works. It is also ascertained that with respect to excavation of earthwork and transporting the earth to the bund the disabled persons shall also engaged. In such cases the outturn in terms of earthwork done by the disabled persons shall not be equated with that of normal persons. Likewise duration of work done by them also not in tune with the ordinary persons.

  (i) In terms of earthwork the disabled persons are able to make about 50 per cent out turn only.

  (ii) In terms of continuous work in the field the disabled persons are able to work continuously around 4 hours only, without fatigue.

(4) Considering all the above details, the Commissioner of Rural Development and Panchayat Raj has sent the draft guidelines on Mahatma Gandhi National Rural Employment Guarantee Scheme works for Disabled Persons and requested the Government to approve the draft guidelines on Mahatma Gandhi National Rural Employment Guarantee Scheme works for Disabled Persons.

(5) The Government after careful examination of the proposal of the Commissioner of Rural Development and Panchayat Raj have decided to accept it and approve the Guidelines on Mahatma Gandhi National Rural Employment Guarantee Scheme Works for disabled persons annexed to this Government Order.

(BY ORDER OF THE GOVERNOR)
N.S. PALANIAPPAN
PRINCIPAL SECRETARY TO GOVERNMENT

To
The Commissioner of Rural Development and Panchayat Raj,
Chennai – 15.
All Collectors,
All Project Directors, District Rural Development Agencies.

Copy to:
The Secretary,
Ministry of Rural Development,
Department of Rural Development,
Government of India, Krishi Bhavan,
New Delhi – 110 114.
The Secretary to Government,
Welfare of Differently Abled Persons Department,
Chennai – 9.
The Principal Secretary to Government,
Finance Department, Chennai – 9.
The Special Personal Assistant to Hon'ble Minister (MA & RD),
Chennai – 9.

//Forwarded by order//

SECTION OFFICER

Appendix 2: Guidelines on MGNREGS Works for Disabled Persons

In para 5.5.10 of operational guidelines of Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) it is indicated that 'if a rural disabled person applies for work, work suitable to his/her ability and qualifications will have to be given. This may also be in the form of services that are identified as integral part to the programme. Provisions of the persons with Disabilities (Equal opportunities, protection of rights and full participation) Act 1995 will be kept in view and implemented'. As a measure to implement the operational guidelines and to provide work to the disabled persons under MGNREGS, it has been decided to identify activities suitable for Disabled Persons.

Time and Motion Study

As a measure to identify the suitable works to the disabled persons and to assess the quantum of work that can be done by them and also to assess the duration of continuous work done by them without fatigue, a comprehensive time motion study was undertaken in 4 districts in 4 regions viz. Coimbatore, Madurai, Tirunelveli, and Kancheepuram.

Based, on the inference arrived out of the study it is understood that some special activities shall be earmarked for the disabled persons in MGNREGS works. It is also ascertained that disabled persons can be engaged in excavation of earthwork and conveying the earth to the bund. In such cases, the outturn in terms of earthwork done by the disabled persons shall not be equated with that of normal persons. Likewise, duration of work done by shall not be in tune with the ordinary persons.

(i) In terms of earthwork the disabled persons are able to make about 50 per cent out turn only.

(ii) In terms of continuous work in the field the disabled persons are able to work continuously around 4 hours only, without fatigue.

This is evident from the time and motion study conducted in the 4 districts.

Special Activities Earmarked for Disabled Persons under MGNREGS

Considering the inference arrived out of the time and motion studies, the following special guidelines shall be issued for involving disabled persons in the MGNREGS works.

The following Special Activities shall be assigned to the disabled persons at the MGNREGS worksite.

(i) Watermen/waterwomen at the worksite, who can distribute water to the workers

(ii) Caretaker to look after the children

(iii) Assisting the caretaker for every 5 child one additional assistant can be employed

(iv) Assisting the worksite facilitator in premarking (if the No. of worker is above 100 then 1 disable person shall be permitted to assist the worksite facilitator)

(v) Further, the differently abled persons may also be engaged in minor works related to desilting activities as listed below

  (a) Clearing uprooted jungle from the site (Only Scrubs, Light Jungle)

  (b) Watering (wetting) the area to be desilted (especially in summers)

  (c) Compacting the earth deposited on bund by using spade, solid rods and earth breaking rods

  (d) Benching and levelling the bund

  (e) Sectioning and sloping the bund

When the disabled persons are engaged in the above listed works for the whole day (8 hours) they should be paid full wage rate.

Engaging Disabled Workers in Regular Earth Work

For engaging the disabled persons in the earthwork related activities the following guidelines may be followed:

(i) The differently abled persons who are able to carry out physical work can be utilized Earth work related

activities like Jungle Clearance, Desilting work, planting and refilling, Watering.

(ii) In the worksite(s) where the number of disabled persons are less in number then they must be engaged only in the special activities enlisted above in para 3 and in para 4(i).

(iii) In the worksite(s) where the number of disabled workers are high then they can be engaged in earthwork. In such cases they can be grouped into group of 5 or 10 and the premarking shall be done only for 50 per cent of quantity earmarked for regular workers.

Considering the physical/mental limitations of these workers, they may be allowed intermittent rest/break during the working hours and the workers may be permitted to leave once they complete the required out turn before time.

Appendix 3: Consolidated Report of Time-Motion Study

The time motion study was conducted in 4 districts viz., Coimbatore, Madurai, Thirunelveli and Kancheepuram. The consolidated report on outcomes from each district is given under.

I. Coimbatore

Places of study	Chikkarampalayam and Jadayampalayam Panchayats in Karamadai Panchayat Union
Activities covered	Jungle clearance and Earth work

Light Jungle clearance

Sl. no.	Date	No. of days	No. of mandays	Quantity executed	Out turn per person (Sqm)
1.	15.02.2012 to 16.02.2012	2	42	403.20	9.60
2.	15.02.2012 to 16.02.2012	2	10	79.92	7.99
3.	17.02.2012 to 22.02.2012	6	28	279.60	9.99
4.	02.03.2012 to 07.03.2012	6	40	347.70	8.69
	Average Outturn per person in Sqm.				9.07

Earth Work (SDR)

Sl. no.	Date	No. of days	No. of mandays	Quantity executed	Out turn per person (Cum)
1.	17.02.2012 to 22.02.2012	6	136	63.90	0.47
2.	24.02.2012 to 29.02.2012	6	134	60.90	0.45
3.	02.03.2012 to 07.03.2012	6	119	56.10	0.47
4.	09.03.2012 to 14.03.2012	6	147	53.40	0.36
5.	16.03.2012 to 21.03.2012	6	149	62.75	0.42
6.	23.03.2012 to 28.03.2012	6	147	62.81	0.43
7.	30.03.2012 to 06.04.2012	6	187	82.39	0.44

8.	24.02.2012 to 29.02.2012	6	43	16.75	0.39
9.	09.03.2012 to 14.03.2012	6	38	17.21	0.45
10.	16.03.2012 to 21.03.2012	6	39	18.28	0.47
11.	23.03.2012 to 28.03.2012	6	43	14.74	0.34
12.	30.03.2012 to 06.04.2012	6	43	16.74	0.39
	Average Outturn per person in cum				0.42

Kancheepuram
Date of Study: 24.03.2012

Places of study	Kayar and Kovalam Panchayats in Tiruporur Panchayat Union
Activities covered	Jungle clearance, Earth work, Planting and Watering

Jungle Clearance

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Scrub	5	51.97	10.39
		5	48.91	9.78
	Average Outturn per person in Sqm			10.08
2.	Light	4	47.78	11.94
		6	44.97	7.49
	Average Outturn per person in Sqm			9.72

Earth Work

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Ordinary Soil	4	3.74	0.94
		7	3.52	0.50
	Average Outturn per person in cum			0.72

Planting

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Ordinary Soil	5	4.51	0.90
		8	4.248	0.53
	Average Outturn per person in cum			0.72

Watering

Sl. no.	Total no. of differently abled persons engaged	Total output	Average output per person
1.	5	55.46	11.09
	4	52.2	13.05
	Average Outturn per person in nos.		12.07

Madurai

Places of study	Kallanthiri Panchayat in Madurai Panchayat Union
Activities covered	Jungle clearance, Earth work, Planting and Watering

Jungle Clearance

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Scrub	6	47.04	7.84
2.	Light	4	30.52	7.63

Earth Work

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Hard Soil	7	3.64	0.52

Planting

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Hard Soil	5	5.05	1.01

Watering

Sl. no.	Total no. of differently abled persons engaged	Total output	Average output per person
1.	8	116.64	14.58

II. Tirunelveli

Places of study	Kolayaneri Panchayat in Kadayanalur Panchayat Union
Activities covered	Jungle clearance, Earth work, Planting and Watering

Jungle Clearance

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Scrub	4	37.56	9.39
2.	Light	8	50.96	6.37

Earth Work

Sl. no.	Detail	Total no. of differently abled persons engaged	Total output	Average output per person
1.	Ordinary Soil	6	4.5	0.75

Planting

Sl. no.	Detail	Total no. of Differently abled persons engaged	Total output	Average output per person
1.	Ordinary Soil	7	4.41	0.63

Watering

Sl. no.	Total no. of differently abled persons engaged	Total output	Average output per person
1.	10	149.40	14.94

Appendix 4: Comparison of Average Outturn of Differently Abled Persons and Average Outturn of Normal Person

Sl.no.	Item	Average outturn per person based on time-motion Study for differently abled persons	Average outturn per person based on time-motion study for normal MNREGS workers	Difference in percentages (Less)
1.	Jungle Clearance			
a.	Scrub Jungle	9.10	17.63	(–) 48%
b.	Light Jungle	8.19	17.10	(–) 52%
2.	Earth Work			
a.	Ordinary Soil	0.73	1.61	(–) 54.65%
b.	Hard Soil	0.52	1.20	(–) 56.66%
c.	SDR	0.42	0.81	(–) 48.15%
3.	Planting	0.78	1.73	(–) 54.91%
4.	Watering	10.19	24.06	(–) 57.64%

On an average it is seen that the average outturn of the differently abled persons is about 50% lesser than the average outturn of the normal persons. Hence, the rates for all the items shall be twice that of the rural schedule of rates fixed for normal persons.

All the 4 districts have suggested that generally the disabled persons where engaged in the following special activities where the disabled workers were able to work for 8 hours without fatigue and the districts have suggested that for the special activities shall be paid the whole wage rate as applicable.

The following Special Activities shall be assigned to the disabled persons at the MGNREGS worksite.

(i) Watermen/waterwomen at the worksite, who can distribute water to the workers.

(ii) Caretaker to look after the children.

(iii) Assisting the caretaker for every 5 child one additional assistant can be employed.

(iv) Assisting the worksite facilitator in premarking (if the No. of worker is above 100 then 1 disable person shall be permitted to assist the worksite facilitator).

(v) Further, the differently abled persons may also be engaged in minor works related to desilting activities as listed below:

- (a) Clearing uprooted jungle from the site (Only Scrubs, Light Jungle).
- (b) Watering (wetting) the area to be desilted (especially in summers).
- (c) Compacting the earth deposited on bund by using spade, solid rods and earth breaking rods.
- (d) Benching and levelling the bund.
- (e) Sectioning and sloping the bund.

N.S. PALANIAPPAN
PRINCIPAL SECRETARY TO GOVERNMENT

SECTION OFFICER

Notes

1. The Annexure can also be checked at http://www.tnrd.gov.in/Central_Schemes/nregs_2012.html or can be downloaded from http://www.tnrd.gov.in/Central_Schemes/linkfiles/mgnregs_go_no_52.pdf.

2. The union budget allocations listed in Demand No. 92, Department of Empowerment of Persons with Disabilities (erstwhile Department of Disability Affairs), Governmentof India.

3. State budgets: Performance budget 2015–16, Department for the Welfare of Differently Abled Person, Government of Tamil Nadu; Odisha budget 2015, At a Glance, Finance Department, Government of Odisha.

4. Persons with Disabilities Act 1995. The act can also be viewed on the linkhttp://www.prsindia.org/uploads/media/Person%20with%20Disabilities/Legislative%20Brief%20%20-%20Disabilities%202014.pdf.

5. The data provided in this paragraph has been obtained from the official website of MGNREGA, MoRD. Available at http://164.100.129.6/netnrega/MISreport4.aspx?fin_year=2013-2014&rpt=RP and http://mnregaweb4.nic.in/netnrega/all_lvl_details_dashboard_new.aspx.

6. The respondents in the sample study (Basavaraju, et al. 2014) also echo a similar statement.

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9

Who Is a 'Worker'?

Problematizing 'Ability' in the Conceptualization of Labour

Kalpana Kannabiran

This chapter focuses on the worker with disabilities, and argues for the urgent need to problematize the notion of 'ability' in an attempt to situate the worker with disabilities in the labourscape—a project that holds possibilities not for workers with disabilities alone but for all workers across the most diverse spread. By 'worker with disabilities', I refer to all persons with disabilities within the broad category of the poor, above the age of 18 not in full time education. A point to be noted is that the 18–60 years cohort of persons with disabilities, not in need of high support, is the cohort which falls out of social protection nets and is not counted as part of the 'labouring poor'.

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) was ratified by India on 1 October 2007. This was followed by a national effort by disability rights groups to draft a new law that would institutionalize the protections and enabling provisions contained in the UNCRPD. Close to ten years later however, the law is still in the making. Importantly however the participation of persons with disabilities, collectives of persons with disabilities, and advocates of disability rights in these deliberations at every level resulted in a new commonsense on the issue of disability rights, and in new measures of capabilities, human diversity, and full participation. The UNCRPD was adopted,

> Recognizing the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of *full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty.*[1]

This chapter is divided into two parts. Part A consists of three sections that present an analysis of the opacities in labour studies and law relating to disability and employment in India. Standards are critical to the understanding of labour rights—in the era of globalization especially, the focus is on standards that are internationally relevant and applicable. The first section looks briefly at the debates around the rights of the poor especially in the context of the growing informalization of labour and shrinking of social security, and interrogates the separation between the labouring and non-labouring poor in terms of its implications for the recognition of the person with disabilities as a worker. The second section looks at the jurisprudence on employment of persons with disabilities within the framework of the *Persons with Disabilities Act*, 1995, and the inadequacies therein in recognizing the person with disabilities as an employee with an autonomous right to equal opportunity. The application of this principle in courts and judicial processes through the interpretation of legislation is a complex one, for the most part fraught with pitfalls that arise from the lack of comprehension of the specific experience of vulnerability of persons with disabilities. The third section, in continuation from the second, is a critical examination of the framework of the *Workmen's Compensation Act* as the single 'labour legislation' focused entirely on 'disablement' and injury. Part B of this chapter contains four sections—four to seven—that are focused on the question: What are the possible ways of breaking out of the circle of misrecognition? The fourth section examines the framework within which we might

understand standards for the treatment and recognition of persons with disabilities as workers by drawing connections between two generations of rights—civil and political rights and economic and social rights. This discussion helps us elaborate on the consequences of the negation of the status of worker for persons with disabilities. The fifth section looks at the inaugural moment of recognition of the 'worker with disability' [*vikalangakooli*], and the import of this moment. The sixth section presents the shift in the legal normative effected by the new draft legislation on the rights of persons with disabilities, followed by the conclusion.

Disabled Lawscapes

ability and the labourscape

Disability's foundational position in the labourscape, arises from its inarticulate presence in imagining work performance, physicality, and embodiment of certain kinds, where capacity and capability are measured on a ladder that drops from the normative. The 'infirm' body in the labourscape by this token, may be female/transgender [the frail/congenitally unproductive sex], scheduled caste [unskilled with a predisposition to inefficiency in all but the most repetitive tasks], scheduled tribe ['primitive' and habitually delinquent—an incarcerated labour force who must be reined in through multiplicities of bondage and surveillance], and disabled [not-worker, in need of care and social security but not wages].

While research on labour in India has unpacked three of these four categories above [there may be more][2]—the presumption of ability, and its definition in ideal terms outside of the life worlds of workers across a range of social locations, have resulted in exclusion, exploitation, devaluation, and misrecognition of the place of labour in the social order. And yet, the person with disability as *the* embodiment of the oppressed worker has not entered the account. An immediate result of this is the treatment of persons with disabilities as bearers of entitlement to social security and the treatment of workers suffering disablement as bearers of entitlement to reparation. This chapter argues that the treatment of persons with disabilities as full bearers of the right to work—*not* as essentially non-workers who must be 'accommodated' within a beneficial scheme—merits serious reflection.

In a recent essay on social security, Breman and Kannan provide an illuminating analysis of the inadequacies of social security in India, and draw a distinction between the labouring poor and the non-labouring poor, arguing persuasively that social security must be made accessible to both categories (Breman and Kannan, 2013). Without in any way detracting from the rich insights this essay provides, I use the distinction between labouring and non-labouring poor as my point of departure in opening out the field for a fresh look at the intersections between disability and labour. This will help us to revisit the rich corpus of existing work on the informal sector and trace continuities between this body of work and the rapidly growing concern with disability rights.

Commenting on the exemption from state benefits of '[p]hysically or mentally disabled persons older or younger than the age limit set (18–60 or 64 years) and still 'able' in body and mind for more than 20 per cent,' they observe that '[i]t is this kind of logic which completely *disregards that non-labouring poor are, by and large, related to households belonging to the labouring poor*, who may or may not have enough to satisfy their own basic needs' (Breman and Kannan, 2013: 19, emphasis added). Elsewhere in the same essay they refer to 'the losses incurred with the household breaking up and able-bodied adults and minors going off, sometimes in different directions, while *members without labour power* stay put and cope as best they can' (Breman and Kannan, 2013: 17, emphasis added). The fact of high morbidity among the labouring poor 'caused not only by income deficiency…but also related to the *abominable conditions* of employment *which have a debilitating effect* on their well-being' (Breman and Kannan, 2013: 8, emphasis added) is certainly cause for concern. However, the observation that state benefits are 'doled out to overcome the *improvidence to which the disabled are prone*' (Breman and Kannan, 2013: 19, emphasis added) sidesteps the key premise of disability rights, which is that it is the abominable conditions in the physical, built, and social environment that is responsible for the destitution of persons with disabilities as an undifferentiated class of the non-labouring poor.[3]

Drawing a connection between disability and poverty, Harriss-White (2003) argues that the intersection between caste, family size, parental/adult care, and poverty create conditions for simultaneous deprivation that is 'further compounded by a syndrome composed of ideological reinforcement, punitive experience, psychological extinction, stimulus deprivation and a cognitive and verbal development which especially affects what is beautified as the "participation" in the economy of low caste groups: the terms and conditions on which they are forced to labour'. This sets up barriers for the participation of women and all persons with disabilities, but especially those with psycho-social and intellectual disabilities (Harriss-White, 2003). Yet, even her account assumes an able-normative

position where disability must be accommodated, and speaks of disability as the exacerbating circumstance in the context of poverty.

There is substantial evidence from studies on the informal sector, and research on occupational health for instance, that point to the fact that disability (or debility, or 'handicap') is indeed a defining condition of labour, especially in the informal sector. This may be signaled by chronic morbidity, early mortality, and psycho-social morbidity leading to suicides, arising directly from the relations of production as for instance with farmers and weavers in India in recent years.

Disablement and even death are seen as resulting from unfair work conditions and the absence of decent work standards. Compensatory moves have been directed against exploitative processes and forces in the neoliberal, globalized economy. While disablement as harm resulting from inequity is recognized, disability is not yet conceived of as a starting premise for the recognition of human dignity of the worker. Disablement is thus 'presenced' through the removal of 'disability' as a *pre-existing condition* in the labour market. And yet, all studies on the informal sector—degrading forms of labour, footloose labour, contract labour, new and increasing forms of unfree labour, unpaid labour—foreground precisely the fact of disability as a *pre-existing condition* to participation in the informal labour market—social disability. Why do persons with disabilities not figure as actors and agents in the deliberations on the multiple and cumulative vulnerabilities that beset the labouring poor? As Harriss-White (2003) observes, perhaps the issue of disability stayed unarticulated because persons with disabilities lacked a political platform and voice for the longest time.[4] What is the cost of shutting workers with disabilities out of the labourscape?

Research in Canada has pointed to the fact that it is not severity of disability that obstructs participation in the labour force—it is the barriers and obstacles that impede the effective and full participation of such people. In Nussbaum's words, 'all capabilities have a material aspect and require material conditions' (Nussbaum, 2006: 179). But, where persons with disabilities are concerned, 'whatever the cost of support that promotes inclusion, this is still smaller than the costs of exclusion, particularly when the costs of exclusion include the productivity foregone'(Rioux, 1998).

The understanding of labour power (including its reproduction and recuperation) and labour cannot be taken as given but need to be problematized in a way that emphasizes the greater variety of ways of organizing each. Labour power, by this argument, is not a given capacity but contains within it an unrealized/unrecognized potential the contours of which are as yet unknown but that are socially produced. The same applies to labour itself and the forms of work organization. In the context of the negation of an entire class from the very category of worker, how might we begin to pose the question of rights, entitlements, inclusion, and indeed justice itself?

These are questions that need urgent deliberation if for no other reason than that we must understand the roots of disability oppression. Young proposes the deployment of oppression as a structural concept that 'designates the disadvantage and injustice some people suffer…[the causes of which] are embedded in unquestioned norms, habits, and symbols, in the assumptions and underlying institutional rules and the collective consequences of following those rules' (Young, 1990: 41). This concept has five faces: exploitation, marginalization, powerlessness, cultural imperialism, and violence. Placing oppression as a central category in looking at disability is useful because it involves an analysis and evaluation of social structures and practices incommensurate with the language of liberal individualism—structures and practices that constitute discrimination in its most extreme forms (Young, 1990).

This project holds the promise of 'envisioning real utopias' by generating knowledge that will help challenge oppression. We could after Eric Wright extend this to delineating a vision for an emancipatory social science that would consist in the main of three tasks: elaborating a systematic critique of the world as it is, envisioning viable alternatives, and understanding the difficulties in transformation (Wright, 2010: 10).

At a more immediate level, if the challenge before us is to create 'an environment at the national and international levels conducive to generating full and productive employment and decent work for all' and thereby to strengthen the possibilities of sustainable development (Ocampo and Jomo, 2007: xvii), how does disability force us to revisit the definition of 'full and productive employment' and 'decent work'? In a context in which the norm distributes all individuals along a continuum from abnormal to normal, arising from the social practices of a social group, and is therefore constitutive of the individual's subjectivity (Golder and Fitzpatrick, 2009: 43, n43), what are the praxiological strategies to recognize disability as a dynamic, heterogenous, and productive category? The figure of the worker with disability forces us 'to put reason and humanity before fear, habit and prejudice; to test our unexamined assumptions regarding some of the basic elements of human life….' (Sen, 2007: 15).

Prosthetic Moves in Employment Jurisprudence

An attempt has been made in the foregoing section to point to some ways in which disability serves as a metaphor for marginality and exclusion.[5]

The foregoing discussion is of relevance because of the urgent need to break with a specific strand in the history of trade unionism and labour rights in the early industrial era where the most vocal protagonists were also eugenicists—the assumption of a 'fit', 'strong' body that is able to work to pre-determined rhythms [the standardization of the worker and the product of labour] is the starting point of the rights talk that surrounds the worker—the fear of increasing the ranks of 'paupers, syphilitics, epileptics, dipsomaniacs, cripples, criminals and degenerates' (Davis, 2010: 10) is all too familiar. The Indian constitution, in its benevolent articulation, follows a comparable enumeration to different effect:

> Article 41: Right to work, to education and to public assistance in certain cases: The State shall *within the limits of its economic capacity and development*, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want. [Emphasis added]

The suggestions for amendments in the *Unorganised Workers' Social Security Act*, 2008 reproduces a similar list in para 8:

> The Act should pay special attention to those individuals and groups, who have traditionally faced difficulties in exercising rights. Additional measures…for adivasis…for dalit workers… for women…and for other excluded categories like *sex workers, eunuch, handicap, abandoned old people/sick people*.[6]

With respect to the right to work, in general, Indian courts have consistently insisted on enforcement of the provisions included in the *Persons with Disabilities Act*, 1995 upholding a comprehensive 'right to work'. However, while the *Persons with Disabilities Act* protects the rights of those who have developed a disability to continue as an employee at the same establishment in a position of equal benefits and pay, thereby protecting their right to work, other labour laws (like the *Industrial Disputes Act* and *Workmen's Compensation Act*) at best award compensation, and at worst provide for complete termination of service without any payment. Since provisions in these laws remain intact even after the passage of the *Persons with Disabilities Act*, 1995, the status of the right to work remains uncertain.

It is not the purpose of this chapter to provide a detailed account of the interpretive twists and turns in courts on the legislations pertaining to disablement or disability. The attempt is in fact even more basic. How do normative assumptions about ability rupture the very construction of the category of the worker with disabilities?

The embodiment of discrimination—the 'infirm body'—disables the articulation of a right through the language of incapacity and impairment that pushes disability out of the social and into the 'natural' (read physical/mental) world. This places a direct restraint on constitutionalism as the following Rule 12 of the *Andhra Pradesh Judicial Services Rules*, currently in operation, demonstrates:

> Rule 12: General Qualifications: No person shall be eligible for appointment to the service unless—
>
> …
>
> (iii) He is of sound health and active habits and free from *any bodily defect or infirmity* making him unfit for such appointment (emphasis added).

The conflation of 'sound health' 'active habits' and 'bodily defect or infirmity' typically represents the dominant construction of disability.[7] The expulsion of disability from the very conceptualization of work, labour, governance and justice, ensures that the standard setting norm is able-normative, which is then applied jerkily to persons with disabilities, to varying degrees, in a back and forth movement that does not add up to a new or radically different standpoint.

Cases concerning employment of persons with disabilities foreground the problems therein especially arising from the prosthetic move where the disabled body defines the able one.[8] Typically, these are central to dominant able normative conceptions of the capabilities of disabled workers.

> [E]quality is not degraded or neglected where special provisions are geared to the larger goal of *the disabled getting over their disablement consistently with the general good and individual merit*.[9]

Special and enabling provisions are at the heart of disability-based entitlements. A plain reading of the court's reflection above points to the responsibility of overcoming disablement resting with the disabled—the successful claims dependent on individual merit. We have

echoes of the merit arguments in the context of caste, tribe, and gender as well. But a subversive interpretation is also possible—the able-bodied norm that is responsible for the disablement of the disabled needs to be overcome in the interests of the general good—preserving and caring for the diversity of abilities that make for a plural society, and merit, which may well be located outside the able bodied norm—utopian, without doubt, but not impossible.

In a typical case the Uttar Pradesh government provided 2 per cent reservation for 'handicapped persons' with the following limitation:

> The physical disability should not be of the nature, which may cause interference in discharge of duties and obligations attached to the concerned service. Accordingly if the service is as such that it require [sic] continuous use of eye, then in such case reservation cannot be given to the blind persons. In the same manner if some services specifically involves the hearing faculty then no reservation can be given to the deaf persons in such services and in a service where the use of a particular organ of the body is to be used then the person disabled of that particular organ cannot be given reservation in that service.[10]

The problem, I have argued elsewhere, is not as much in the setting out of an 'eye for an eye' or 'an ear for an ear' approach, but in the able bodied imagination of what tasks require an eye or an ear or a limb, what tasks are suitable for the disabled and what are the ways in which they may be 'accommodated' (Kannabiran, 2012: 58). The Supreme Court's insistence that the state government provide an opportunity for employment to the person with disability in this instance ends with the observation that

> The State Civil Service…is a large enough service which can easily *accommodate* physically handicapped persons *in suitable posts*[11] (Emphasis added).

The Government of India issued a circular in 1986, that set out the degree to which disability would be accommodated in the banking sector:

1. BL: Both legs affected but not arms
2. OS : One arm affected (R or L)
3. OL: One leg affected (R &/OL)
4. MW: Muscular weakness and limited physical endurance.

A probationary officer in a bank dealt in cash, accounts, signature verification, customer relations, and the diversification of tasks consequent on liberalization of the economy. Hence, it called for 'greater alertness, presence of mind and maximum utilization of all his/her physical and mental facilities (sic)'. Therefore, this job was not identified for 'blinds' by the government.[12] The assumption that sighted persons with physical disabilities are closer to the norm of alertness and 'mental capacity', and the distancing of the 'blinds', constructs lack of vision or sight as impaired comprehension, using the norm of comprehension through sight as equivalent to mental alertness and capacity. The Standing Committee set up by the Ministry of Welfare to identify jobs for the disabled in the public sector observed unequivocally that

> [i]t would not be possible to generalise that blind persons can do most jobs as we have found for those with locomotor and hearing disabilities.

The report then goes on to mark the shortfalls of blind persons against the norm:

> To compensate 'reading deficiency', readers' allowance can be provided to blind employees to enable them to engage a reader. Similarly, to compensate for 'writing deficiency', the blind employee should be required to know typing. Adequate knowledge of typing should be prescribed as an essential qualification for blind employees for public employment. Where mobility may also be one of the main ingredients of a job it is difficult to compensate blind employees for this 'deficiency'. The Committee would also emphasise that the blind employees should be fully responsible for the duties assigned to them, despite the provisions of reader's allowance and typing skill.[13]

Very clearly, the blind are the Other—what the able-bodied are not. The other striking aspect of the discourse on disability is the problem 'sightlessness' poses to the imagination of the sighted. In a nutshell the able-bodied are not 'deficient' and therefore need not be compensated. But also, interestingly, they are not deficient and therefore need not possess additional skills like typing. There is an inversion here of the dominant assumption that disability is possessed of deficiency which includes a diminished capacity to acquire skills necessary for efficiency. Here, deficiency necessitates a higher acquired skill on the part of the disabled. And the language of 'deficiency' marks the exclusion of those who cannot read and write without assistance. There is in this framework no space for literacy skills or languages of competence that are measured differently (Kannabiran, 2012: 60). What is even more interesting

is the description of the lawyer arguing the case for the National Federation of the Blind:

> Mr. Rungta—(himself visually handicapped) has argued his case *with utmost clarity*. Mr. Rungta was *fully conversant with all the relevant annexure* to the petition. He referred to the relevant pages in the bulky paper book with *perfect ease*. *We did not feel even for a moment that the case being argued by a visually handicapped lawyer*. Mr. Rungta's performance before us amply proves the point that the visually handicapped persons can perform the jobs entrusted to them with *equal efficiency*[14] (emphasis added).

Even while forcing the state to open up public employment to persons with disabilities, the Supreme Court absorbs the able-bodied norm as a result of which capacity to carry out particular tasks and the contestation of such capacity are both constructed in ways that are deeply discriminatory. In this view, ability and efficiency are reduced to the smoothness with which a disabled person negotiates a barrier-ridden environment. The deep flaws in this assessment have not yet begun to enter the account of disability rights jurisprudence.

In 2001 the Delhi High Court found that with respect to providing employment opportunities to persons with orthopedic and visual disabilities, 'not-withstanding clear, unambiguous and laudable objectives sought to be achieved by a decision [of the University of Delhi],… it remains only on paper because of apathy, lack of will and lackadaisical approach of the authorities who are supposed to implement such decision'.[15]And yet, the court found there was no dearth of persons with disabilities, who not only met the general standard but excelled it as well, throwing into sharp contradiction yet again, its own delineation of disability as 'handicap', or 'deficiency':

> The petitioner, who is a handicapped person, as she was born with congenital blindness, *has not allowed this disability to disable her*. Even without any vision or proper vision since birth, *the petitioner not only pursued her studies but proved to the world at large that what a normal student could do she could do the same equally well or even better*. This is clearly demonstrated by the testimony of her academic record.[16]

What was the measure of ability? Was it dependent on specialized training, or was it dependent on being 'able-bodied'? Could, for instance, persons with disabilities who were trained in physical education be disqualified on immutable grounds that 'a physically disabled person could not perform this job'? At what point must the assessment of ability be made? Having received the requisite training and acquired the formal qualification necessary to meet the general standard of the job, the court held, the government [in this case, the 'benefactor' and the violator both] could not at a later stage declare unsuitability. Training institutions must determine suitability prior to selection for training.[17] This is not, however, only a question of discourse. It speaks to the way in which public institutions, public employment, indeed the entire public domain is organized outside of and in opposition to the entire diversity of disability and also the entire diversity of ability.[18]

Finally in 2013, the Supreme Court of India, took on board the spirit and specific arguments put forth by Santhosh Rungta—within the framework of the Constitution, the decision in *Indra Sawhney*, the 1995 enactment (as distinct from its interpretation) and the *Rights of Persons with Disabilities Bill* 2012—to confirm that the correct interpretation of the 3 per cent reservation rule is 3 per cent of cadre strength in *all groups* in the civil services—A, B, C & D. This, according to the Supreme Court was not subject to the 50 per cent ceiling, which was explicitly set out in *Indra Sawhney* for vertical reservation not for disability, which is horizontal reservation. This judgement marks a significant shift in judicial discourse on employment and disability rights, bringing it in tune with the spirit of the campaign for disability rights.[19]

The definition of 'disability' cuts across a very wide range of physical, mental and social disabilities, many of which might coexist with sound health and ability, throwing into question the homogenizing of disability and its opposition to the able-bodied norm evident in judicial discourse on physical disabilities.

The right to work, which includes the creation of assistive devices to enhance work capacity, physical access to enable mobility to and in the workplace, development of collateral skills to make optimum use of productivity, and importantly the treatment of the worker with disability as an independent, *autonomous* worker with a right to livelihood, is conspicuous in its absence in the conceptualization of state policy, and in the interpretation of the constitutional right to livelihood for persons with disabilities.[20]

Disablement, Labour and Law

The *Workmen's Compensation Act*, 1923 provides an excellent illustration of the central point of this chapter.

'Partial disablement' means where the disablement is of a temporary nature such disablement as reduces the earning capacity of a workman in any employment in which he was engaged at the time of the accident resulting in the disablement and where the disablement is of a permanent nature such disablement as reduces his earning capacity in every employment which he was capable of undertaking at that time:

Provided that every injury specified in Part II of the Schedule shall be deemed to result in permanent partial disablement; (Section 2(g) *Workmen's Compensation Act*, 1923).

Schedule I of the WCA sets out the 'list of injuries' and corresponding disablement in finely calibrated percentiles: for instance, loss of four fingers—50 per cent; loss of three fingers—30 per cent; loss of two fingers—20 per cent; and so on, starting of course with the amputation at the shoulder joint at 90 per cent.

Schedule II lists 48 occupations that are covered by the WCA, of which workers with disabilities can perform at least 35 on an equal footing with workers without disabilities. Of the remaining, handling of animals (spread through three other items) is again work that will have a range of people with diverse abilities. Even if we do not take these into account, on a plain reading workers with disabilities might quite easily perform 73 per cent of the occupations listed in the WCA.

The WCA clearly contemplates compensation for workers without disabilities who acquire disability in the course of work. It denies compensation to workers who are callous of safety measures at the workplace, or those that are irresponsible and inebriated at work. There is no indication, however, that the safety measures in place include measures that meet the special needs of workers with disabilities, even though, this might well mean exposing such workers to increased risk in the same conditions. Second, assuming a worker with disabilities is employed, will occupational disablement be computed in the same terms? For instance, the loss of an eye for a sighted worker and for a visually impaired worker or the loss of a leg for a worker who already uses one prosthetic leg results in very different outcomes.

Even if one looks within the quantified measures of disability that are at the core of this legislation, the injuries listed in Schedule I could result in total disablement (within the meaning of the WCA) of the worker with disability while it might result in partial disablement of the worker without disabilities. Further, if total ability is the starting point of the WCA, is it even conceivable within the parameters of this legislation to posit the possibility of the disablement of a disabled worker? How might we then approach the question of compensation?

The resolutions to these questions will show the way to building a more inclusive and plural foundation for our understanding of decent work. As Somavia observes, '[n]ormative action is an indispensable tool to make decent work a reality'.[21]

The Idea of a Worker with Disabilities

rethinking the 'social floor'

Impairment and disability raise a distinct and urgent problem for our conception of social justice: that is, what is the meaning of fair treatment? (Nussbaum, 2006: 99) The tension for instance between 'equal treatment' and 'reasonable accommodation' and the tendency towards isomorphism in social arrangements underwrites popular and juridical understanding on fair treatment, especially evident in legislation, case law, and research on labour rights and conceptions of the worker in India. Michael Walzer's observation that 'the principles of justice themselves are pluralistic in form' challenging the idea that a singular principle is even possible, is especially relevant to an understanding of disability (Walzer 1983: 6). The 'social floor', in Nussbaum's view is human dignity.

Retracing our steps for a better understanding, it is useful to reflect on the relationship between civil and political rights on the one hand and economic and social rights on the other. Rawls delineates two principles of justice, where the full enjoyment of the most extensive scheme of equal basic liberties is the precondition for the distribution of wealth and income (Rawls, 1999 [1971]: 53). '[I]nfringement of the basic equal liberties protected by the first principle, cannot be justified, or compensated for, by greater social and economic advantages' (Rawls, 1999 [1971]: 53–4), nor can there be any 'exchanges between basic liberties and economic and social gains except under extenuating circumstances' (Rawls, 1999 [1971]: 55).

Inequalities, by this token, are permissible [and fair, or just] only insofar as they are to everyone's advantage and more importantly, come into play after the guarantee of liberty is accomplished. Sen interrogates Rawls' 'downplaying' of the possibility that different people 'can have widely varying opportunities to convert general resources (like income and wealth) into capabilities—what they can or cannot actually do…[which] reflect pervasive variations…in the human condition and in the relevant social circumstances' (Sen, 2009: 261). This obstruction that people face in converting resources into

opportunities that are embedded in social circumstances is discrimination, not just inequality.

In a manner of speaking, we are here entering the debate on two sets of rights—social and economic rights and civil and political rights. Supiot, in asserting the centrality of social and economic rights, argues for instance that people concern themselves with the defence of freedoms only when minimum physical and economic security is assured: 'freedom is impossible where physical or economic insecurity prevail' (Supiot, 2007: 199). Yet, physical insecurity itself is the loss of freedom—the loss of liberty. And if economic insecurity engenders dependence, is insecurity—economic and physical—itself not the loss of liberty? This is a view that has been adopted by constitution makers and jurists in South Africa as well, where, as Justice Yacoob has persuasively argued, 'all rights [civil and political or first generation, socio-economic or second generation, and environmental or third generation] were in fact indivisible and interrelated.... At the risk of overstatement it might be as well to say that a human being without clothes, food, water or work could hardly be said to have inherent dignity which is both respected and protected' (Yacoob, 2002).

When may we consider that the guarantee of liberty has been established? Challenging the liberal understanding of freedom that force or the coercive threat of it constitute the only forms of constraint that interfere with individual liberty, Skinner invokes the insistence of neo-roman writers that 'to live in a condition of dependence is in itself a source and a form of constraint. As soon as you recognize that you are living in such a condition, this will serve in itself to constrain you from exercising a number of your civil rights...[T]o live in such a condition is to suffer a diminution not merely of security for your liberty but of liberty itself' (Skinner, 1998: 84). The anticipation (or danger) of coercion erodes liberty, by this argument.

It is not out of place in speaking about liberty in the context of disability, to recall Bauman's analysis of Bentham's panopticon, as a model of a mini society precisely because it details for us the specific ways in which discrimination restrains liberty:

> Some actors are freer than others: discrimination in the degree of freedom allotted to various categories of actors is the very stuff of which the social system is moulded. Discrimination precedes action...Instead of being an unanticipated outcome of the interplay between 'phenomenologically equal', similarly free agents, social order is something which some people set for others...If it is true that 'men make society', *it is also true that some men make the kind of society in which other men must live and act. Some people set norms, some other people follow them* (Bauman, [1988] 1997: 23. Emphasis added).

This precisely then, is the predicament of workers with disabilities in an able normative labourscape.

The second aspect of re-visioning the labourscape has to do with looking at care. What is the place of care in the conception of justice for persons with disabilities—especially the profoundly disabled? The need for good care for asymmetrically dependent would focus on support for life, health and bodily integrity, stimulating the senses, and imagination and thought in the process. The need for good care for the caregiver is reflected in the need for social and institutional arrangements that allow for care-giving as a real choice, enabling it and providing every support that it requires—ranging from the cultural/emotional to the economic (Nussbaum, 2006: 168). What are the ways in which the construction of the caregiver as worker (with a claim to care giving as employment guarantee) displaces settled notions of 'the worker'? (Breman and Kannan, 2013: 8).

It is pertinent at this point to recall Pothier's delineation of the social construction of disability:

> The 'social construction' of disability refers to the way an able-bodied conception of disability magnifies its consequences. The social construction of disability assesses and deals with disability from an able-bodied perspective. It includes erroneous assumptions about capacity to perform that come from an able-bodied frame of reference. It encompasses the failure to make possible or accept different ways of doing things. It reflects a preoccupation with 'normalcy' that excludes the disabled person. (Pothier, 1992: 526)

The disability framework, in Rioux's view, helps us step away from tinkering with existing systems, structures, and mindsets, to reshaping in fundamental ways, the manner in which social and human relations are organized with disability serving as one measure of diversity, for which accommodations are made not on an individual level but at a systemic level (Rioux, 1998).

THE EMERGENCE OF THE 'VIKALANGA KOOLI'

Picture this:

Case 1: Malik has one leg, the other leg is small and non-functional. He ploughs his own field—wraps his second bad leg around the stick and uses the stick as his leg in the mud. His hands are free for the plough.

Case 2: Achali has one hand and a stump for the other, which she uses with the armpit to hold crop and

wields the sickle with her good hand. She sows and harvests with one hand and is active in paddy cultivation.

Case 3: Shanthi uses calipers for one leg and is active in cotton fields with the caliper on.

Case 4: Amrutha has two non-functional legs and supports herself with two short sticks. She picks cotton and works in the fields in sitting position.

Case 5: Building anicuts, clearing stones from fields in preparation for cultivation, clearing mud after digging trenches and wells are all done by persons with disabilities in Mahbubnagar district.

Case 6: Visually challenged people carry headloads, build bunds, and clear mud and earth after digging.

Case 7: A large group of workers with disabilities—visually challenged, physically challenged, and intellectually challenged—have been given the task of digging pits in an afforestation drive in Mahbubnagar district. They have done this so well that they are now being given the job of planting trees as well.

Case 8: Bhavani in Srisailam ITDA has one hand and no legs. She uses her thigh and one hand to stitch leaves together for the temples (*istari*) in unimaginable speed. At any time you can see her with a pile of unstitched leaves on one side and a pile of stitched leaves on the other (*istari*). She supports herself and her old mother with the income.

Case 9: Hussain with two stumps for legs stands on the base of the plough and directs the bullocks to plough the field.

Case 10: Yasin with no hands and one leg asked for goats in a livelihood drive by a newly emerging political party. He was given 20 goats—his flock has increased to 30. He takes them out to graze, and instead of going ahead of him, which is the scene we usually see, they follow him. They move ahead only when he asks them to, and he has to give only one unique call and they all return to him and follow him home.[22]

We of course have the classic description of Hippolyte in *Madame Bovary*:

> But on the equine foot, wide indeed as a horse's hoof, with its horny skin, and large toes, whose black nails resembled the nails of a horse shoe, the cripple ran about like a deer from morn till night. He was constantly to be seen on the Square, jumping round the carts, thrusting his limping foot forwards…by dint of hard service it had acquired, as it were, moral qualities of patience and energy.[23]

We have seen in several contexts—notably through the scholarship of feminist economists—that actual work participation does not automatically confer the status of worker. As Tokman observes, '[t]he legal and explicit recognition of the employment relationship is crucial because it constitutes a pre-requisite for the recognition of rights to labour and to social protection' (Tokman, 2007: 262). The UNCRPD accomplishes this through Article 27, which speaks of the rights of persons with disabilities to work and employment:[24]

> 1. States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities.
> 2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.

In the discussion in the preceding section on the centrality of social and economic rights to the enjoyment of life with dignity and personal liberty, we have examined in fair detail the relationship between the condition of dependence and the loss of liberty. Testimonies from persons with disabilities point to the direct relationship between abject dependence and abuse within families and communities (Menon-Sen and Kannabiran, 2010).

While 'participation' in the economy is a euphemism for acquiescing to conditions of forced labour for the entire range of persons who suffer the most aggravated forms of simultaneous deprivation (Harriss-White, 2003) and cumulative discrimination, the cases cited above demonstrate ways in which persons with disabilities adapt and accommodate themselves to hostile environments [in a reversal from the mandatory provision of enabling environments under internationally accepted standards] in order to define themselves as workers. That this is a sizeable section is evident in census figures from 2001—these are workers with disabilities who push themselves in through the fault lines in the exclusionary labourscape, working as the non-disabled do, under the same terms and conditions.

A second illustration of workers with disabilities moving a step further in negotiating a space in and recognition for themselves in the labourscape, is contained in the deliberations around employment guarantee.

How might we approach the question of the social organization of labour and the definition of labour power using a disability standpoint? We need to move from looking at the differently abled and destitute as non-labouring poor in need of social security (Breman and

Kannan, 2013: 27), to thinking through how we might transform the labourscape so as to recognize the different and diverse abilities through which workers—with disabilities and without—might contribute to a more robust and representative collective voice for human dignity and the right to decent work.

The focus of this section will be on the definition of work, labour power, capabilities and reasonable accommodation that crystallizes around the emergence of a new category of 'worker'—the '*vikalangakooli*' or wage-worker with disability.

The National Rural Employment Guarantee Act, 2005, defines employment guarantee as a provision

> …for the enhancement of livelihood security of the households in rural areas of the country by providing at least one hundred days of guaranteed wage employment in every financial year to every household whose adult members volunteer to do unskilled manual work and for matters connected therewith or incidental thereto.

Even while there was a cascade of studies, assessments, and audits on the NREGA in different parts of the country, a storm of a different kind was brewing in the rural labourscape changing in fundamental ways the contours of 'labour' (see Appendix).

The Government of Andhra Pradesh, in a series of GOs and circulars, outlined the contours of the meaning of the right to work for persons with disabilities. The inclusion of persons with disabilities within APREGS can be traced to a gazette notification in 2006 that stated simply, 'Disabled persons may be provided wage-employment by entrusting suitable works in the form of services that are identified as integral to the programme'.[25] Pursuant to this, the government of Andhra Pradesh issued the *Operational Manual 2006* for the implementation of APREGS.[26] A close reading of the manual suggest no major departure in the traditional view/treatment of persons with disabilities: a household with a disabled person was entitled to 150 days of wage employment per year instead of the standard 100 days (para 4.4.5); 'if a rural disabled person applies for work, *work suitable to his/her ability* will have to be given. This *may also be in the form of services* that are identified as integral to the programme. Tasks such as water-carrying, ayah, village information wall writing, shade arrangements and nurseries may be given to the disabled persons' (para 4.4.9); and if more than five children below the age of six years are present at the worksite, a person (preferably a disabled woman) should be engaged to look after them… (para 5.8).

Very soon thereafter, we witness a clear and radical shift in the articulation of the entitlement of the 'wage-worker with disabilities' (*vikalangakooli*) in a succession of communiques issued by the government, although the clauses cited above were reiterated. And a diktat that all reviews at all levels on the MGNREGS must mandatorily include issues concerning persons with disabilities on the agenda.[27]

As an idea, it was revolutionary and driven by the new consciousness of dignity and full participation triggered by the deliberations around the UNCRPD, the reconceptualization of disability legislation, and a reassessment of the possibilities of the existing law in India. The process was initiated and carried through by rural collectives of persons with disabilities who had been engaged in the protracted debates around disability rights. In making this demand for a special place in the NREGA, disability rights advocates were drawing on two rarely cited provisions in the Persons with Disabilities Act, 1995: Section 68 of the act speaks of unemployment allowance to persons with disabilities who have registered with the special employment exchange and could not be placed in gainful occupation for two years; the second provision, in Section 40, provides for a reservation of not less than 3 per cent of vacancies in all poverty alleviation schemes for persons with disabilities.

Who Is a Worker?

Persons with benchmark disabilities in accordance with the *Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act*, 1995, who completed 18 years of age and were able and willing to work were identified as '*vikalangakooli*'.[28] In the multi-tiered system of wage work under the NREGA, the directive that 'persons with disabilities are to be given preference in selection of mates, not only for the disabled workers' collectives, but also for the workers' collectives',[29] bears significance that can scarcely be understated. Where parents of children with disabilities seek work, a woman with disability is to be appointed as ayah (caretaker) for a maximum of 150 days after which another ayah would be appointed. Where an ayah is found necessary either for the work site of a workers' collective or a disabled workers' collective, a poor woman with disability shall be appointed as ayah.[30]

The relationship between gender and disability in the delineation of work is important and complex, first because of the unproblematic application of the standard norms of the sexual division of labour to women workers with disability, but also because the allotment

of care-giving and 'service' responsibilities to men with disabilities might serve to signal the 'feminization' of the disabled workforce.[31]

Dignity of Workers

Given the way persons with disabilities are generally labeled and abused, a circular specifically states that all workers with disabilities must at all times be addressed by their given names; and the name along with the family name must be entered in the job cards. Authorities are under obligation to ensure that disabled workers' collectives shall not be humiliated, or discriminated against in any manner whatsoever in the areas in which they work.[32] This communiqué draws attention to the unusual presence of the disabled worker in the worksite that might trigger social approbation. This particular circular is strongly reminiscent of a memo issued by S.R. Sankaran in the context of widespread discrimination against persons belonging to the scheduled castes: 'In relation to Harijans there is the practice of using the suffix "gadu" to the names. The government direct that such suffix should be scrupulously omitted in all government records including birth registers hereafter'.[33]

Disabled Workers' Collectives

The formation of disabled workers' collectives, the identification of persons with disabilities and formation of collectives—the Disabled Shram Shakti Sanghas (DSSS) facilitate effective access to wage work. All workers with disabilities who are part of disabled workers' collectives are entitled in AP to wages 30 per cent higher than the rural SSR, an advantage not available to workers with disabilities who work alongside non-disabled workers in the workers' collectives.[34] Disabled workers' collectives may be allotted the works from the shelf that they choose and feel they are able to perform, in addition to managing and growing nurseries—a job reserved for workers with disabilities. If in order to perform the works better, workers with disabilities require implements suited to their use, or training and expertise, the same shall either be provided to them or the costs met if they procure them directly.[35] Apart from this the entire scheme of APREGS for workers with disabilities is mediated, negotiated and monitored by the APNA(D)—a network of community based organizations covering every district and mandal in the state that are recognized as the bridge between workers and government. The primary task of collective bargaining in securing maximum entitlements, as also in defining the conditioning environments is critical to this endeavour.

The Household

While the Operational Manual adopts the standard definition of the household (and includes households consisting of single women), there is a sharp departure very soon thereafter: Whether unmarried, or single, or without family, every adult person with disability who seeks work under the NREGS, shall be recognized as a single member household and issued a separate job card. Where there is a single adult person with disability living with other members of the family, and the family has been issued a job card, the person with disability shall be removed from the family job card and issued an independent card. Where there is a person with high support needs in the family, the job card for 150 days of work shall be issued to the family. Where two persons with disabilities are married, they shall be entitled to only one job card.[36] The definition of the household is revisited and defined through the medium of wage work and participation in productive activity, with the worker with disabilities simultaneously defined as autonomous wage earner and head of household.

The change in orientation in the regulation of the NREGS was driven by disabled peoples' organizations that persisted with the need to define the person with disability as a worker. As a result, we have, in a stark reversal, the definition of the worker premised on a situation of unemployment relief, where the dependent non-worker (definitionally 'unemployed') becomes a bearer of the right to work arising from recognition of unemployment. That there were, till the introduction of the NREGA, no measures for the quantification of work by persons with disabilities is evident from the extensive time and work motion studies supported by the government in order to arrive at a Rural Standard Schedule of Rates (Rural SSR) for payment of wages to workers with disabilities. This is also validated by a recent study of NREGA for persons with disabilities in three states that found that an overwhelming majority of disabled people interviewed had never engaged in wage work prior to the NREGA (Kumaran, 2013). The question with respect to the terms and conditions under which workers with disabilities enumerated in the Census of India 2001 as main and marginal workers toiled of course then remains unanswered.

This initiative of persons with disabilities to access employment guarantee, redefining in the process, ideas of capabilities, measurement of work performance, and most importantly the right to work of persons with disabilities, points to a crucial way forward. This fact represents a theoretical leap, from a position of absolute

non-recognition to the claim of entitlements springing from official recognition.

THE DISABILITY STANDPOINT IN THE CONSTRUCTION OF THE LEGAL-NORMATIVE

If regulation, collective representation, and protection are at the core of our understanding of labour rights, what would a regulatory order envisioned within a disability framework look like? This section will focus on the labour provisions in the new *Rights of Persons with Disabilities Bill* 2012 (hereafter RPWD Bill), also an initiative driven in the main by persons with disabilities, as a possible way forward in reconceptualizing labour—the organization of work, labour power, and social security.[37]

The guiding principles for the proposed legislation are immediately relevant to this exercise: respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; and accessibility, among others. Recognizing the diversity within the broad category of disability, the bill draws a broad classification into disability, benchmark disability, and disability with high support needs, within which it delineates and *defines* 18 forms of disabilities in the schedule to the bill. Sections 25–28, in speaking of the right to non-discrimination in employment, equal opportunity, maintenance of records relating to employment of persons with disabilities and a clearly defined grievance redressal procedure, write the disability framework into the fields of employment, re-shaping workplace rights and practices by defining capabilities differently.

Employment jurisprudence foregrounds the insidious ways in which employers, despite a veneer of compliance, defeat disability rights in the workplace. Sections 38–41 speak of the reservation of posts for persons with benchmark disabilities, reservation of 5 per cent of posts for persons with disabilities (with an internal categorization and allocation between disabilities), special employment exchanges, and incentives and disincentives to employers in the private sector: for compliance to 5 per cent reservation; added incentives for going beyond 5 per cent and disincentives for dropping below 5 per cent. Financial inclusion, a key concern is set out in Section 7, along with provisions for loans for self-employment in Section 24 and comprehensive insurance in Section 29.

Apart from employment in its recognizable form, the bill provides recognition of care giving (voluntary and paid) as central to the organization of labour, thus rupturing the public-private divide in the recognition of labour power, as also the distinctions between reproductive and productive labour, which in this context become extremely tenuous.

The key principle, which forms the basis of the social organization of work and labour is non-discrimination:

> 'Discrimination on the basis of disability' means any distinction, exclusion, or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field and includes all forms of discrimination, including denial of reasonable accommodation.[38]

The barriers are defined in Section 2(e) RPWD as 'any factor including attitudinal, communicational, cultural, economic, environmental, institutional, political, religious, social or structural factors which hampers the full and effective participation, of persons with disabilities in society'. This is a principle that is at the core of the equality code of the Constitution of India, as part of Article 15. But in fact what the RPWD Bill accomplishes is a cogent definition of discrimination that may then serve as a benchmark for the definition of discrimination under Article 15 of the Constitution, which has to this point been restrained in application to its special provisions clauses, possibly because of the absence of clear definition.

* * *

This chapter began with looking at the ways in which persons with disabilities are situated in the discourse and practice of social security, particularly relating to the labouring poor in informal sector employment in India. As an area that is primarily concerned with counterbalancing and compensating the negative consequences of social vulnerability and poverty, the discussion on social security is particularly relevant to an understanding of the predicament of persons with disabilities, since their categorization as the non-labouring poor is at the root of their exacerbated vulnerability to poverty and destitution.

In looking at case law on employment of persons with disabilities, I have attempted to underscore the ways in which the ends of justice are dis-abled through a mis-alignment between the purpose and text of enabling legislation and its interpretation, which reproduces the rhetoric of able-normativity. This is finally reversed in the case of reservations in public employment at all levels

brought to the Supreme Court of India by the National Federation for the Blind:

> Employment is a key factor in the empowerment and inclusion of people with disabilities. *It is an alarming reality that the disabled people are out of job not because their disability comes in the way of their functioning rather it is social and practical barriers that prevent them from joining the workforce*. As a result, many disabled people live in poverty and in deplorable conditions. They are denied the right to make a useful contribution to their own lives and to the lives of their families and community.[39]

There is a disjuncture between disability legislation and labour legislation compensating disablement, prompting questions: What is the position of a worker with disabilities who suffers disablement? How may we redefine socially necessary labour time in a manner that represents the contribution of the worker with disability, and the contribution of the caregivers of persons with high support needs, instead of defining the norm independently and outside of her/his experience, and thus setting up barriers? And how might we assess skill, intensity and magnitude of value in terms of the range of diversities in abilities and the range of disabilities? I return here to Walzer's delineation of *complex equality* where distributions of social goods must be different across differences—'when we see why one good has a certain form and is distributed in a certain way, we also see why another must be different' (Walzer, 1983: 318).

That this is a clear possibility is demonstrated to us through the work participation of persons with disabilities, not just in formal employment, but importantly, as part of the labouring poor. How might we use the *interstitial strategy* crafted by persons with disabilities in the scheme of the NREGA to revisit the deliberations on workers' rights with a view to opening out a space for workers with disabilities—in government spending in all spheres of development and social sectors; and in deliberations around social security for the labouring poor.[40] The starting premise for a new beginning is the redefinition of the 'social floor'.

In speaking of revisiting discourse on the labourscape, the wisdom of the movement for disability rights has undoubtedly played a key, constitutive role. This is a defining moment that holds the possibility of catalyzing a radically different understanding of disability in the labourscape, reinforcing Wright's statement that 'if emancipatory visions of viable alternatives are to become the actual real utopias of achieved alternatives it will be the result of conscious strategies of people committed to democratic egalitarian values' (Wright, 2010: 28). To the extent that the disability standpoint shines the torch on a 'real utopia,' and redefines democratic egalitarian possibilities, the concern with disability is not limited to persons with disabilities, but proliferates from there to encompass resistance to all forms of discrimination and creates a different language for law and justice.

Appendix

Table 9A.1 Employment Generated for Persons with Disabilities under NREGA during Financial Year 2015–16

S.No	State	No. of disabled persons registered in NREGA (2015–16)
1	2	3
1	WEST BENGAL	41,2642
2	ANDHRA PRADESH	23,1469
3	TELANGANA	18,0955
4	MADHYA PRADESH	17,5922
5	GUJARAT	14,7830
6	TAMIL NADU	12,7654
7	MAHARASHTRA	11,3006
8	CHHATTISGARH	11,2380
9	UTTAR PRADESH	52,174
10	KARNATAKA	41,918
11	ODISHA	32,218
12	BIHAR	27,956
13	JHARKHAND	26,309
14	RAJASTHAN	26,269
15	TRIPURA	21,262
16	ASSAM	17,776
17	JAMMU AND KASHMIR	12,265
18	HIMACHAL PRADESH	6,762
19	KERALA	6,754
20	DADRA & NAGAR HAVELI	2,688
21	PUNJAB	2,337
22	HARYANA	2,329
23	UTTARAKHAND	2,240
24	MANIPUR	1,767
25	MEGHALAYA	754
26	ARUNACHAL PRADESH	700
27	SIKKIM	392
28	MIZORAM	287
29	PUDUCHERRY	199
30	NAGALAND	159
31	ANDAMAN AND NICOBAR	142
32	LAKSHADWEEP	39
33	GOA	20
34	DAMAN & DIU	0
	Total	**17,87574**

Source: Ministry of Rural Development, Government of India, accessed from http://nrega.nic.in/netnrega/home.aspx on 21 November 2013.

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abbreviations in case citations

AIR: All India Reporter; DLT: Delhi Law Times; SCC: Supreme Court Cases; SC: Supreme Court.

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Notes

1. Clause (m) in the Preamble. Emphasis added.

2. Harriss-White (2003) observes that social welfare agendas in India have pushed disability to the foot, and intellectual, and political engagement on this issue is halting and inadequate.

3. Figures from Census of India 2011 indicate that out of a total of 2,68,14,994 persons with disabilities (males 55.9, females 44.1), 69.5 per cent lived in rural areas. Figures for the proportion of workers in total disabled stood at 36 per cent of which 72 per cent were located in rural areas and non-workers to total disabled stood at 64 per cent. However, problematic as this concentration of the disabled in the category of non-workers might be, the proportion of main workers in total disabled workers stood at 72 per cent, a fact that is significant to the present argument (Census of India, 2011).

4. The case of *Veena Sethi vs. State of Bihar* where sixteen prisoners, held in prison for periods ranging from 25 to 35 years despite having been cleared for release by psychiatrists were sent off with bus fare and a meal allowance for two days by Justice Bhagwati’s court epitomizes the situation of workers with disabilities generally.

5. The title for this section is adapted from the discussion on ‘narrative prosthesis’ in literature, where the authors argue that the person with disability serves as a prosthetic device in defining the ‘normalcy’ (Mitchell and Snyder 2010). For a more detailed discussion on employment jurisprudence and the cases discussed in this section, see Kannabiran (2012), especially Section I.

6. The proposed amendment among other things suggests (a) life and disability cover (b) additional protection to Dalits, women, adivasis and other excluded groups like sex workers, eunuch, handicap, abandoned old people/sick people. This residual category conflates an occupational group, a sexual minority, disability, aging and illness. Available at http://www.socialsecuritynow.org/SSNOW%20WEBSITE/booklets/amendments%20to%20the%20act.pdf accessed on 13 October 2013.

7. According to the Constitution of the World Health Organisation, ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity…The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health…Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.’

8. See Mitchell and Snyder (2010) for a discussion on narrative prosthesis, adapted in this chapter to look at the law. This is particularly relevant given that law and literature are two major representational forms that imagine bodies, societies, and sources of legitimacy in specific ways, serving to discipline them in the process.

9.Justice Krishna Iyer in *Dr. Jagadish Saran & Ors. vs. Union of India*, 1980 2 SCC 768.

10. G.O. No. 43/90/66-Apptt. 4 dated July 18, 1972 cf. *Daya Ram Tripathi vs. State of UP & Anr* 1986 Supp SCC 497.

11. *Daya Ram Tripathi vs. State of UP & Anr 1986 Supp SCC 497.*

12. *Amita vs. Union of India,* 2005 (13) SCC 497.

13. *National Federation of Blind vs. Union Public Service Commission*, 1993 AIR (SC) 1916. See also *Swadesh Chandra Majumdar vs Chief Operating Manager, Calcutta Tramways Company Ltd*. Case no. 636/Com-2009 where an employee is assigned light duties owing to low vision and then retired on 'medical grounds'.

14. *National Federation of Blind vs. Union Public Service Commission*, 1993 AIR (SC) 1916.

15. *Pushkar Singh and Others vs. University of Delhi and Others* 2001 (90) DLT 36.

16. *Smt. Shruti Kalra vs. University of Delhi and Ors* 90 (2001) DLT 262. Emphasis added.

17. *Government of NCT of Delhi vs. Bharat Lal Meena & Surinder Singh* 100 (2002) DLT 157 (DB).

18. The case of Ravi Arora brings to the fore the crux of the problem faced by persons with disabilities in the field of employment, in this case, public employment of the most prestigious order, the civil services in the country. In fact the issues in this case are a slide back from the National Federation of the Blind case, with the court forced into a repetitive jurisprudence rather than one that demonstrates a progressive development of the principle of non-discrimination. *Ravi Kumar Arora vs Union of India and Another*, 2004 (111) DLT 126.

19. *Union of India vs. National Federation of the Blind and Ors*. Civil Appeal No. 9096 of 2013, Supreme Court of India, paras 51–52; *Indra Sawhney vs. Union of India* (1992) Supp 3 SCC 217.

20. Available at www.ncpedp.org/policy/pol-res02.htm, accessed on 03 December 2008. This is evident in the scale and nature of service provision—17 Vocational Rehabilitation Centres run by the Government for disabled people across the country; 30, 390 clients admitted during 2003, but only 9,292 rehabilitated; training in non-productive skills—spice-making, cane-weaving, candle making, block printing and the manufacture of stationery items—none of which can assure a viable livelihood. For a more detailed discussion on policy, please refer to Kannabiran (2012).

21. Juan Somavia, 2001, www.ilo.org accessed on 30 September 2013.

22. I am grateful to Abdul Sajid Ali and Narra Thirupathamma, for accounts of these workers.

23. Cf. Lennard Davis (2010: 12). Of course Charles Bovary decides to surgically correct Hippolyte's 'deformity', leading to gangrene and amputation.

24. For a detailed and succinct analysis of Article 27, see Ferraina (2012).

25. 8(4), G.O. Ms. No. 27, Panchayati Raj and Rural Development (RDII), 28 January 2006.

26. G.O. Ms. No. 80, Panchayati Raj and Rural Development (RDII), 22 March 2006.

27. Circular No. 1688/EGS/PM(D)/2010/ dated 07.05.2011.

28. Circular No. 1456/EGS/PM(D)/2010 dated 30.09.2010, Commissioner, Rural Development, Government of Andhra Pradesh. Although this circular stipulates an upper age limit of 60 years, this was subsequently removed vide Circular No. 1456/EGS/PM(D)/2010 dated 20.10.2010. Commissioner, Rural Development, Government of Andhra Pradesh.

29. Circular No. 1456/EGS/PM(D)/2010 dated 30.09.2010, Commissioner, Rural Development, Government of Andhra Pradesh. Para IV.

30. Circular No. 1456/EGS/PM(D)/2010 dated 30.09.2010, Commissioner, Rural Development, Government of Andhra Pradesh. Para V.

31. The complex intersections among gender, disability, and work, especially in the context of the gender division of labour among workers with disabilities is an area that requires greater attention. I can only flag the concern in this chapter.

32. Ibid. Para IX.

33. Government of Andhra Pradesh, Employment And Social Welfare (B2) Department, Memo No. 873/B2/74-12 dated 18-7-1974.

34. Government of Andhra Pradesh, Employment And Social Welfare (B2) Department, Memo No. 873/B2/74-12 dated 18-7-1974 Para VI.

35. Government of Andhra Pradesh, Employment And Social Welfare (B2) Department, Memo No. 873/B2/74-12 dated 18-7-1974 Para VII. Further detailing of works in Circular No. 395/PM(T)/EGS/2012, dated 30.03.2012. Commissioner, Rural Development, Government of Andhra Pradesh.

36. Circular No. 1456/EGS/PM(D)/2010 dated 30.09.2010, Commissioner, Rural Development, Government of Andhra Pradesh. Para II. Translation by author.

37. This possibility of using the bill as a vantage point to envision a different labourscape is fulfilled even without the passage of the legislation (although undoubtedly the force of the enactment could be a game-changer).

38. Section 2(l) of RPWD Bill 2012.

39. *Union of India vs. National Federation for the Blind and Ors*. Civil Appeal No. 9096 of 2013, Supreme Court of India, para 49. Emphasis added.

40. Wright uses 'interstitial strategy' to refer to processes 'that occur in the spaces and cracks within some dominant social structure of power' (2010: 322) that has the potential to 'play a central role in large scale patterns of social change' (2010: 323).

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10

Invisible People, Invisible Violence

Lives of Women with Intellectual and Psycho-social Disabilities

Mahima Nayar and Nilika Mehrotra

'Disability' and 'disabled' remain terms which are contested and often misunderstood in the Indian context. The recent controversy with the introduction of a term 'Divyang' reasserts that the way in which disabled persons view themselves remain different from the way the government and others view them. This new term also displays a paternalistic approach to the disability question and an attempt to view disabilities largely through a religious lens. The position is complicated as disabled do not constitute one group; this group needs to be disaggregated further.

The difficulties that the disabled face become invisible in their other identities; this becomes more acute in the case of women with disabilities. They are invisible through their gender and further through their disability. This invisibility has been apparent in the various social movements as well where issues of disability have not been addressed. This results in increased vulnerability. According to the report of International Workshop on 'Going beyond the Taboo Areas in CBR (2013)' it has been found that children, women, and elderly persons with disabilities are more vulnerable to violence and abuse than the non disabled peers. The vulnerability of the women with disability is more significant.

In addition the nature and kind of disability further determines their position. People who experience mental health conditions or intellectual impairments appear to be more disadvantaged in many settings than those who experience physical or sensory impairments (cf. World Report on Disability, 2011).Women with psycho-social and intellectual disabilities are a group which can be considered one of the most vulnerable amongst the disabled as well. Concepts of mental illness and distress are not just determined by the social structure but are related to interaction between structure and individual. These concepts are largely defined through a biomedical lens whereas the intersections of gender, caste, class, region, and religion with disability further complicate the picture.

Misconceptions about psychosocial and intellectual disabilities and related stigma add to the difficulties faced by this group. It also makes the women more vulnerable to violence. This chapter seeks to highlight how the 'invisibility' of the disability creates vulnerabilities and renders invisible the violence faced by women with psychosocial and intellectual disabilities. At the outset we attempt to define the three main concepts utilized in this chapter namely what we mean by psychosocial and intellectual disabilities as well as violence.

Intellectual disability is a condition characterized by significant limitations both in intellectual functioning (reasoning, learning, and problem solving) and in adaptive behaviour, which covers a range of everyday social and practical skills. Intellectual disability forms a subset within the larger universe of developmental disability, but the boundaries are often blurred as many individuals fall into both categories to differing degrees and for different reasons. Examples of intellectual disability include Autism, Down's syndrome, and some forms of cerebral palsy (Human Rights Watch, 2011).

Psychosocial disability is the preferred term to describe persons with mental health conditions such as depression, bipolar disorder, schizophrenia, and catatonia. This term expresses the interaction between psychological differences and social or cultural limits for behaviour,

as well as the stigma that the society attaches to persons with mental impairments (World Network of Users and Survivors of Psychiatry, 2013).

The expression 'violence against women' refers to any violent act based on the kind that results in possible or real physical, sexual, or psychological harm, including threats, coercion, arbitrary deprivation of liberty, whether occurring in public or private life' (Fourth World Conference on Women, 1995).

People with these disabilities are rendered invisible because of a lack of 'voice'. Their voice can get lost because of communication difficulties which often arise out of a lack of trained people who can work with this group. Another aspect which emerges is the manner in which they are viewed—since they are seen as 'discredited individuals' (Goffman, 1963). Through this chapter, we aim to bring out how living as a discredited individual makes a person vulnerable to violence and increases the chances of their rights being violated. In the year 1999, the National Human Rights Commission (NHRC) observed that the mental hospitals were more like prisons than hospital, where mentally ill people were admitted more for punishment rather caring. Till the present they are considered as 'non-persons', lacking recognition before the law, on any life dimension (Davar, 2012). Many of the issues faced by them remain more medical than social. Pre-natal tests used for detection of disabilities bring out this point clearly. Ghai and Johri (2008) argue that prenatal testing has disadvantaged both girls and disabled people. Parents are often pushed for testing and a positive test is likely to result in parents aborting the foetus as in this particular social space disability has a negative connotation (Ghai and Johri, 2008: 308). This is especially true for pre-natal tests for screening for intellectual disabilities like down syndrome. Therefore, it can be seen that discrimination and marginalization begins early for people with intellectual and psychosocial disabilities.

Invisibility is a state which women face very frequently, which gets exacerbated for women with intellectual and psychosocial disabilities (they will be henceforth referred to as disabled women in this chapterr. Women with disabilities refers to women with all kinds of disabilities—physical, sensory, intellectual and psychosocial). There is a need to understand the kind of violence (active and passive) this group of women was experiencing. This chapter attempts to do so in three sections—the first section deals with the brief situational analysis of all women with disabilities. The second section presents data related to violence against disabled women across settings and the systemic responses to the same. The third section presents the role of disability rights movement and civil society in bringing out the issues of disabled women and further steps to reduce the social isolation of this group of women.

The data presented in the chapter is primarily based on secondary sources—through a review of reports, journal articles, and position papers. In addition to that brief field work was carried out by a research assistant in Delhi. There were no statistics available specifically for violence against disabled as will be seen from the data. Narratives drawn from different sources have been presented here.

The systemic (police, crime against women cells, and NCW) responses to violence against women with psychosocial and intellectual disabilities were collected through interviews with functionaries of the different government and non-government organizations (NGOs) working on issues related to violence and crime, against women. One of the major challenges in this work was paucity of information on this issue owing to lack of awareness. When the research assistant went to ask about information related to violence against women with intellectual and psychosocial disabilities; at first she had to explain the meaning of disability. People were unable to understand the word disability and used words like *Apang, viklang and handicapped* underlining the ignorance and apathy on this question. Although within the disability movement terminologies have been discussed, debated, and modified, the use of these terms show that not much change can be seen at the grassroots level. The usage of these terms also give an indication how the institutions/systems (in this case 'the police') still perceive disability and the disabled.

For understanding systemic responses, it was felt that contacting a police station needed to be the first step in order to examine the extent of crime. Chittaranjan Park police station was chosen first because of its convenience to the researcher. The primary aim was to find out what kind of information was available to police regarding violence against women with disabilities. From then on a snowball sampling technique was used. The researcher was directed to one place from the other (see Figure 10.1).

After visiting the various government departments the researcher was given the reference of Human Resource Law Network (HRLN) which has been at the forefront in working with disability rights movement. It is also working to realize the rights of disabled people through

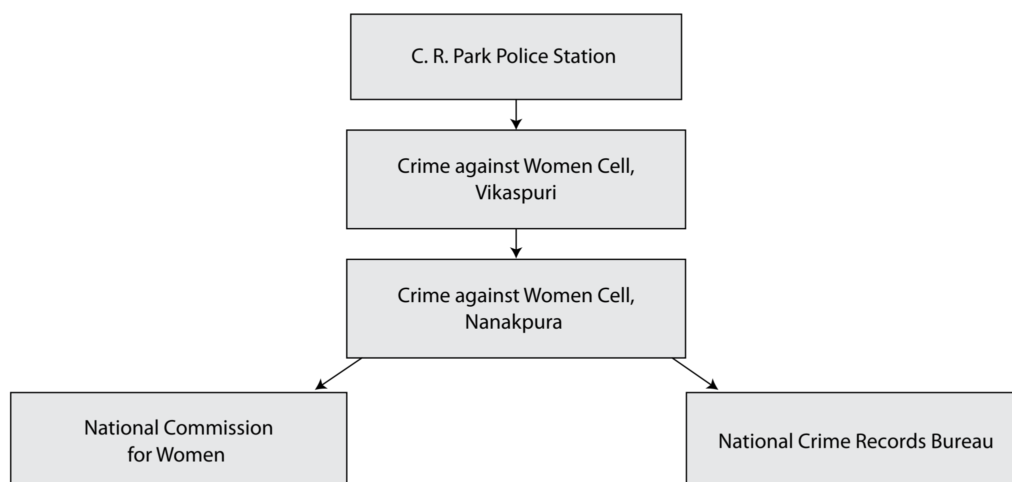

Figure 10.1 Government Organizations Contacted by the Researcher
Source: Field Survey.

education and awareness campaigns, legislation for the disabled, legal aid, and publication of material required by the disabled. The disability rights initiative of the organization is also a part of Women with Disabilities India Network which works on critical issues related to women.

Situational Analysis of Women with Disabilities

According to the 2011 *World Report on Disability* of the World Health Organization and World Bank, it is estimated that approximately 15 per cent of the world's population lives with some form of disability. The disability level threshold indicates that the male disability prevalence rate is 12 and the female 19.2. Available data suggests that at least 70 million Indians live with psycho-social disabilities and over 1.5 million have intellectual disabilities. Yet just 0.06 per cent of India's federal health budget is devoted to mental health and available data suggests that state spending is similarly negligible (Human Rights Watch, 2014).

The 2011 Census estimates that only 2.21 per cent of the Indian population have disabilities—including 1.5 million people (0.1 per cent of the population) with intellectual disabilities and a mere 7,22,826 people (0.05 per cent of the population) with psycho-social disabilities (such as schizophrenia or bipolar condition). The Indian Ministry of Health and Family Welfare claims a much higher percentage of the Indian population is affected by psycho-social disabilities with 6–7 per cent (74.2–86.5 million) affected by mental disorders'and 1–2 per cent (12.4–24.7 million) by 'serious mental disorders'. The disaggregation of data on persons with disabilities is limited to types of disabilities and gender but does not extend to other categories.

Out of the total population of disabled people 44 per cent are women with disabilities. Intellectually disabled women constitute around 42 per cent of the total population of people with intellectual disabilities. For psycho-social disabilities also the figure is similar, 42 per cent women as per census 2011.

Women with disabilities go through different kinds of violence at home as well as outside. They become more vulnerable to violence as often they are often dependent physically, socially, and emotionally on others; this dependency can enhance their vulnerability. Majority of them remain silent because either they fail to realize that they are victims or they fail to communicate the act of violence.

The kinds of violence which women with disabilities face range from physical abuse due to rough handling during transportation, sexual abuse whenever they are forced into sexual activities in return for help or being left naked or exposed, emotional abuse which may include threats of abandonment, and financial abuse when it includes burden of demand of the personal assistance providers. Refusal of assistance often becomes life-threatening to them (Curry and Navarro, 2002). Nosek et al. (2001) found that educated women with disabilities have a higher likelihood of experiencing violence It is also found that younger women with disabilities are more physically abused than older women (Nosek et al., 2001). Moreover, it is evident from the research that in comparison with women who are not abused, women abused by an intimate partner are more likely to be disabled or have an illness (Collins et al., 1999 cf. Smith, 2008).

Another form of discrimination that women with disabilities face is that of being considered asexual. Such an assumption related to the sexuality of women with disabilities is often the root of their abuse from their extended family or neighbourhood. Though girls are allowed to interact with their male cousins in North Indian Punjabi culture, they are not allowed to sleep in the same room. Whereas, such prohibitions may not be found in case of the disabled girls as they are assumed sexually safe or asexual as Ghai (2002) asserts in her personal narrative. In most of the cases women with disabilities are victimized by known persons. This occurs because of their dependency on the caregivers. Irrespective of gender, persons with disabilities are mostly socialized into dependence, requiring constant monitoring or supervision. They are usually too overprotected to take care of themselves or to think independently and for the women it becomes more. Such dependence makes the women with disabilities more vulnerable (Copel, 2006, cf. Powers et al., 2009).

In India, protection, support, and gender-sensitive services for women and girls with psycho-social or intellectual disabilities are largely absent (Human Rights Watch, 2014). Families are found to shield and protect persons with disabilities. It is found that widows and women with disabilities with mental retardation are more vulnerable (UNDP, 2007). The categories are created by the state and society in order to manage that difference between the iniquitous powers that resist the voices of the disabled person (Tomlinson, 1982 cited in Mehrotra and Vaidya, 2008). It is evident that research related with sexual abuse either ignores disability or hardly recognize the sexual abuse of women with disability. Since women with disabilities are heterogeneous population hence generalizations about their risk for sexual abuse can be questionable.

Intellectually disabled women face a double discrimination—the stigma of the intellectual impairment combines with rigid stereotypes of femininity to exacerbate their life situation (Mehrotra and Vaidya, 2008). Although in recent years there has been a paradigm shift in giving importance to the rights of the disabled persons, for the persons with psycho-social disabilities it is difficult to be considered at par with others due to excessive stigmatization (Addlakha and Saptarshi, 2009). In spite of the difficulties arising out of stigma and labeling, a range of academic perspectives, medical and technological advances, and social movements have influenced notions of intellectual disabilities (Mehrotra and Vaidya, 2008). Parent-run organizations and mental health groups have highlighted these issues within disability rights movement, leading to voices being raised against their violence.

Violence against Women with Disabilities

This section presents information about violence against women gathered from various sources. An attempt is being made to present an overview of the kind of data available from various sources. This is important as there is very little research related to the issues of violence against disabled women. They are silenced partly because of the stigma and partly because of difficulties in communication. One of the biggest barriers is the lack of trained personnel who can communicate effectively with disabled women. This is true of professionals who directly work with this group as well. Juvva (2015) argues that degree programmes in social work have not paid adequate attention to equipping social work students with relevant and specialized knowledge, critical perspectives, and attitudes and skills in working with people with disability using the social model and the rights-based frameworks.

Studies show that persons with disabilities are victims of abuse on a far greater scale than persons without disabilities (European Disability Forum, 1999). In one study, 40 per cent of the 245 women with disabilities interviewed had experienced abuse. Twelve per cent of them had been raped. However, less than half of these incidents were reported. Another study found that 25 of 31 interviewed women with disabilities reported abuse of some kind (emotional, sexual, or physical) (Young et al., 1997). Women with disabilities experience a wider range of violence: by personal attendants (emotional, physical, and sexual abuse) and by health care providers (emotional and sexual abuse), as well as higher rates of emotional abuse both by strangers and other family members (Young et al., 1997 cited in Nixon, 2009). A study among children and adults with disabilities living at home revealed that at least 50 per cent were traumatized by sexual, physical, verbal, and other severe and often repeated abuse (Helander, 2004).

Women with disabilities in particular tend to be more vulnerable to exploitation of various kinds, such as sexual harassment, domestic violence, and exploitation in the workplace (*Human Development Report*, Geneva, 1995). Women with disabilities also tend to be relatively easy targets of sexual exploitation, particularly if they are intellectually disabled. In general, women with disabilities tend to be in a state of physical, social, and economic dependency. This can lead to increased vulnerability to exploitation and violence (Thomas and Thomas, 2010). Although prevalence of violence against women has been

well documented, the same cannot be said for figures related to violence against women with disabilities. Most studies report that there are few studies that report on violence against women with disabilities (Mohapatra and Mohanty, 2004). Mehrotra (2006) reports on neglect and deliberate malnutrition of young girls and increased incidence of domestic abuse of rural women in case of acquisition of impairments at a later age. Violence against women and girls with disabilities is not just a subset of gender-based violence: it is an intersectional category dealing with gender-based and disability-based violence. The confluence of these two factors results in an extremely high risk of violence against women with disabilities (INWWD, 2010).

For women with intellectual and psycho-social disabilities, the scope of violence increases. The different kinds of abuse they face include forced abortion and sterilization, forced psychiatric interventions, involuntary commitment to institutions, and forced or 'unmodified' electroshock (electro-convulsive therapy or ECT) (Minkowitz, 2007). Deprivation of the legal capacity to make one's own decisions facilitates coerced treatments and violence of all kinds, and may constitute torture and ill-treatment in itself, as it can amount to a denial of full personhood (OHCHR). Though the Mental Health Act (MHA), 1987, and the Mental Health Care bill have talked about 'rights' of people with mental illness and about the protection and promotion of the rights of the mentally ill patients in the community for their dignified life but in practical it is hardly practised. Though notion of mental illness always understood from medical aspect especially associated to psychiatric labelling determined by law (Dhanda, 2000 cited in Davar, 2013) and imbued with negative social consequences (Davar, 2013). It is argued by Dhanda (2000) that primary concern of legislations is to devise mechanisms to manage what are believed to be the disruptive consequences of mental disorder. The Rights of Persons with Disability Bill 2012 brings about reforms both in private and public sphere. It enabled women with mental disabilities to exercise legal capacity either through themselves or with other support. But in the private sphere personal laws continue to hold sway (Thomas, 2013).

Women labelled with psycho-social disabilities are likely to be silenced and ignored when speaking out or attempting to defend themselves, particularly when the violence is authorized by law or committed in a context where the woman is deprived of her legal capacity and/or freedom. These women and the forms of violence practised against them are also likely to be ignored in studies of violence against women with disabilities (INWWD, 2010). Denial of legal capacity can and often does lead to extreme discrimination can cause severe suffering. Valliappan (2015: 7) states, 'It is not possible for someone like me to receive education, employment, marriage, hold an office or sign any documents according to the Contract Law. The Hindu Marriage Act considers someone like me of *unsound mind* irrespective whether I am someone who can function in daily life.' This denial of personhood and identity is evident in the examples given in the next two sections which give an idea about violence faced within homes as well as in institutions.

(a) Institution-based Violence

Within institutional settings, disabled women are subjected to numerous forms of violence, including the forced intake of psychotropic drugs, or other forced psychiatric treatment. Furthermore, forced institutionalization itself constitutes a form of violence. People with mental health conditions and intellectual disabilities are sometimes subject to arbitrary detention in long-stay institutions with no right of appeal, thereby robbing them of their legal capacity (Adams, 2008; Agnetti, 2008). Conditions within institutions are also very poor. The report by Human Rights Watch 2014 found that in 12 of the 24 institutions visited, residents or staff exploited women and girls with psycho-social or intellectual disabilities, forcing them to cook, clean toilets, or bathe other women with more severe disabilities. In the course of its visits to institutions, Human Rights Watch found 12 cases of verbal, 38 of physical, and four of sexual violence against women and girls with psycho-social or intellectual disabilities.

Some examples of violence within institutions are given in Boxes 10.1, 10.2, and 10.3.

The Special Rapporteur in 2005 focused on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, focused on the right to health of persons with mental disabilities and found that women with intellectual disabilities were especially vulnerable to forced sterilization and sexual violence.

Not only are the women vulnerable to abuse they also do not have many avenues to seek help. Women with psycho-social or intellectual disabilities told Human Rights Watch that they seldom report abuse against caretakers and fellow residents for fear of the repercussions. In the 24 institutions and hospitals Human Rights Watch visited in 2013, there were no adequate mechanisms to report abuse. The only existing mechanism in some

Box 10.1 Forced Institutionalization

Human Rights Watch interviewed 52 women and girls with psycho-social or intellectual disabilities who were admitted in institutions without their consent. Once the police identify the women in the road or public place is dangerous for others or the women are incapable to take care of themselves, they get the women admitted to these institutions through court orders where they usually have no real possibility of appeal.

In mental hospital of Ranchi, Jharkhand the female to male ratio at the time of admission is 29 per cent to 71 per cent; the long stay patients are predominantly women: 67 per cent women as compared to 33 per cent men.

Source: WWDIN, 2013

Box 10.2 Invasive Medical Procedures

In 1994, forced hysterectomies were conducted on several women with intellectual disabilities between the ages of 18 to 35 at the Sassoon General Hospital in Pune. The hospital authority explained that those women were incapable of maintaining menstrual hygiene. Moreover for the hospital staff it was straining on their resources and time (Badjena, 2014).

Box 10.3 Sexual Abuse

A 19 year old girl was raped at a Nari Niketan in Chandigarh. Her pregnancy was detected after shifting to another shelter home. On the basis of an opinion from a medical board that diagnosed her to be mildly mentally retarded the Chandigarh administration then filed a P.I.L. to terminate her pregnancy. As a girl with intellectual disabilities she had lost her right to motherhood because it was assumed that she would not be able to take care of a child.

Thirty-five of the 68 women and girls Human Rights Watch interviewed had either experienced sexual violence or had multiple partners. However, unless they were previously involved in sex work, staff in 15 institutions told Human Rights Watch that women and girls with psycho-social or intellectual disabilities living in institutions do not have information about or access to testing and treatment for HIV/AIDS and other sexually transmitted diseases (Human Rights Watch, 2014).

institutions was to report abuse to the institution's staff, which does not constitute an independent mechanism, as staff themselves were often the perpetrators of the abuse. Most of these women come from poor background and often have little social support.

(b) Violence within the domestic context

Incest is very common in India. Sexual abuse being very common girls and women with disabilities is the easy prey for the exploitation within the family. These issues are not discussed in public. Intellectually disabled women often face social exclusion (Rao, 2004). A mother of a 32-year-old woman with an intellectual disability reported how she has not told her extended family about her daughter's disability, 'In our family, no one knows about her' (Human Rights Watch, 2014). One of the recent cases which appeared in the papers of a man from Thane who murdered his entire family one night; the surviving sister reported how he had been sexually abusing their sister who had mental health issues (*Mumbai Mirror*, 2016).

One way of exclusion is the denial of opportunities. In Arpan School for Mentally Retarded in Rohtak, Haryana, out of the 150 students, 120 are boys. It was found that girls with disabilities are rarely sent to acquire any education and training on account of the double jeopardy faced by them, that is, depreciated for being female in a highly patriarchal society and further devalued on account of being disabled. Many girls with disabilities are subject to absolute neglect by their families in the hope that they will die (Mehrotra and Vaidya, 2008: 328).

In the study in Odisha by Mohapatra and Mohanty (2004) it was found that intellectually disabled girls and women were often isolated in their own homes only 40 per cent of them were given the opportunity of family dining. Only 42 per cent of respondents take bath on a daily basis, 38 per cent comb their hair and 43 per cent

change clothes daily is a grim reflector of the apathy with which they are treated. A serious concern is lack of use of toilet both for bathing and other activities (19 per cent use toilets). This provides a threatened environment which can provide easy access for both physical and sexual abuse.

It was also found that 48.5 per cent women with intellectual disabilities reported being beaten at home. Sixty-two per cent of them said that they did not resist being beaten at home. Researchers found when they changed the format of the question that actually all the women were being beaten at home often for no or minor mistakes. Twenty-five per cent reported rape and 19 per cent being pinched, 21.6 per cent reported forced sex by a family member, many of them had not reported it. Around 61 per cent said that family members pretended that it had never happened. Eight per cent of the women also reported being forcibly sterilized (16). High incidence of sexual abuse within families which is known and often hidden is also evident. The large demand of parents of intellectually disabled daughters for compulsory sterilization brings out this issue (Rao, 2004).

A report by WWDIN (2013) gives several examples of intellectually disabled girls being abused at home. The report presents the case of one girl who was abandoned by her family. She was pregnant because of being raped; her family forcibly took her child and abandoned her. In another incident a 21-year-old was found to be five months pregnant, and it was also found that she had been raped by her father.

There is a loss of personhood for disabled women who are isolated; often not given opportunities to learn to be independent and protect themselves. In addition they have no control over their bodies and no scope for making decisions about themselves. Forced sterilizations bring out the manner in which both within the institution and within the home women have no control over their sexual and reproductive choices. Families often do not allow women to make decisions. There are very few ethnographic works available on these issues therefore generalizations are difficult to make. Social location often determines the life chances and protection against violence for women with intellectual and psycho-social disabilities.

From the above mentioned examples it can be seen that violence against disabled women is sustained at a structural level. The violence which is often very apparent and visible is rendered invisible by the status accorded to disabled women. In Goffman's terms (1963) they are 'discredited' as individuals and hence invisible. This happens even when women's 'symptoms' are exacerbated by the structural violence they face. In the doctoral work done by Nayar (2012), based in Jahangirpuri, there were several narratives in which the psycho-social disability in women was exacerbated by structural violence. This was evident through the narrative of Suraiya, a 45-year-old Muslim woman's description of her symptoms.

> We feel scared because a few days back, police came and took all the young men. We said that they were innocent—police said that they would release them after questioning—but this puts a fear in our mind. I get headaches when so many women are talking, heart starts beating, and feel dizzy. Everyone has problems but when I go out I get tense. When I go to my daughter's place I take auto although it costs Rs100 for one side but I can't take bus or metro; I feel very tense—I feel something will happen to me. So I don't go anywhere, I have been taking medicines for a long time—have gone to several doctors. I have been married for 30 years and my oldest son in 24. My husband used to drink from the beginning–never did regular work-I used to segregate garbage or make papads. I had to bring up children on my own-now older son helps—gives me Rs150 when he can—I don't ask for more I can't.
>
> I went through full X-ray but nothing came out—doctor told me that my problem is *chinta* (worrying)—it affects my body but what to do? Have to give money to my married daughters, their husbands ask for money—1000, 1500, than there is my 13 year old daughter too; have to save for her too. I keep thinking about that–heart beats faster, sweat–sometimes I sit quietly when I am worried. As long as husband is not drinking—I am happy—my body feels light. Even if he drinks and then sits quietly I don't mind but he talks too much, laughs—I don't like it. Then I fight—he never hits me just becomes loud.

Suriaya had been on medication for a long time with no improvement. Her status in society as a low income Muslim woman made her vulnerable to violence. Women who have received a diagnosis such as schizophrenia face different kinds of violence. One of which includes social isolation of the woman and her family. Satwanti whose daughter had been diagnosed with schizophrenia, explained how everything that went wrong in the neighbourhood was blamed on her daughter forcing her to change houses frequently. This violence which often leads to and sustains disability in women in society is reflected in other studies as well. Addlakha (2001) describes the narrative of Pushpa who had received the diagnosis of undifferentiated chronic schizophrenia. Pushpa's symptoms are considered to be severe because

she does not 'perform' the normative role of a housewife in a middle class urban family. This includes her inability to have a child, arguments with the mother-in-law, speaking out in public, spending on useless items without taking into account her husband's needs and her duty towards the conjugal home. She is wilful and obstinate. According to Addlakha (2001: 323), Pushpa's refusal to perform her designated role as an average housewife is re-labelled as 'abnormal'and 'ill or mad'. For Pushpa her difficulties have arisen because of a difficult marriage. Pushpa remains in the ward for three months. Through this narrative Addlakha brings out how in the present form psychiatric treatment in a medical setting goes against the interests of female patients. Gender and class related biases in which the mental health personnel have been socialized prevent them from recognizing the ways in which they can discriminate against female patients (Addlakha, 2001: 332).

Social class intersecting with gender and disability makes women more vulnerable to violence. Violence against disabled women often gets normalized because of stigma they face. This is evident in the narratives above where the actual experience of the women is considered unimportant and emphasis is on the manner in which they are perceived. In rural areas mental illness is not seen as disability as Mehrotra reports (2006) from Haryana. She cites cases of women with mild and moderate mental disability being married off as other women. They set up families and also have children. They face relatively less exclusion in relatively well-knit communities.

In the literature reviewed, case studies of violence were found but there was very little evidence on the response of the state and other organizations in dealing with this violence. Most of the violence went unreported. There was a need to understand what factors prevented reporting of these crimes. And the response of different institutions to deal with violence against disabled women.

SYSTEMIC RESPONSES

While reviewing secondary data to learn about statistics related to violence against disabled women it was found that there was no such data available with the National Crime Records Bureau. In NFHS 3 violence amongst women has been studied in the categories of age, residence, education, employment, residence, religion, wealth index, marital status, household structure, caste/tribe but not disability. In a report by CREA on marginalized women—disability has been defined as physical or sensory and hence violence against women with intellectual and psycho-social disabilities was not measured. Disabled women have been left out of most research because of difficulties in understanding the nature of disabilities and communication issues.

C.R. Park Police Station

Initially RA had some difficulty in explaining what she meant by disability. She was told that the record of violence against women was quite less because people belong to higher income groups in this area and therefore the complaints about violence against women are rare. In the police station, RA was told that the police had registered two cases of rape, six cases of domestic violence and 21 cases of molestations in the year of 2015. All these were registered either by the outsiders or by those women who are working in C.R. Park mainly as domestic workers. The inspector explained that there was no system of keeping any record of the victims on the basis of their identity; disability is never mentioned in their record. It was also found that officers in the department of record room were not acquainted with the term disability. For their better understanding some common terms used in Hindi (such as viklang) had to be used.

The staff at the C.R. Park police station suggested that the researcher should contact the Crime against Women Cell in Vikaspuri as many complaints of domestic violence got registered there. She was told that in Vikaspuri people from different socio-economic backgrounds were living, many of them were from middle to low income groups and hence more cases were registered there. The suggestions and comments of the staff revealed the existing stereotypes about violence—that it occurs more amongst people from low to middle income categories only. Disability did not figure in the understanding of the system.

Crime against Women Cell, Vikaspuri

It was found that most of the cases registered there were related with dowry and out-of-marriage relationships. Both the ACP and Inspector said that since the beginning of their service they had not registered any complaints from disabled women.

They also said that if ever any initiatives were taken to record disabilities, the record would be based on visible disabilities only and the unseen disabilities could not be registered. This was because they felt that asking questions about the disability would be 'embarrassing.' In addition they have also mentioned that there is no system to record the identity of the victim according to their ability/disability.

From Vikaspuri, the researcher was asked to go to the Nanakpura women cell which was the head quarters of Crime against Women Cell.

Crime against Women Cell, Nanakpura

The senior inspector explained that she had registered only one case of domestic violence from a woman with speech and hearing impairment during her service period (which has been more than 20 years).

The senior officer shared that although while talking to some women she felt that there was a 'mental disorder', she never considered referring the women for several reasons. First, she herself was not trained to know exactly what she was dealing with, secondly she felt that families would not like it if she said that they needed a referral, also recording this might weaken the case of women.

After receiving almost no information (no records) about violence against women with intellectual and psycho-social disabilities from police station and crime against women cells in the city, the researcher was then directed to the National Commission for Women. The experience here was not very different.

National Commission for Women

On asking for the records related to violence against women with disabilities from the Deputy Secretary the R.A was told

All complaints are recorded on basis of violence, people complain against certain organizations or institutes who are troubling them. Complaints are also taken from the women who are non residential Indians. Complaints are only taken from women against men. Since it is the National Commission for Women, the complaint against woman from any woman is taken but man has no right to make a complaint to us. It is important to keep a record of violence against disabled women but so far we have no records. Most of the complaints are on the phone where only the name, address and type of violence is recorded. There is no way of knowing whether the caller was disabled or not. Disaggregated data is not collected.

Although initially the deputy director said that they may be able to give the R.A. access to some records; later they said that none were available.

The National Crime Record Bureau was the next place that the researcher visited. There were no records about violence against women with disabilities on their website so the researcher wanted to find out if they had any system of collecting data for disabled women.

National Crime Record Bureau

Junior Staff Officer at the NCRB explained

There is no system of maintaining detailed record of crime on the basis of disability. There are different records related to crime committed against women on different types of rape, kidnapping and abduction; assault on women that outrage their modesty as well as records on the status of the disposal of crime against women and various other records. But nor records have been kept on the basis of disability or of any disability resulting from violence. There is only the provision of keeping records according to the age of the girls and women who are raped and the relationship of the offender with the victim. From 2017 certain records will be easily available from our department.

Most of the interactions that she had in the police station and crime against women cell were after promising anonymity, no one wanted to be quoted on this subject. Initially they were reluctant to talk to the RA but once they were promised confidentiality they were ready to share information.

In every place the RA visited, the response from the service providers indicated lack of preparedness to work with disabled women especially those with intellectual and psychosocial disabilities. It appeared that questions about violence against disabled women had never occurred to them or had not been given much attention in the system to which they belonged.

Human Rights Law Network

The experience was somewhat different in the Human Rights Law Network (HRLN). The RA spoke to one of the law officers there. She was informed that although rate of crime against disabled women is high due to the lack of awareness and lack of confidence of the victim and her family members the complaints are not usually registered. There is a provision for assistance when they lodge a complaint, during the hearing and to provide them help to register the crime, such initiatives are not in practice. The law officer also pointed out that the within the police system investigating officers were reluctant to proceed in cases related to disabled women. She explained that since police officers were not trained to work with disabled women; they found the process of recording the complaint very time consuming. It has also come to their notice that in case of the women with psycho-social disabilities, complaints cannot be recorded in a proper manner as the woman is not able to give the details of the crime in the same way repeatedly. All this leads to refusal to register a case by the police citing different reasons like jurisdiction issues.

Though Justice Verma Committee recommended the assistance of interpreters or special educators at the time of recording the complaint by the police and also during the trial but in practice this is not very promising. It is important to address the difficulties of the disabled women in accessing the legal system and navigating through the trial process.

On the other hand the legal officer has also mentioned about the harassment that disabled women face in their families. According to her, parents usually try to hide such cases to maintain their family honour as well as to avoid the harassment in the society. She also explained that women with psycho-social and intellectual disabilities were not given any sex education or taught any ways of self protection. Mostly intellectually disabled women are unaware of their own body. She also emphasized the importance of raising awareness in the community about intellectual and psycho-social disabilities.

The Criminal Law (Amendments) Act, 2013, states that when a sexual offence takes place against a disabled girl, the complaint would be recorded at home or wherever she is most comfortable. Help of sign language interpreters, social workers can be taken. Entire process shall be videographed (Section 154). But as pointed out by the law officer of HRLN this is not functional in practice.

From the interviews it was evident that knowledge and sensitivity to the issues faced by women with intellectual and psycho-social disabilities was minimal in all the government systems (police, crime against women cells, NCW, and NCRB). The word 'handicapped' was the term being used in all these places. The understanding about the nature of these disabilities was in itself problematic as they were seen as incompetent and unreliable. They were also not considered important enough to warrant a lot of time and attention. Hence, the difficulty the researcher had in being able to interview anyone. In contrast to this the NGO was fully aware about the issues and the law officer brought out many nuances of the situation of girls within the household as well.

In the court proceedings as well disabled are not given the same status. Mandal (2013) argues that the legal process often undermines and devalues the testimony of the disabled prosecutrix. This is done by in various ways—not recording the testimony of the prosecutrix at all; recording her testimony without following the correct legal procedure, which renders such testimony ineffectual for the purpose of law; recording her testimony in the legally valid manner, but dismissing it eventually for its lack of 'intelligibility'; recording her testimony in the legally valid manner, but dismissing it eventually for not being consistent with the evidence borne by her body. He argues that often the rape accused was acquitted because of non-recording of testimony of the prosecutrix in the legally valid manner and the lack of any supportive evidence from medical examination (Mandal, 2013: 11). According to him, in order to ensure justice for disabled women it is important that their testimonies be regarded as relevant and recorded as per the Indian Evidence Act. He further states that the legal process marginalizes the non-verbal thus undermining the testimony of the disabled witness (Mandal, 2013: 23). Since, it is through non-verbal (gestures, movements, and interpreters) that disabled women communicate marginalizing the non–verbal reduces the likelihood of justice being served.

The systemic responses emphasize the necessity of disabled and women's movement to intervene and advocate for the rights of disabled women. The next section focuses on the response of the disability rights movement and civil society in order to ensure rights for disabled women.

Violence Against Women with Disabilities and Civil Society Responses.

There are hierarchies among women who face violence, and there are hierarchies among the disabled population as well. In both of these hierarchies, women with psycho-social and intellectual disabilities appear to be at the lowest priority. Disability legislation adopts a gendered approach, with the result that out of twenty-eight chapters outlining various issues, not a single one addresses the problems of disabled women (Ghai, 2002: 53). Being ignored by the feminist movement meant the reinforcement of the construction of disabled women as being outside the hegemony of 'normalcy'. This reduced their chances of becoming a part of the political movements (Ghai, 2002: 58). For women with disabilities, their issues needed to be voiced within the ambit of the women's movement or disability rights movement. However, their voices were lost within both these groups.

Women with psycho-social disabilities faced a more difficult problem of not being adequately represented by any group. This was alleviated to a certain extent through the changed use of language. As Davar (2008) has argued moving from the language of mental illness to the language of disability helped the women to normalize their experience. This also allowed them to be a part of the disabled women's groups which were attempting to carve out a niche for themselves. However, it has been seen that issues of disabled women are inadequately represented.

The history of the Indian women's movement has been one with a focus on poverty, caste, and employment; social issues such as dowry and sati; population control and female foeticide; and sexuality and domestic violence. Its agenda did not include disability. Critical feminist analysis of disability in India was initiated by, among others, Addlakha (2006, 2005, 2001, 1999, 1998), Addlakha and Das (2001), Bhargavi Davar (1999), Dhanda (2000), Ghai, (2002, 2002), and Hans (Hans and Patri, 2003), Mehrotra (2006, 2008, 2011, 2015), Nayar (2015).

These feminist scholars challenged both the disability movement and the women's movement for their lack of focus on disabled women (CREA, 2012: 56–7).

Till the 1990s, only persons and groups with physical disabilities tended to constitute the disability rights groups and those with mental and developmental disabilities were largely left out as these impairments were considered to have their own special issues, which were largely medical in nature (Mehrotra, 2011: 67). In addition, within disabled women's organizations the focus seems to be on organizing and advocating for women with physical or visual disabilities. There is very little attention paid to women with other disabilities such as women with mental retardation, cerebral palsy, and mental illness even to the point of lack of access to these organizations (Rao, 2004). This ensures that their position remains extremely vulnerable as they become more dependent on their family. As seen in the earlier section if the family itself is oppressive, women are left with very few choices and end up living in abusive situations.

Another reason for their vulnerability is that in India a person with a psycho-social or intellectual disability may be deprived of the right to exercise legal capacity in India in three main ways: (1) if he or she is declared to be of 'unsound mind' by a competent court; (2) if parents assume de facto guardianship following a medical diagnosis; or (3) upon a request made for guardianship to a committee set up by the Board of the National Trust, a body set up under the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999. Laws depriving legal capacity violate India's obligations under the Convention on the Rights of Persons with Disabilities (CRPD), which grants legal capacity to all persons with disabilities on equal basis with others.

It is not that disabled women are missing only from the vocabulary of the government. Even in reports and services of civil society organizations there is a difference. In case of sexual abuse against women with disabilities there are few facilities available. For example in a report by Human Rights Watch, 2013 regarding child sexual abuse in India there is no mention of the vulnerability of children with disabilities. In addition while going through websites of organizations working on the issue of child sexual abuse it was found that many of them do not cater to the needs of disabled children. Many of the homes for sexually abused girls do not take in girls with disabilities because of lack of infrastructure and human resources to meet their needs (example Advait foundation). These examples depict how even the nongovernment organizations are not able to provide adequate services to women with disabilities.

From aforesaid discussion it can be inferred that women with psycho-social and intellectual disabilities face structural marginalization. Their rights are often violated with poor scope for any kind of justice as they are simply 'not counted'. Valliappan (2015) describes the need for reasonable accommodation for people with psycho-social disabilities. Valliappan gives an example of reasonable accommodation through her experience of attending a conference. She describes that she is someone who hears voices, this can often lead to restlessness. In one of the conferences she was given the flexibility to stand outside the room while listening to the speakers, she could sketch if she wanted to. She was given a space to sit so that she could move around without disturbing other people around her. If she did not want to have verbal communication—she was given the option of writing and communicating (2015: 8). Similarly, there is a need for reasonable accommodation for other disabled women who would have different kinds of needs depending on the nature of disability or impairment and also in relation to their social location. To a certain extent, this kind of reasonable accommodation can be seen in the work done by Banyan in Chennai. They make different kinds of rehabilitation plans for disabled women. They provide residential care for women with psychosocial disabilities (socio-medical model) and help them to return home by locating their families. Some of the women are given vocational training; others who are not able to return home are rehabilitated through a community living project; the residents work and support each other over there. Disabled women have different kinds of needs and therefore different facilities/accommodation has to be provided depending on their needs.

To ensure visibility for disabled women the following steps are required:

Increasing understanding of gender and disability interface and raising awareness among families and

communities comes first. This would mean working with families and societies to reduce the stigma faced by this group. Stigma often results from the complicated process of 'othering' wherein disabled women are viewed as a group which is widely different and therefore to include them in the everyday lives of non-disabled seems extremely difficult. It also results from negative and misinformed portrayals in the media (T.V, films, print media). This process of 'othering' results in further isolation of disabled women. Physical, emotional, and social isolation leads to violation of their basic rights. These violations can be evident in instances like police men avoiding registering cases of disabled women because they find the process time-consuming and are not sure of their testimonies. Thus, it becomes important to sensitize and raise awareness amongst different groups including families, medical personnel, legal systems (police, lawyers, and judges), administrators, and policy-makers.

Introducing disability studies perspectives in curriculum and pedagogy is important to highlight the marginalization of disabled women. Disabled women have been missing from academics and from women's movement as well as from the disability movement. It is important for not only their issues to gain visibility but to increase their presence in both the women's and disability movement. Therefore, there is a need to increase the presence of disabled women in public arenas which would enable 'others' to interact with them and see their 'real' selves rather than relying on stereotypes and myths. An intersectional approach would go a long way in identifying specific types of violence women belonging to different social locations encounter.

Other concrete suggestions are as follows

- There should be provision of spaces where women are allowed to heal/express their feelings. Design counseling services catering to the needs of disabled women. This would mean trained personnel who have the requisite communication skills. In addition to that the centers should have special educators as well who can work with the women.
- Opinions of intellectually disabled women should be taken in formulating policies for them. Studies have been conducted with them using the technique of one to one interview with women with good communication skills (example Taggart et al., 2009). These studies show that it is possible to ensure that voices of intellectually disabled women can also be included in formulation of policies for them.
- Police officers should be trained and sensitized at the station house, which is the first place where complaints are registered.
- Disability has to be an important module in legal teaching to sensitize the lawyers and judges.
- Adequate mechanisms in hospitals should be created to report abuse. There should be clear instructions for the hospital staff about steps to be taken when issue of abuse of disabled women comes up. If there are clear mechanisms present services would become more accessible to disabled women.
- The recommendation of the Justice Verma Committee, which states that when complaints are lodged then special educators should be present when required, should be implemented.
- Proper sex education should be provided to disabled women.
- Self protection strategies (which include recognition of good touch–bad touch) must be taught in schools or organizations working with disabled girls/women.
- Allocation of adequate budgetary resources is required to create and sustain facilities for disabled women and their families.

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11

Custody, Conflict, and Psycho-social Wellbeing

Bihar and Kashmir

Kriti Sharma

Outside the public gaze, discrimination, violence, and denial of rights are routine occurrences for psycho-socially disabled persons (PSDPs) in state custody, irrespective of location—be it shelter homes, hospitals, detention centres, or prisons. Institutionalization places PSDPs in a precarious position, robbing them of fundamental freedoms and rights as it squares PSDPs as medico-legal subjects of the state. This chapter highlights the coercive laws and practices prevalent in state institutions in Bihar and Kashmir, which further reinforce the stigmas stemming from their socio-economic condition and disability. It is pertinent to mention here that the usage of the term psycho-social disability is based on the understanding of the shift from colonial medical-legal paradigm which incapacitates and institutionalizes Persons with Disabilities (PWDs), to an evolving international human rights conceptualization that 'disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others' as recognized in the Preamble to the United Nations Convention on Right of Persons with Disabilities, 2007 (UNCRPD). In this regard, PSD denotes a range of disabilities arising out of one's psychological development in, and interaction with, a social environment, a broadened concept, which labels such as 'mental illness' and 'lunacy' fail to capture. With the introduction of the Rights of Persons with Disabilities Bill, 2014, and the Mental Health Care Bill, 2013, there is an increasing consensus on overhauling the medico-legal paradigm in line with the UNCRPD, and in this context the colonial prison laws and state mental health models too require immediate reconsideration.

Pychosocial disabilities arising out of social environment marred by deep-rooted armed and social conflicts in Kashmir and Bihar, respectively have hitherto received inadequate state attention. In conflict ridden Kashmir and around eleven districts of Bihar 'under left-wing extremism', a complex web of violent actors: factions of insurgents, military, paramilitary and police, pro-state militias (*Ikhwan* or *Salwa Judum*), terrorists, and village defence councils, play out in day to day lives of the civilians. The nexus of armed conflict with other crimes such as sales of narcotics and small arms, kidnapping, ransoms, and assassinations add to the direct physical and psychological violence. The culture of violence, also affects the society and domestic violence, suicides or abuses increase, disproportionately affecting the women. Violent crimes induce 'a sense of insecurity and fear in the community'[1] and comprise of crimes related to body, property, public safety and women. These offences have a high occurrence rate in all armed conflict embroiled states in India, including Jammu and Kashmir at 30.6 (per lakh) in comparison to 26.6 at the national level[2] ('National Crime Records Bureau 2014: 60 hereafter NCRB 2014: 60). It still does not account for atrocities being committed by the armed forces due to culture of impunity (particularly under Armed Forces Special Powers Act, 1990) and a weak rule of law, which provides little succour to victims of extra-judicial killings, forced disappearances, rape, sexual assaults, and armed 'cleansing' operations.

In Kashmir as a result, there has been a 20-fold increase in psycho-social disabilities in the last few decades according to *Medicins Sans Frontiers*, the lone international organization providing psychological counselling in the valley where more than one lakh patients receive treatment

annually (PSDs sufferers also include stationed soldiers and militants) reporting mainly trauma, depression, somatization, and addictions. Yet this connection between armed conflict and psycho-social disabilities has received little attention from centre and state health departments. Even in the limited health budget (mere 2 per cent in J&K), focus is on centralized schemes and policies, which do not take cognizance of these disabilities; and with only six empaneled psychiatrists at district hospital level, the state is unable to provide extensive outreach to PSD sufferers across the valley. Tellingly, there is no state mental health policy in place and only certain disabilities are categorized to receive state support such as body mutilation, that is, 'handicapped' or 'mental retardation' conditional on the civilian's onus and ability to prove to the state that he/she does not have link with militants. On the other hand, continuous presence of military not only exacerbates PSDs, but instances of targeted attacks and torture on PSDPs to frame them as militants or to extract local information are also not unheard of.

Bihar also acutely depicts normalization of caste-based atrocities in the country; and between 2011 and 2015 on average 9596 riots have broken out annually in the state.[3] Most violent crimes such as murder, kidnapping, rape, and dacoity, are intertwined with questions of land disputes, failure of land reforms, payment of minimum wages, alienation of tribal land, bonded labour, indebtedness, etc. The upper-caste violent outfits, including Ranvir Sena (banned), Diamond Sena and Brahmarshi Sena (Bhumihars), Bhumi Sena (Kurmis), Kuar Sena and Sunlight Sena (Rajputs), Lorik Sena, and Kisan Sangh (Yadavs) militate against the attempts by dalit and tribal civilians, as well as violent outfits or naxal groups, to assert land, political, social or economic rights. In the year 2014, 7,874 atrocities under Schedule Caste and Schedule Tribes (Prevention of Atrocities) Act, 1989 were registered in Bihar, next only to the state of Uttar Pradesh. The active or tacit complicity of police, state administration or local judiciary with upper caste groups, results in collective failure of law and order. This is evident starkly through two of the major massacres in the history of independent India Bathani Tola (1996) and Laxmanpur Bathe (1997) where 21 and 58 dalit men, women, and children were brutally killed by members of Ranvir Sena, an occurrence which could not be denied by the courts yet for which not a single person was convicted even after 15–16 years of prolonged judicial trials.[4]

Of course the violence has a two way connection with governance issues and underdevelopment; and Bihar followed by Kashmir are also perceived as the most corrupt states in the country (Transparency International, 2005). In rural Bihar and particularly among the tribal population there is widespread poverty, hunger, and malnutrition (at 6.6 million second highest in the country). Mental health is enmeshed within these economic, social and political concerns. Yet a glance at the public health system reveals that the penetration of Public Health Centres (PHCs) is one of the lowest at 8.9 per lakh as against the country average of 31.8 according to the Bihar State Policy on Disability, 2011. The specialized psychiatric care is not available till the district hospital level and there is acute shortage of psychiatric medicines. The situation is dire in the 'naxal areas' and forests, where it is extremely difficult to provide outreach and PSDs have received little attention. For the 12,70,851 tribal population of Bihar, there are 23 sub-centres as against the required 423, six Public Health Centres instead of mandated 63 and no Community Health Centres exist where the requirement stands at 15.[5] Within the six PHCs there is only one doctor and no specialized doctors, not even a gynaecologist. Thus, the most rudimentary health care is in abysmal condition and no assessment has been made of the extent of psycho-social disabilities in these areas. This is in addition to taboos related to PSDs and greater reliance placed on available faith healers, due to lack of awareness in India.

The conditions of persons in state custody are not divorced from this social reality, as many of the persons in state custody belong to the disadvantaged groups: the tribals, dalits, or the minority. For example, police and judicial custody in preventive detention cases for 'breach of peace or disturb of public tranquility' under Section 106–110 Code of Criminal Procedure, 1973 or J&K Public Safety Act, 1978, is most commonly invoked to harass tribals as 'naxal sympathizers' in Bihar and to quell public dissent in Kashmir.[6] Many PSDPs from disadvantaged and impoverished backgrounds, who are abandoned and abused by society also end up in the custody of the state, and find themselves in involuntary confinement. The state follows the centralized model of mental health care through state psychiatric institutions and homes with low penetration beyond, and it is at this touch-point that I have attempted to capture the relation between state and PSDPs.[7]

Therefore, to assess the conditions of PSDPs in custody, field visits were made to Bihar and Kashmir during the months of October–November, 2015. Interviews were conducted among various stakeholders involved in providing psychiatric services at the prisons, particularly to the Beur Central Jail (BCJ), Patna, and Srinagar Central Jail (SCJ) in Jammu & Kashmir. These include prison

medical staff, along with medical professionals from local government hospitals such as Patna Medical College, Bihar, and JLNM Hospital, Srinagar, Jammu & Kashmir who visit and facilitate treatment inside the central prisons. Mental Health and Allied Sciences, Koelwar, Bihar, and Government Psychiatric Diseases Hospital, Srinagar, Kashmir, are single full-fledged psychiatric institutions in their respective states which provide treatment and admissions to general population, as well as, prisoners across the district. Day-to-day interactions of PSD patients with psychiatrists and psychologists, and treatment of ward patients were observed at these centres. Institutionalized care is provided to PSD men and women here, as well as, at the government homes under the social welfare department, of which one of the largest in Bihar is Gai Ghat After Care and Women's Remand Home, Patna. Therefore, women in conflict with law or categorized as 'mentally retarded' staying at the Gai Ghat Home have been interviewed.

Prison Report: Kashmir and Bihar

Before delineating the issues of PSD prisoners in Bihar and Kashmir, some of whom have been interviewed for this study, it is important to clarify that the terms 'jail' and 'prisons' are used interchangeably in India and convicts and undertrials, who form 68 per cent of all inmates (73 per cent in Bihar) are confined in the same establishment. Given the size of the population, Bihar has 31,295 prisoners across eight divisions totalling to eight central jails, 22 district jails, and 18 sub jails while Jammu and Kashmir has 2,284 prisoners across two central jails, 10 district jails, and 2 sub jails. The maximum security central jails of each state confine high profile cases, foreign detenues, or individuals on trial or convicted for heinous and serious crimes. This includes offences with death penalty, rape, murder, dowry, narcotics, thefts, etc., usually crimes where sentence is of more than 2 years. Most women inmates carry charges for crimes of dowry, theft, or murder. Some prisoners are able to exert more influence inside the jail and avail better facilities based on their economic and social background, particularly and notoriously in Bihar. A sizeable section of the prisons consists of men or women charged with militancy (approximately 10 per cent in SCJ), naxal related activities (approximately 25 per cent BCJ) or caste based violence (numbers unknown). In Kashmir, higher number of political and militancy related prisoners are kept in jails outside the valley, including in Jammu, Punjab, Delhi, and Maharashtra.

Beur Central Jail, Patna, one of the eight central jails in Bihar, has 2200 inmates against the actual capacity of only 1400, of which 2120 are males and 80 are females. Around 300 of these inmates have been convicted and the rest 1900 are under trials. The sheer number of inmates lodged against the capacity leads to higher number of inmates per cell, which pose serious threat to issues of health and sanitation; and remain a matter of grave concern. The three juvenile wards are also situated within the compound though it is extremely detrimental for the young offenders to be confined along with adult convicts and under trials.

The Srinagar Central Jail is the only central jail in Kashmir valley with other one being situated at Kotbhalwal, Jammu. It has 520 inmates against the actual capacity of 300, of which 402 are males and 18 are females. Srinagar Central Jail also has a segregation of general (political and militancy related) and special wing (for serious offences). With a smaller prison population there is tremendous difference in prison accountability at Srinagar Central Jail, as compared to the Beur Central Jail and medical staff is able to track and provide focused care to the lodged inmates.

With regards to juveniles, petitions have been filed in the High Court of J&K on implementation of J&K Juvenile Justice (Care and Protection) Act, 2013, by establishing juvenile justice board and reviewing cases of juveniles confined under preventive detention (in cases of stone pelting, riots, etc) in jails under Public Safety Act, 1978 and Ranbir Penal Code, 1989. However, despite repeated orders for establishment for juvenile justice board by the court, state has not complied yet.[8]

Saheel, from Pattan has been in jail for three to four years. He has been lodged since he was 16–17 years of age on militancy related offence (charges not revealed to author) though he alleges army picked him up. Presently he is suffering from trauma and major depressive disorder. This is after his brother was killed in mysterious circumstances. Now only an aged mother is left with meagre means of living. This has put both the mother and son in precarious position and has led to deterioration in mental health of both.

It should also be recognized that prisons have been traditionally designed for confinement of men, are not gender sensitive and constitute an inappropriate environment for accompanying children.[9] Therefore, the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women as Offenders (The Bangkok Rules), 2010 urge the state governments to provide for suitable alternatives. In context of political prisoners, the account given by Soni Sori, on prison conditions after transfer to jail custody is revelatory:

But it isn't my suffering alone-in this jail, there are other women who are in deep trouble. Like me, they were hunted

and brought here, and then charged in false cases. Now even these people don't need them.....they are pregnant ladies. Women have been raped for months, impregnated and thrown in jail. Armed forces go into villages and get women. They are having deliveries in prison, no one is seeing all this. They have electrocution marks on their bodies, but no one is seeing! In Jagdalpur, Chattisgarh there were 70 tribal women, they never thought they will get out....They (jail authorities) were trying things like this. Like undressing me, trying to prove I am mentally unsound, insane. I thought I will try and lodge FIR from jail. Then who knows what they would do to me? How could I carry on? How would I get out? So decided to keep quiet in jail then as I had no one there.....Lingam (her relative) was told at the entry of jail why he has been brought as he should have been killed in the first instance.[10]

Along with unbearable prison conditions, the Parliamentary Report of 2001 also points out that 'women prisoners suffer from greater disabilities than men. The psychological stress caused by separation from children, the unhelpful attitudes of close relations, uncertainty about the future are all factors which make their life miserable'[11] and lead to psycho-social disabilities particularly depression, anxiety or trauma. Tellingly, NHRC data (2014) reveals that amongst all deaths, the suicide percentage among incarcerated men is 16.12, but for women it stands at 34.60. However, no concrete steps have been undertaken for gender sensitive prison reforms in any state so far.[12]

Accounting for PSDPs in Prisons

At the outset, prisons and lock-ups cannot be accepted as mental health care facilities. Since the 1980s, the Supreme Court has taken cognizance of the 'shocking and disturbing' fact that many psycho-socially disabled persons (PSDPs) languish in jails under the order of 'safe custody and proper treatment'.[13] In 2001, the National Human Rights Commission (NHRC) still found illegally detained non-criminal PSDPs in prisons of ten Indian states NHRC 2001).[14] The acutely suffering PSDPs will continue to be vulnerable as long as they are seen as a 'law and order' issue. Carrying forward from the Indian Lunacy Act 1912, the Mental Health Act 1987 (the Act) seeks to 'protect society' from the 'presence of mentally ill persons' who may be 'dangerous or nuisance'. Under the Act (Section 23) the police has powers 'to take into protection' PSDPs, usually picked from open spaces, for up to 24 hours before production before the Magistrate.[15] Upon Magistrate's order (Section 29) such custody can be extended for up to thirty days before transfer to the hospital. This prerogative of the police to detain PSDPs could entail their stay in lock-ups, fettered with ropes and little medical supervision, or even indictment in false cases:

The case of Matiya–non literate middle aged person from Jargaon, Maharashtra, undertrial for three years in Srinagar Central Jail. 'He was picked up by the police roaming around a bus stop *paglon ki tarah* (like a mad person) at around twelve in the afternoon. Later he found himself in prison as an undertrial for causing fire at Hazratbal Durgah, Srinagar. He says he has no clue even about the occurrence of such fire. When he was taken to the Magistrate he kept on repeating the word "Matiya, Matiya" for all questions, hence we named him Matiya. The Magistrate then asked for his medical examination upon which he was diagnosed with schizophrenia. With medical assistance after months some basic recovery has been possible but all contacts with his family members have failed, therefore we cannot grant him leave from the jail or ask anyone to pursue his case in a proper manner'.[16]

The system is thus open to abuse till the law allows police custody to fill the gap of mental health services. Section 328 (3) CrPc (2008 amendment), which provides for Magistrate to discharge a person of 'unsound mind or mental retardation' against whom there is no *prima facie* case, is a belated and inadequate safeguard. Often magistrates are reluctant to quash proceedings at an early stage, as in the case of Matiya.

Second, for a meaningful discussion on incarcerated PSDPs the state needs to recognize the importance of collecting 'standardized and internationally comparable' method of administrative data collection, a requirement insisted upon by the World Health Organisation (World Report on Disability, 2011).[17] The National Crime Records Bureau (NCRB) data on Prisons, collated through state prisons departments, grossly underestimates the presence of incarcerated PSDPs. The NCRB Prison Statistics, 2014 states there are 5,394 'mentally ill' prisoners (1.3 per cent) out of a total 4,18,536. Bihar reports of only 44 'mentally ill' persons among 31,295 inmates while Jammu and Kashmir has 96 'mentally ill' persons among 2,284 inmates. In comparison, the prison statistics of other countries reflect presence of psycho-social disabilities in 20 per cent to 35 per cent inmates, a 5 per cent to 10 per cent higher prevalence rate than the general population.[18]

To illustrate on how data is undermined, while the officially reported 'mentally ill' persons in Beur Central Prison and Correctional Home are 9, an independent survey by Bihar State Legal Services Authority (BSLA)

mentions *prima facie* at least 29 patients to be PSDPs, in the *Interim Report No. 10: Beur Central Prison and Correctional Home* (2015).[19] Under the final report of BSLA throughout prisons in Bihar, at least 102 persons receive psychiatric treatment (not discounting several others who are unable to access psychiatric help) but in a press statement the Beur Central Jail Superintendent refuted that even these prisoners are merely 'under observation of a team of psychiatrists of the Patna Medical College and Hospital. They do not come under the category of "mentally challenged"'.

The reason for this underreporting is the narrow definition given to 'mental illness' under the state prison manuals (See Section 660 Bihar Prison Manual, 2012)[20] which translates to account for only those who are 'visibly psychotic' and/or qualified to apply for legal defence of insanity. A range of psycho-social disabilities such as depression, post-traumatic stress disorder (PTSD), anxiety, and substance abuse known particularly to prevail amongst prison population do not require statutory recognition and protection. Conversely, these disabilities aggravate in prisons due to discipline and force induced stressors.

For example, an independent study '*Psychiatric Ailments in Inmates of Central Jail Srinagar*' conducted there by local psychiatrists (Malla and Maghroob, 2013) reveals as many as 161/480 (33.06 per cent) prisoners were PSDPs at the given time, even discounting the political prisoners who were not allowed to participate. This study underlined that often the visible mania and psychotic disorders constituted only 2 per cent and 1.8 per cent respectively but major depressive episodes prevailed in 23.5 per cent, PTSD (post traumatic stress disorder) in 4 per cent and other disabilities in 3–4 per cent. Further, 55.7 per cent prisoners carried a history of substance abuse, while 18.7 per cent prisoners had developed morbidity subsequent to incarceration. To gauge the real statistics, the authors conducted surveys through prisoners participation and involvement, along with sustained psychiatric evaluation (Malla and Magroob, 2013; Lateef, 2013). Thus, the results are in stark contrast to the prison records which states that only 38 out of 520 prisoners (7.3 per cent) receive psychiatric treatment in 2015 and 256 have received treatment between 2011–15.

A 2014 NHRC report[21] also brought out that the most prominent reasons for 71 per cent of total unnatural deaths in prisons being due to suicides, include depression and withdrawal symptoms (NHRC, 2014: 3–13). Between 2007 and 2011, on an average 1,518 inmates have committed suicide every year, as reported to state human rights commissions, compared to the conservative report of 1,410 by NCRB prison statistics. This makes prison suicide rate at 16.9 (per lakh) higher than the reported suicide rate in general population of 10.6 (NCRB Accidental Deaths and Suicides in India, 2014). Within this, the female to male suicide ratio continues to remain double, in general population (67.7:32.3) and in prison custody (34.6:16.12) on account of gender burden amidst conflict and poverty.

Right to Health for PSD Prisoners

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)—of which India is a signatory, guarantees Right to health care and services (Article 25) for which reasonable accommodation (Article 5) should be made in the state institutions to ensure the treatment resources and level of care meet the community standards. In view of these obligations, the architectural design of health facilities for PSDs in Indian prisons is outdated, in provision and in practice.

Screening and Early Intervention: Pre-trial prisoners, usually young males, are particularly vulnerable during the early stages of incarceration which can onset anxiety, depression, withdrawals, and exacerbate existent mental health conditions. They require immediate counselling and attention.[22]

Manjeet Singh (Age 30 from Ludhiana, Punjab) incarcerated under Section 8/20 of The Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS) suffer from major drug withdrawal symptoms: I have been here in prison for one month for selling *doda,* I was caught at Batmalla on the state bus while going to Jammu along with two others in possession of 4–5 kilogram. Since last 4–5 years I consumed 200 grams regularly by making a drinking mixture. Everyone had it back at the *bhatte*. After consuming it you feel sleepy and cannot function. It has been extremely difficult now, as I have severe body pains and tremors all over (points to hands, legs and head). Doctor prescribes me medicines for these pains. Sleep is another major problem. I suffer from pains and cannot sleep throughout the night, so I needed (help).

National Human Rights Commission mandates a detailed health card proforma to be filled within 24 to 42 hours of confinement, which includes history of substance abuse and reporting of any mental health history with the objective of starting early intervention and support, followed by periodic review and half-yearly reports. However, the prison staff views undertrials as shifting population, therefore, filing the proforma becomes a

manual process based on self reporting or apparent signs without the aid of trained psychiatrists. The prison manuals envisage belated intervention of a psychiatrist, for e.g. under Section 662 BPM only after observation of general medical officer for one week followed by medical specialist for two weeks. In the interim, for 'unsound and mentally retarded prisoners', Section 328 CrPC (2008 amendment) empowers the Magistrate to postpone the entire proceedings till psychiatric treatment is completed. This can further prolong trial of PSDPs when already judicial delays have seen undertrial PSD prisoners languish in jail for decades, warranting the courts to order their release on bail after having overseen half their prison term (Under provision 436A CrPC, see *Charanjit Singh vs. State*).[23]

Access and Communication: Access here is understood as 'the ability to reach, understand or approach something or someone'. Devoid of any understanding about mental health and their rights, the PSD prisoners remain untreated because they are unaware that they require medical attention and consider their feelings 'natural', 'expected' or 'ill-fated to suffer'. Further, the PSD prisoners may not trust the authorities to reveal their condition though their access to healthcare is entirely dependent on communication with the convict officers, medical health providers or the prison staff.

– Convict officers: Convict watchmen and convict overseers (prison inmates as incharge including for suicide watch, reporting and tending the sick) are not trained in recognizing verbal and behavioural cues and are, therefore, ineffective and uncomfortable in communicating with the PSD prisoners.
– Medical Health Care Providers: General practitioners do not have trained knowledge on mental health, yet a great reliance is placed on them for treatment. In overcrowded jails, the PSD prisoners can be ignored as they demand too much time and attention. Any treatment provided is always subordinate to custodial and security concerns.
– Prison Staff: Prison staff's role in maintaining discipline and punishment, at the same time as purporting to provide security, creates lack of trust[24] between the prisoners and the prison staff which is problematic as the ultimate prerogative to send a prisoner to the visiting psychiatrist, if any, or the hospital lies with them. The psychiatrists do not have open access to the prisoners and no periodical psychiatric evaluation is conducted.

Further, some of the PSD prisoners may not be able to follow simple orders like eating, sitting, or walking in a line and can display lack of care, aggression, or self-injuries which constitute prison offences inviting punishment and loss of prison privileges.[25] In such a scenario, the staff is authorized to use force and resort to violent methods and is not trained in de-escalation technique to calm and reassure PSD inmates. Torture and inhuman treatment is prohibited under the Constitution and international human rights obligations.[26] However, as Professor Saibaba, incarcerated in 2014 despite 90 per cent disability, reveals 'People are beaten at the slightest provocation, paraded completely naked and then tortured; …a huge number of prisoners become mentally challenged after years in jail. They are kept in the mental ward and are handcuffed and beaten' (Punwani, 2015). In one of many telling cases (*Satyabhama Das vs. State of Orissa*, 2011),[27] where torture lead to custodial death of a prisoner receiving psychiatric treatment, the police disposed of the body to destroy evidence and declared it a case of suicidal death due to mental illness. The interventions in legal challenges to custodial violence by the court, NHRCs and state human rights commissions, to which each prison death and rape incident must be reported, continues to be limited to determination of compensation.

Attitudinal and environmental barriers: Numerous barriers are experienced by PSD prisoners during the process of receiving psychiatric treatment, as seen in Bihar and Kashmir. Once prison authorities decide to seek psychiatric evaluation or treatment for a prisoner, escort facilities have to be arranged, through Superintendent Police on official application, which causes delay particularly in district and sub-divisional jails. During the escort, no prison medical staff accompanies the PSD prisoner, no allowance for food or other provisions are provided in case of long journeys and no briefing on PSD's condition is made to the escorts in case of emergency or to relay to the doctors.

On arrival at the hospital, PSD prisoners are fettered in ropes at all times, against the directive of the Supreme Court in *Citizens for Democracy vs. State of Assam.*[28] No privacy is provided to the PSD prisoner and the doctor, given the presence of two to six guards and curious bystanders especially in case of open clinics. There are no medical history sheets with behavioural observations and records of any prior treatment which is maintained and provided to the doctor in most cases, creating difficulty in diagnosis and reliance on prescription of generic psychosis medicines.

Subsequently, no follow-up on treatment and medicines can be guaranteed by the psychiatrists and neither do prisons have provisions for support from psychologists

and community counsellors. There are no indications of consent on treatment, or allowing continuous presence of family members in case of hospitalization; rather constant tranquillizers and chaining is resorted to in closed wards of prisons and hospitals.

Case of Atma Ram, accompanied by six guards and fettered with ropes, 35 years old male, produced at BSIMHAS from district Jail Kata. Produced in general outpatient department, referred from local hospital, also suffers from tuberculosis, in custody for a naxal case.

D: Doctor, P: Patient, G: Guards.

D: From where are you? P: Aurangabad.

D: *Gaon*? P: I don't know,

D: Work? P: My own, I cannot tell you.

D: Who caught you? P: I don't know.

D: Did you do any wrong? P: No.

(few basic questions asked, patients responds with: 'I don't know. I cannot trust anybody, I cannot trust you, you are with them (the jail official's)).

D: (to guards): What do you know? G: He did not look outside the window even when coming here, doesn't ask anything, said yes to food that is all and tells when he needs to go to the loo.

D: Did he mutter to himself? G: No.

D: Do you know what happened? G: He has odd behaviour, we heard this led him in an altercation with the senior police official during regular checking so he must have faced consequences.

D: (to patient): Maybe you are not taking medicines that is why this happened? P: What medicines, they do not provide me with any medicines.

D: Why don't they, have you been involved in a case of naxalism? P: Naxalism is everywhere.

(Psychologist stops, tries to build trust by simple gestures and conversations, assures he is not with the jail authorities) D: How long have you been in the jail? P: Four years.

D: Tell me how you feel? P: I don't get sleep, my mind does not feel okay. Jail is not for me.

D: Have you taken bhang or anything in past? P: Yes, (reveals cannabis and bhang) before jail, others can get it in jail also but not me.

Psychological tests carried out through questions. Suspected of chronic schizophrenia.

Bihar State Institute of Mental Health & Allied Sciences Mental Hospital (BSIMHAS), the only state psychiatry hospital of Bihar is not equipped to admit PSD prisoners, therefore most of them are returned to the prison wards. In extreme situations, referrals are made to psychiatry division of local hospitals or to Central Institute of Psychiatry Ranchi, Jharkhand, if there is court intervention. Alarmingly, the prison staff continuously collects medicines from the hospital against the name of PSD prisoners without even producing the patient, as has been noted repeatedly in the hospital's medico-legal register. Government Psychiatric Diseases Hospitals, Srinagar has a highly secured and enclosed ward for prisoners, with wooden traps blocking access to light, an environment from which anyone will find it difficult to recover.

Incapacity and Disqualification: The identified PSD prisoners are kept in separate barracks or wards in the prison and incapacitated as 'invalid gangs' under the state prison manuals, including that of Bihar and Kashmir (see for example Sections 216 and 239 of BPM, 2012). In isolated wards, absence of healthy social interaction and lack of activities to preoccupy the mind can aggravate their health condition. The PSD prisoners experience loneliness and negative response such as display of insensitivity or involuntary treatment and become reluctant to re-approach for help. There are no rehabilitative or therapeutical engagements, occupational therapy, group activities, individual psychotherapy etc., rather they are invalidated even from the normal prison activities and functions.

Even still the most grotesque statutory consequence of being found to be 'mentally ill' is subjection to solitary confinement in a high security ward. MPM, 2003 Rule 7.91 states 'Prisoners showing signs of lunacy shall not, if they are dangerous, noisy or filthy, be kept in the hospital but shall be kept in a separate cell'—a rule replicated in prison manuals of the state. This practice is against fundamental human rights and unconstitutional as it violates right to life, dignity and liberty of a psycho-socially disabled person and is extremely torturous, degrading and cruel; it has invited successful class action suits from PSD prisoners in Canada and in the United States where a judge described it as: 'is the mental equivalent of putting an asthmatic in a place with little air'; and should be removed forthwith from all prison manuals.[29]

PSDs and Death Penalty Inmates

For a death row inmate, confinement in a solitary cell under harsh and dehumanizing conditions, with severe restrictions on movement and interaction with family and society, can lead to severe mental health impact. Death penalty executions are rare in India and though death penalty should also be awarded in 'rarest of the rare' cases (*Bachan Singh vs. State of Punjab*),[30] it is still given in large numbers by the lower courts. Therefore, a phenomena

recognized today as torturous 'death penalty syndrome' could have been faced by some of the 1512 known death penalty convicts between 2000–2015,[31] of which Bihar had accounted for more than 178, next only to U.P. 'Prisons of Bihar Status Report 2015'[32] highlights condition of one such prisoner from Beur Central Prison, Patna:

Sanaullah Khan, given capital punishment by lower court, was thus kept in isolation for 9 years. Then High Court converted his sentence to life imprisonment. He has developed psychological disorder. When he was kept in a separate cell he tried to burn himself several times, was often heard wailing, weeping, shouting and would often stop eating for long period of time. He is now kept in the medical ward with other inmates but he still remains emotionally rattled. As he rarely speaks to other inmates and is often found speaking to the wall. He sits for hours staring at the wall with his back towards the other prisoners in the hospital ward. His only request was that he should be kept in company of others.

In Kashmir the chances of being awarded death penalty is 6.8 times higher than the rest of the country, according to The Law Commission of India Report on The Death Penalty (2015). In Srinagar Central Prison, one such case is of Hukum Dhar who has a death penalty appeal pending in the Supreme Court. He has already spent 12 and a half years as an undertrial, before being convicted by the lower court in 2009, leading to nineteen years of total incarceration. His present condition is diagnosed as panic disorder.

Earlier I had a habit of reading newspapers but I cannot anymore. The day I heard of Afzal Guru's hanging was the worst attack of my life. When I hear anyone discussing their court case or my case I get tense. I do not like talking to anyone. I follow through my court case at every stage. I go through the evidence and proceedings again and again on my own to re-evaluate. It is a case of death of a family. The two army officers who were with me got six years by army trial, and the main accused got four years but I get death as civilian informer. I sometimes have uncontrollable anger and beat myself up. When I hear loud noise I start running away. For last two-three years as the case is pending in the Supreme Court I have been getting get continuous panic attacks. Therefore, they took me to the doctor. Right now, I am taking medicines as without them I cannot even sleep.

The UN Resolution 2000/65 on death penalty urges state to not impose the death penalty on a person suffering from *any form of mental disorder* or to execute any such person (emphasis applied). The Supreme Court acknowledges this as well as the connection between the delay in execution and mental disability,[33] yet the law excuses only those death penalty inmate who presents the most 'serious and acute' symptoms of this condition. In *Shatrughan Chauhan vs. Union of India*[34] while quoting expansive international legal obligations and obfuscating between 'mental illness/insanity/schizophrenia' the court came full circle and clarified 'to put it clear, (only) "insanity" is a relevant supervening factor'. This has so far included 'chronic' schizophrenia and 'incurable' depressive disorder *Navneet Kaur vs. State (NCT of Delhi)*.[35] This old test of legal insanity is reflective of a narrow understanding of mental disorder.

There are instances where courts have altogether failed to take into consideration personal circumstances and condition of death penalty convict; and the method of reaching upon the conclusion of mental disorder has been inherently problematic and arbitrary. This can be seen through three cases decided in 2015. In the *Devinder Pal Singh Bhullar vs. State,*[36] the plea was first rejected in 2013 on the grounds that court was not convinced that the convict was of unsound mind sufficiently to halt execution. The medical opinions were later taken into consideration for Devinder Pal Singh Bhullar in the case filed by his wife *Navneet Kaur case* (supra). This was done after the ruling of *Chauhan case* (supra) wherein one of the petitioners Sunder Singh, suffering from chronic schizophrenia, was reprieved after his mercy petition was rejected wrongfully in full awareness of his mental condition by both the Governor and the President. Subsequently, in 2015, the mercy petition of Yakub Memon[37] was filed on grounds including suffering from schizophrenia but was not determined upon, perhaps due to the superseding political considerations. In the final curative petition the court also refused to dwell and satisfy on this aspect (*Yakub Memon vs. State of Maharashtra*)[38] including whether there was compliance of *Shatrughan Chauhan* (Supra) court order to conduct regular mental health evaluation for death row prisoners, to report certification on physical and mental condition and furnishing necessary materials to the court.[39] Facts seem to be the contrary, as though the independent medical determination should be in cognisance of the judges and the executives throughout the legal process, for Yakub Memon the lawyers mentioned depression as a mitigation consideration during the Supreme Court appeal[40] but, at later stages schizophrenia and hallucination for last twenty years were reported.

It has been vehemently argued that the award of death penalty itself is based on various arbitrary and

discriminatory determinations[41] and to add there should be blanket exclusion of PSD prisoners like in the cases of juveniles, because the moot question remains: can the exact measure of culpability for persons with mental disorders be determined precisely?

Women in State Custody: Bihar Report

Shelter homes and psychiatric hospitals for 'protection' often capture the vulnerable *viz.* the destitute, dislocated, disabled, indigenous, sexually trafficked, migrant, victim of armed conflict etc. from extremely turbulent backgrounds:

Chaaya Kumari (teenager, identifies herself with different birth name, Oraon Tribe, Assam Christian): 'I lived in Assam with an uncle, aunt and three children in whose house my parents left me when I was a child. My little brother was also sold for Rs 10,000 to a house in *Ukha* Basti in front of me despite my protests. My mother use to work in tea estate, my father was an alcoholic who use to fight a lot at home. In the new house they did not treat me well. I use to start working at six in the morning-first cleaning the balcony, then house, followed by help in the kitchen, dishes, washing, setting the room, yet if anything remained I was beaten up. I ultimately left the house after ten years. I met an uncle and ran away with him. He brought me to Patna and gave me to his friend for Rs 5,000 who kept me constrained in the house and gave me food for work. There were four of us girls, other two from Kolkata and his wife. The house was then raided in anticipation that the girls were brought together for further sale…I don't want to learn work here, I want to study but there is no teacher. I called the uncle who got me to Patna to take me out from here. I hope he won't sell me again. I have no idea where my real parents are.'

Many of the PSD women in state custody have already experienced physical and psychological violence at the hands of family, society, and the state. The very concept of confining disabled persons in institutions, is reflective of the intolerance of the society towards their human condition and, characteristically in patriarchal societies more often than not women are abandoned and deemed 'non-useful' upon discovery of their disabilities. Instances of PSDPs being sold for marriages as part of the 'bride trafficking' phenomena came forward in both Bihar and Kashmir. Women suffering from PSDs are sold off without disclosing their health conditions to avoid burden of care. At the same time, for a PSD male, a woman is purchased from far-flung areas where his conditions is not known, to reduce the burden of other family members as care provider.

Kharum, married middle aged woman and sent off in teen years from Bengal to Kashmir: 'when my family realized, and everyone thought I had "weird characteristics", like staying in a corner and brooding, they just decided to marry me off. My husband's family is poor and could not afford a local wedding so they bought me. Here, away from my family I had difficulties in adjustment. My own brothers have hardly come to enquire. My in-laws family speak Kashmiri and I do not understand the language. I am excluded in all discussions and decisions, and not even introduced when visitors come to the house. The responsibility of all the house work is left to me. My husband is showing me to the doctor (psychiatrist) but I really have no one to share and talk to throughout the day, so how can my depression be cured with medicines?'

On the other hand, the abandoned PSD women who reach state custody too become an object, susceptible to exploitation, coercion, involuntary treatments or other torturous, inhuman and degrading behaviour (Davar, 2012; Dhanda, 1996: 347–67; Kannabiran, 2012). Therefore, BSIMHAS, which has two female wards for PSDPs has come under severe criticism by Director General of Health Services for 'going against expert opinion worldwide which favours community-based mental healthcare rather than prolonged incarceration in mental hospital'[42] and for sharing the campus with Central Para Military Force (CPMF) jawans deployed to counter naxalism with no trained staff on duty beyond working hours.[43]

For more than 30 women at BSIMHAS and over 180 women at After Care and Shelter Home, Gai Ghat most cases are of involuntary admissions through police. There are 85 cases of 'mental retardation' in after care ward of the home and 30 PSDPs at psychiatric hospital under the MHA, 1987. The other ward of the home, within the same compound provides shelter to women in conflict with law, many of whom are also PSDs. These include cases of anti-human trafficking laws that further victimise the trafficked women (7), elopement cases (*habeas corpus*) mostly for overstepping the traditions of caste or religion (56), juvenile offenders from juvenile justice board (7) and missing women (25); cases where the state seeks to step in as 'protector' and 'guardian'. In fact, in 2014, a request was forwarded to Secretary, Social Welfare Department, Bihar to shift the 85 women in after care to BSIMHAS to provide space in the shelter home which is running over the capacity and is reluctant to admit acutely suffering PSDPs. Though, no decision has been taken so far in this direction it displays that hospitalization and after care essentially speak to authorities as inter-changeable confinement spaces.

Discrimination, Legal Capacity, and Rehabilitation

At the After Care and Shelter Home the PSDPs suffer discrimination as they have unequal access to even limited state resources. Meditation classes and work training, such as embroidery and stitching, due to their course design are availed more by non-PSDPs than PSDPs. 'The mentally retarded' also have segregated stay in a separate building at the back of the compound with minimal health care facilities. At both the institutions, the permanent ground staff is not trained to provide care to PSDPs. Engaging psycho-socially disabled persons in paid work assignment or educational activities provides them with dignity (Kumar and Mohanty, 2012: 49), but there are limited work or recreational facilities available in these institutions and most PSDs lie vacant throughout the day which explains the utmost desire and will of these women to leave the confined premises of the shelter home. The consequences, as explained by doctors, of not allowing recovered PSDPs to leave the confined space without their next kin is that, many recovered patients continue to relapse while staying in a non-conducive environment. Instead of providing them with autonomy and allowing a chance to reintegrate in society, their de-institutionalization is based only on the transfer of 'guardianship' on to their next kin. This wrongfully assumes that PSDPs are incapacitated to take their life decisions and their 'best interest' lies with their guardians.

Seema (Missing woman case, bipolar, from Jhunjhunu, Rajasthan): 'I was really good in studies, but when I was 16 years old in 2003 before 10th exams I started getting severe fits. After falling ill, school was stopped and I was hospitalized which cost my family 3–4 lakhs. Then I was married off, my in-laws were told about my mental health condition. My first husband started to beat me and would not buy things even for the newborn child. With my in laws, he used to tie me with ropes, or kick me out of the house so I had to sleep in fields, or at the railway station. I did not do any wrong (cries). I have a seven-year- old child who I had to leave. My brother was made to pick me up, then he married me again. Immediately after the re-marriage—my family was accused of taking money from my new in laws. They kept me in a room for three days with no food and water. So, I became 'mad'. My *Sasur* (father-in-law) beat me all over with his fists. (cries) Then my mental condition became much worse. They were angry that I had been sterilized after my first child. Now, my parents are saying they will get the operation undone. Both times I was married off in Haryana. After assaulting me, my in-laws left me at my parents' place and my mother said evil things to me, so I took hundred rupees and boarded the train to Haryana. Mid-way I asked 5–6 people how to return. I was scared and "in fits", therefore, jumped in a train which was leaving the platform. Then I found myself in Patna…In both my marriages they accused my family of taking money and selling me which hurts me the most. Why would I not try to make my own home? At my parents' house, I work the whole day in field but they give me sorrow by selling me again and again. They say what use am I to them and insult me. I could have studied B. Ed like my neighbour, I wanted to study. Now my brother decides and he is the one who married me off both times. I miss my child, he stays with my husband's sister but he is suffering without proper education as I am far away.'

UNCRPD Article 4 urges state parties to take appropriate measures to promote the physical, cognitive, and psychological recovery, rehabilitation and social reintegration of PwD who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. WHO *World Report on Disability* (supra) emphasizes reintegration and rehabilitation as integral part of mental health. Measures such as compulsory health insurance, support for studies and employment, shifting to independent facilities, ensuring enrollment for state benefits, and simple follow-up post reintegration are some of the basic steps that could have helped women like Seema regain their autonomy and fundamental freedoms.

Authorities are also aware that many family members will not return nor would they undertake the responsibility of care, as the additional cost of disability is unaffordable for their impoverished household and had probably abandoned the PSDPs earlier. Thus, on leaving the institution, there are high chances of abuse and relapse for PSDP women, yet authorities limit their role to transfer of 'guardianship', try to convince the PSDP women that kin's decisions are in their best interest, and provide no counselling to the family members at the time of discharge.

In essence, PSD women are denied personhood through law and practice by active denial of their legal capacity to act, including whether it is the decision on admission, treatment, or release under the Mental Health Act, 1987, right to decide on termination of pregnancy (Under the Medical Termination of Pregnancy Act, 1971) and a range of decisions affecting their day to day life. This is in addition to the fact that under an array of laws PwDs' personal, social, political and economic rights continue

to be negated (Dhanda and Raturi, 2010), despite CEDAW Article 15 and UNCRPD Article 12 which mandate that all women with disabilities are entitled to legal capacity on an equal basis with others in all areas of life, in deprivation of which torture is being inflicted on PwDs.[44] On this crucial issue however, even the Mental Health Bill, 2013 does not envisage full legal capacity to PwDs as it sustains provisions on guardianship.

* * *

There is an urgent need for The Prisons Act, 1894, and state prison manuals, seeped in colonial criminal justice system, to attune to modern international human rights obligations. At present, 'Prison and Allied Institutions' fall under the State list in the seventh schedule to the Constitution. Prison manuals devised by the states, such as the Bihar Prison Manual, 2012, seem to be attuned for administrative convenience and do not reflect the ethos of model prison manuals released by the Centre periodically. Therefore, a central legislation which has been in suggestion since the Mulla Committee on Jail Reforms (1980–83) is imperative to address human rights concerns, funding and accountability factors. Many of the prison manuals, (for example Kashmir Prison Manual, 2000) are not made publicly available and accessible, which makes them difficult to be challenged.

In line with UNCRPD, 2007 (Article 12(4)) it is imperative to have a competent, independent and impartial authority such as the National Human Rights Commission or a Courts ombudsman, to ensure accountability and transparency lacking in the prison system.[45] For this, state human rights commissions have to move beyond providing compensations to the victims, and be given enough powers to hold state administration accountable. *Bandi Darbar*s organized in prisons under District Magistrates have to provide space to the prisoners for personal interaction, protection and maintenance of confidentiality and cannot be conducted in the presence of Superintendent, Prison Medical Officer, Deputy Superintendents and Assistant Superintendents. The judiciary has to take an active interest, for example under the orders of *Sheela Barse vs. Union of India*, the High Court of Patna had the opportunity to enquiry into (i) persons who are mentally ill, (ii) female inmates of the jail, and (iii) juveniles in state prisons. However, despite the prevailing conditions the hearings on the matter were last conducted in 2002. In 2011, the court closed the matter with perfunctorily remarks that 'on record' there is no man or woman who is mentally ill without criminal background in jail, and 'the state government has taken up measures to update jails' therefore there is no requirement for monitoring.[46] Lastly, the attitude of prison administrators to restrict any access, accountability and transparency process has to change. In the first instance, even state manuals are not made publicly available for scrutiny, as is the case with Jammu and Kashmir Prison Manual, 2000. At present, the prison administration has further placed severe restrictions to prohibit interaction and interview with prisoners, due to internal orders of Ministry of Home Affairs in light of release of the BBC documentary *India's Daughter* (Udwin, 2015) *which* infringe on prisoners' freedom of expression[47] and is untenable in law.

Access to health is one of the major concerns of PSDPs lodged in prisons. In a law suit admitted in the Canadian Supreme Court on June, 2015 on behalf of hundreds of PSDPs incarcerated from 1992 to 2013, the Canadian government has been charged with breach of duty of care and negligence due to impropriety of policies and neglect of operation in the prisons. In striking similarity to the Indian prison conditions, the plaintiffs have argued that the unavailability or delay in access to health and lack of psychotherapy, which is a direct result of funding and inadequate staff, along with use of force has worsened the health conditions of PSDPs. The PSDPs have suffered discrimination due to prolonged incarceration and are more likely to offend again due to lack of rehabilitation.[48] In India too prisons' acute shortage of medical staff, who otherwise work on very low wages in overcrowded conditions, is a far cry from the provision for a comprehensive system as envisaged under the Model Prison Manual, 2003—involving psychiatrists, psychologists, counsellors, and social workers. Overcrowding directly affects the quality of healthcare, decreases safety and security of inmates, creating an atmosphere of intimidation and violence. Yet, the Supreme Court in *In Re: Inhuman Conditions of 1382 Prisons*[49] remarked that despite numerous court orders since June, 2013 on overcrowding and undertrials nothing has changed on the ground—'the prison statistics indicate…there is no perceptible change and in fact the problem of overcrowding has perhaps been accentuated with the passage of time'.

It should also be acknowledged, discrimination towards PSDPs has further ramifications in their access to justice, with many PSD prisons having no awareness

about their legal rights and not receiving legal aid (as mandated under *M.S Haskot vs. State of Maharashtra*).[50] Their life and liberty are valued little by the state. Despite 25 PSDPs having charred to death in a fire while being chained to a chair[51] in Tamil Nadu there is no protection against natural or man-made disasters in Bihar or Kashmir state institutions, as was also witnessed during an earthquake in Srinagar.

For PSDPs in custody, it is necessary to replace the Mental Health Act, 1987 with the new Mental Health Bill, 2013 which seeks to recognize a whole new range of rights. The bill restricts long term institutionalization, guarantees rights to visitors and communication, access to legal aid, a complaint making mechanism, and increases accountability of mental health institutions. Though the bill is not without controversy, as it continues to permit reception order from police to confine PSDPs, includes psycho-social disabilities but within the ambit of mental illness and obfuscates on legal capacity among others.

State focus should be to support community living for PSDPs by providing reasonable accommodation and assistive decision-making, if required; and institutionalization should be in rare cases. Within the institutions to curb rampant violence and abuse against PSDPs recruitment of well-trained mental health care professionals is necessary. Similarly, to ensure de-institutionalization, autonomy and fundamental freedoms for PSDPs, a comprehensive program covering physical, educational, and vocational rehabilitation is required. In both these cases, the assistance of the National Trust (under The National Trust Act, 1999) and Rehabilitation Council of India should be sought.

At larger scale, the state has to recognize the direct impact of violence when risk factors due to crimes, poverty, poor governance, unemployment and sense of demoralization, contribute to psychological pressures. Apart from comprehensive framework on PSDs in state health policies, there is a need for specific intervention to deal with mass trauma in conflict zones. Ultimately, however to end this culture of violence the larger questions on eroded substantive democracy and breach of constitutional boundaries because of abuse of human rights and lack of state accountability will need to be addressed.

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Armed Forces Special Powers Act, 1990
Bihar Prison Manual, 2012
Bihar State Policy on Disability, 2011
Code of Criminal Procedure, 1973
Code of Criminal Procedure, Amendment 2008
Jammu and Kashmir Public Safety Act, 1978
Jammu and Kashmir Juvenile Justice (Care and Protection) Act, 2013
Jammu and Kashmir Prison Manual, 2000
Medical Termination of Pregnancy Act, 1971
Mental Health Act, 1987
Mental Health Bill, 2013
Model Prison Manual, 2003
Model Prison Manual, 2016
Narcotics Drugs and Psychotropic Substances Act, 1985
National Trust Act, 1999
Prisons Act, 1894
Public Safety Act, 1978
Ranbir Penal Code, 1989
Rights of Persons with Disabilities Bill, 2014
Scheduled Caste and Scheduled Tribes (Prevention of Atrocities) Act, 1989

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Shatrughan Chauhan v. Union of India (2014) 3 SCC 1 para 71.
Sheela Barse v. State of Maharashtra 1983 AIR 378.
The State of Bihar v. Ajay 2012 (2) PLJR 601.
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Upendra Baxi v. State of Uttar Pradesh AIR 1987 SC 191.
Veena Sethi v. State of Bihar AIR 1983 SC 339.
Yakub Memon v. State of Maharashtra (2013) 13 SCC 1.
Yakub Memon v. State of Maharashtra Writ Petition (CRL.) No. 129 of 2015, dated July 29, 2015.

Abbreviations in Case Citations

AIR	All India Reporter
Crim	Criminal
CRL	Criminal
F. Supp	Federal Supplement
ILR	Indian Law Reporter
JT	Judgment Today
NCT	National Capital Territory of Delhi
N.D. Cal	Northern District of California
OJC	Original Jurisdiction
SCC	Supreme Court Cases
PLJR	Patna Law Journal Reporters
RCR	Recent Civil Reports
TN	Tamil Nadu
W.P.	Writ Petition

Notes

1. Violent crimes affecting body: Murder, attempt to commit murder, culpable homicide not amounting to murder, attempt to commit culpable homicide, dowry deaths, and kidnapping and abduction; Violent crimes affecting property: dacoity, making preparation and assembly of committing dacoity and robbery; Violent crimes affecting public safety: riots and arson; Violent crimes affecting women: rape and attempt to commit rape.

2. National Crime Record Bureau, Crimes in India, 2014. Available at http://ncrb.nic.in/StatPublications/CII/CII2014/chapters/Chapter%203.pdf, accessed on March 20, 2016 p. 60.

3. Bihar Police, Crimes in Bihar, http://biharpolice.bih.nic.in/menuhome/crime-in-bihar.html, accessed on March 25, 2016.

4. *The State of Bihar vs. Ajay,* 2012 (2) PLJR 601 and *The State of Bihar v. Girja Singh* 2013 (4) PLJR 464.

5. Rural Health Statistics, 2015, https://nrhm-mis.nic.in/Pages/RHS2015.aspx?RootFolder=%2FRURAL%20HEALTH%20STATISTICS%2F(A)RHS%20-%202015&FolderCTID=&View=%7BC50BC181-07BB-4F78-BE6F-FCE916B6 4253%7D,Section VIII, Rural Health Infrastructure in Tribal Areas, p. 95, accessed on March 25, 2015.

6. On the other hand, conviction rate on atrocities cases are extremely low (around 30 per cent) and the major hurdle is to get the First Information Report (FIR) in the first instance, particularly when state actors are involved Crimes committed by armed forces, even outside their official capacity, cannot be tried by the courts.

7. The real names and identities of prisoners, jail medical officers, psychiatrists, and senior officers have been withheld on request. All interviews are on file with the author.

8. Public Interest Litigation, filed by activist Tanvi Ahuja, orders by Justice Muzaffar Hussain Attar and Justice B S Walia to Chief Secretary, dated February 3, 2016 with rejection of 'unsatisfactory' compliance report' against December 1, 2015 order for implementation of the act.

9. Supreme Court guidelines in *R.D. Upadhyay v. State of A.P.* (WP 559/1994, dated April 13, 2006) delineate treatment of children staying with prison inmates but have failed to resolve the issue of children lodged in non-conducive environment of jails. Further, many states have failed to implement these guidelines. The Model Prison Manual, 2016 seeks to establish well-equipped creche and nursery schools apart from health care. Also, this should be extended to men with children as there are instances on the ground where a male offender is accompanied by an infant.

10. Soni Sori, Lingaram Kodopi and the Chhattisgarh Story, https://sonisori.wordpress.com, accessed on March 20, 2016. Soni Sori is a tribal teacher and activist from Chhattisgarh, arrested in October 2011 who suffered extreme custodial torture and sexual assaults.

11. Committee on Empowerment of Women (2001–2002), Women in Detention, Ministry of Home Affairs and Department of Women and Child Development, August 24, 2001.

12. Justice Krishna Iyer Committee on Women Prisoners (1986–87) has been the only other official report. Although as a first step The Model Prison Manual, 2016 envisions introduction of rehabilitative programmes, healthcare measures, counselling, laxity on severe punishment and introducing gender sensitivity programmes in the prisons, even the previous model guidelines have not been incorporated in the state prison manuals.

13. *Veena Sethi v. State of Bihar* AIR 1983 SC 339. It is troubling that the court only passed orders against recovered and acquitted prisoners, not recognising the rights of other mentally suffering prisoners. It only provided minimal compensation for the gross human rights violation PSDPs suffered for over three decades see Kalpana Kannabiran (2012). Also see *Sheela Barse v. State of Maharashtra* 1983 AIR 378, *Rudal Shah* vs. State of Bihar (1983) 4 SCC 141 and *Upendra Baxi v. State of Uttar Pradesh* AIR 1987 SC 191.

14. National Human Rights Commission, *Annual Report 2000–2001*, http://nhrc.nic.in/ar00_01.htm, Section 3.53 accessed on February 2, 2016.

15. While there are no nationwide or state specific studies available in India on number of PSDPs sent to police custody under Section 23, in the United Kingdom—according to the report 'Policing and Mental Health', reportedly 6,000 PwDs were detained by police in 2014 alone under a similar provision (The Mental Health Act, 1983, Section 136). Eleventh Report of Session 2014–2015 by House of Commons Home Affairs Committee, U.K., available at http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf. See p. 9.

16. Interview on file with author, dated October 28, 2015. Although terms such as '*pagal*' or 'mental' are derogatory, officials continue to use similar terms to describe persons with psycho-social disabilities.

17. Available at http://www.who.int/disabilities/world_report/2011/report.pdf, p. 267, accessed on February 5, 2016, India's first report under UNCRPD after eight years also invited similar criticism of failure in national census to capture disability.

18. Canada 13 per cent male offenders and 29 per cent female offenders in 2009, Correctional Service Canada, *Towards a continuum of care: Correctional Service Canada Mental Health Strategy*, http://www.csc-scc.gc.ca/text/pblct/health/tcc-eng.shtml, accessed on February 5, 2016; USA 22.4% offenders in 2012 Treatment Advocacy Centre, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (2014) http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars-abridged.pdf, accessed on February 5, 2016, page 7; and UK 26 per cent women and 16 per cent men in prison Prison Reform Trust, http://www.prisonreformtrust.org.uk/projectsresearch/mentalhealth, accessed on February 5, 2016.

19. Interim Report No. 10, http://bslsa.bih.nic.in/prision-report/REPORT-010.pdf, accessed on February 3, 2016.

20. Section 660: The expression mentally ill prisoner shall be deemed to include persons of the following classes, namely:

(1) A person who is charged with an offence, in respect of whose soundness of mind the Magistrate trying the case entertains doubts and the prisoner is put under medical observation.
(2) A person, who is charged with an offence, but who, by reason of unsoundness of mind, is incapable of making a defence.
(3) A person who has been held to have committed an act which would but for the unsoundness of mind of the doer, have constituted an offence, but who has been acquitted on the ground that he/she was of unsound mind when the act was committed.
(4) A convict or under-trial who becomes mentally ill or insane after their admission into prison.

Section 2 (q) of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 states 'mental illness' as any mental disorder other than mental retardation, a similar explanation defines 'mentally ill prisoner' under the Mental Health Act, 1987. Under the criminal law the strict standards of Mc'Naughten rule is applied.

21. National Human Rights Commission, *Suicide in Prison: Prevention Strategy and Implication from Human Rights and Legal Points of View* (2014). Available at http://nhrc.nic.in/Documents/Publications/SUICIDE%20IN%20PRISON%202014.pdf, pp. 3–13. This report, while raising many important points, did not confront presence of rampant torture techniques in prison, which aggravate prisoner's psycho-social vulnerabilities.

22. World Health Organisation, *Prison and Health* (2014) http://www.euro.who.int/data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf, p. 36, accessed on February 1, 2016.

23. (2015) ILR 1 Delhi 760. On the position for all undertrial prisoners see 436A CrPc; *Rama Murthy v. State of Karnataka* JT 2002 (8) SC 314; *Bhim Singh v. UOI* 2014 (4) RCR (Criminal) 234; Law Commission Report 78th, *Congestion of Under-trial Prisoners in Jails*, February, 1979; Law Commission Report 239th, Expeditious Investigation and Trial of Criminal Cases Against Influential Public Personalities, March, 2012. The Mulla Committee on Jail Reforms (1980–83) had suggested even then 'if the prisoner falls to recover from mental illness even after completing half of the maximum term of conviction, the State Government should consider his case for release.'

24. Political prisoners and militants, for example, in the general wing of the jail, greatly rely on religious support to overcome any trauma, depression or other psychosocial disabilities.

25. Under Section 59 Prisons Act, 1894 and Section 389, 390 Bihar Prison Manual, 2012 prison offences are open

ended and include: wilful disobedience, the use of insulting or threatening language, disrespect to any prison officer or visitor, making groundless complaints, not taking care of materials, committing a nuisance, feigning illness, not working, wilful destroying food or throwing it away, creating environment of fear amongst the inmates, quarrelling, refusing to eat food, omitting to keep oneself clean or to refuse to walk in line among others. Punishment and privileges are defined under Section 395.

26. The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1997 has not been ratified. Prevention of Torture Bill, 2010 did not pass in the Parliament, but protection is provided for custodial torture under the Article 21 of the Constitution including the landmark case of *D.K. Basu vs. State of West Bengal* (1997) 1 SCC 416.

27. O.J.C No. 13732 of 1998, decided on 20 September 2011.

28. *Citizens for Democracy vs. State of Assam and ors* (1995) 3 SCC 743.

29. *Madrid vs. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995). *Christopher Brazeau vs. Attorney General of Canada,* in Supreme Court of Ontario, July, 2015, http://kmlaw.ca/wp-content/uploads/2016/01/AmendedSoc_18nov15.pdf.

30. (1980) 2 SCC 684.

31. Law Commission of India, Report No. 262, *The Death Penalty,* August 2015, http://lawcommissionofindia.nic.in/reports/Report262.pdf, p. 37 footnote. Number of death sentences in Jammu and Kashmir are stated as 'lower' (18) but many *Kashmiris* are also lodged outside the state, including in the prisons of Delhi, Punjab and Maharashtra.

32. Bihar State Legal Service Authorities, Prisons of Bihar, Status Report-2015 http://bslsa.bih.nic.in/prision-report/bihar-prison-report.pdf, accessed on February 1, 2016.

33. *Shatrughan Chauhan vs. Union of India* (2014) 3 SCC 1 para 71.

34. (2014) 3 SCC 1.

35. (2014) 7 SCC 264.

36. (2013) 6 SCC 195.

37. Yakub Memon mercy petition full text at http://www.thehindu.com/news/national/eminent-persons-request-president-to-consider-yakubs-mercy-plea/article7467000.ece. *(accessed on?)*

38. Writ Petition (CRL.) No. 129 of 2015, dated July 29, 2015, pp. 30–31.

39. Other mandatory requirements include provision of legal aid, communication on rejection of plea and facilitating final meeting with prisoner and his family, all of which have also been incorporated in Model Prison Manual, 2016.

40. *Yakub Memon v. State of Maharashtra* (2013) 13 SCC 1.

41. Law Commission of India, Report No. 262, *The Death Penalty,* August 2015. Despite recognizing inherent arbitrariness of the death penalty sentence under the constitution, in final conclusion the commission asks death penalty to be retained in terrorism cases.

42. DGHS Report, 2004 cited in National Human Rights Commission, *Mental Health Care and Human Rights* (2008), http://www.bhrc.bih.nic.in/Docs/Mental-HealthCare-and-Human-Rights.pdf, p. 426, accessed on February 6, 2015.

43. Submission by Bihar Legal Service Authority to Patna High Court in In the matter of *News Reports vs. The State of Bihar,* Case no. 21462 of 2013.

44. UN Special Rapporteur on Torture Manfred Nowak, A/63/175.

45. The present system under the manuals of periodical hearings for complaints by Judicial Magistrate, in presence of prison superintendent and other staff within the jail has yielded poor results.

46. *High Court Legal Aid Committee vs. State of Bihar* July 1, 2011 Crim Writ No. 384 of 1996.

47. *R. Rajagopal vs. State of Tamil Nadu* 1995 AIR 264.

48. *Christopher Brazeau vs. Attorney General of Canada,* in Supreme Court of Ontario, July, 2015, http://kmlaw.ca/wp-content/uploads/2016/01/AmendedSoc_18nov15.pdf.

49. Writ Petition (Civil No. 406/2013, Decided on: 05.02.2016, Judges Madan B. Lokur and R.K. Agrawal.

50. 1978 SC 544.

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PART II

Vulnerabilities, Precarity, and Social Development

12

Status of Elderly Population in India

Issues and Concerns

K.S. James, T.S. Syamala, and Supriya Verma

India is experiencing rapid demographic changes in recent times with faster fertility transition, considerable leap in life expectancy, and resultant increase in the share of elderly population. The Total Fertility Rate (TFR) of India has reached to 2.3 in 2013, close to the desired replacement level. Although there are considerable regional differences, the fertility transition is evident in all parts of the country in the last decade (James, 2011). The life expectancy stands at 66 years for males and 69 for females during 2009–13. Despite the fact that there is lot to be achieved in terms of ensuring good health status to the people of the country, the recent demographic changes are significant as it has considerable economic and societal implications.

The first major impact of demographic changes is towards a shift in the age structure of the population initially a bulging adult population and consequently in the share of older persons. India currently has a larger proportion of adult population amounting to 60 per cent of the total population according to 2011 census. However, the fast growing segment of the population in India is elderly aged 60 years and older. The elderly were growing at 3 per cent per annum in the last decade while the overall population growth was less than 2 per cent. While the overall population in India is expected to grow by 40 per cent between 2006 and 2050, the population of those aged 60 and above will increase by around 270 per cent. The proportion of elderly is over eight per cent constituting around 100 million. Further, the share of female elderly (9 per cent) is higher than that of male elderly population (8.2 per cent) in the country. The elderly population is projected to grow to 324 million, constituting 20 per cent of the total population, by 2050. (Help Age India, 2014). The proportion of elderly varies from 6.7 per cent in Assam to 12.6 per cent in Kerala (Figure 12.1).

The rapid rise in the elderly population gives rise to several challenges. Lack of ensured and sufficient income to support themselves, absence of sound social security measures, increasing widowhood and discrimination against them, persistence of ill health, disability, and functional limitations are some of the daunting problems faced by the elderly (Alam et al., 2012). The epidemiological transition and consequent increase in non communicable diseases particularly among elderly pauses considerable challenges. Moreover, disability and functional limitations are most commonly go with older ages. All these necessitate increased care provision both within the family and outside. Adequate backing of social security is mandatory in such cases. In absence of adequate support systems, the burden of old age care falls on to the family with considerable strain on their budget and time. The demographic transition also contributes to large scale adult migration due to increased aspiration and in search of better opportunities challenging the provisioning of old age care within the family. Undoubtedly, therefore, it is time to look for systems and support other than the traditional familial exchange.

This chapter provides an overview on the status of the elderly and the current support system so as to get a situational analysis. The discussion on the profile of the older persons also conveys the emerging challenges that are apparent and the need for support particularly a strong social security measure. The chapter discusses the health issues of the older persons in terms of their subjective well-being and functional disability and health seeking behaviour. This chapter mainly utilizes the data from a large scale survey conducted as part of the study on

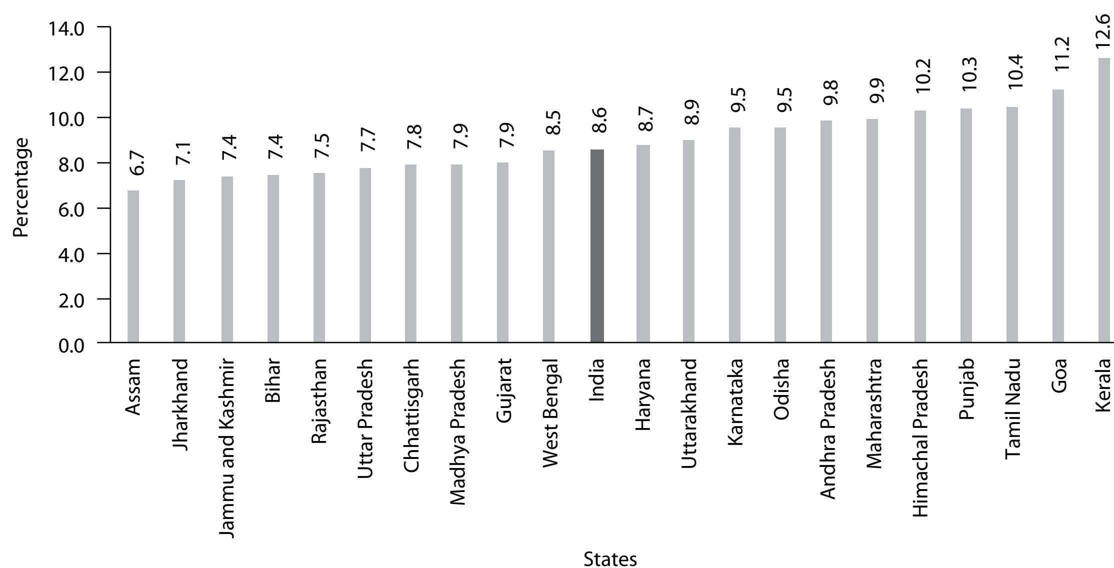

Figure 12.1 Proportion of Elderly Across Major States in India, 2011

Source: Computed from Census of India, 2011.

Building Knowledge Base on Population Ageing in India (BKPAI) in late 2011. The survey was done for elderly aged 60 and above. This study collected information from 9852 elderly from 8329 households with at least one elderly across seven states of India where the proportion of elderly (60 years and over) was above the national average. The states covered in the survey are Himachal Pradesh, Kerala, Maharashtra, Odisha, Punjab, Tamil Nadu, and West Bengal. These selected states are also demographically more advanced and have already achieved the replacement level fertility. The sample for each state was fixed at 1280 elderly households and all elderly present in the sampled households were selected for interview.

Compulsive Work Participation

The issue of work participation during old age has always been debated. The general consensus is that labour force participation of the older persons is good if they work out of choice and it is not desirable if they work out of compulsion. The decision of work or not to work during old age has direct link with the existing social security systems of a country (Kalwaij and Vermeulen, 2005; Mete and Scultz, 2002). Most developed countries have systems to provide pensions during old age while in many developing countries economic support for the older people is mainly provided through the family. It is well known that in countries like India, the labour force participation of the elderly and women is often driven by poverty (Bhalotra and Umana-Aponte, 2010; Bhalla and Kaur, 2011). India's occupational structure is dominated by informal sector employment with neither retirement age nor any pension benefits (Unni and Raveendran, 2007).

Figure 12.2 shows the current work participation of elderly based on 2011 census by place of residence. The Figure clearly shows that a substantial proportion of the older persons continue to work particularly among men. The labour force participation rates vary considerably across rural and urban areas and also across gender. The work participation rate is higher for rural areas for both older men and women perhaps indicating the insufficiency of available resources and the necessity of working in older ages.

This is to some extent evident when the work participation of elderly is analysed across different age groups.

The fact that 35 per cent of elderly men and 11 per cent of elderly women are engaged in labour market even beyond the age of 80 years is a clear manifestation that the work participation at older ages is poverty linked and presumably the work is out of economic compulsions (Figure 12.3). The studies, in general, found that the elderly workers are mostly drawn from lower wealth quintiles and have no formal education reinforcing economic necessarily as reason to work during old age (Alam et al., 2012).

The information on the motivation for elderly to work was gathered by the BKPAI study. The data clearly

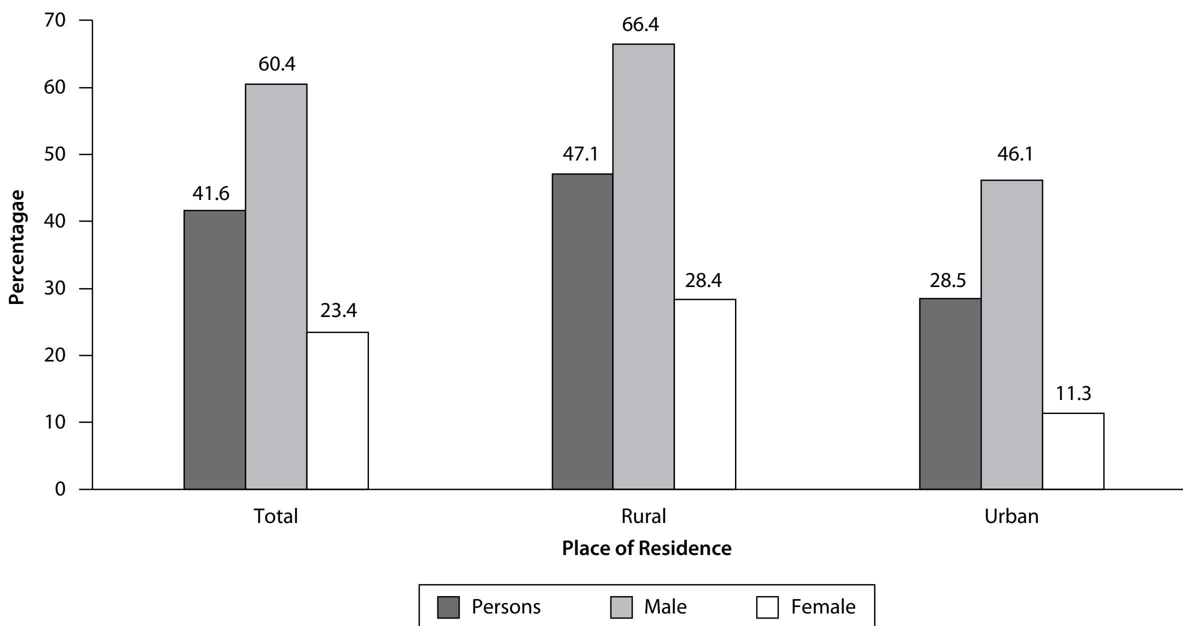

Figure 12.2 Work Participation (Main and Marginal) of Elderly Women and Men by Place of Residence, 2011
Source: Computed from Census of India (2011).

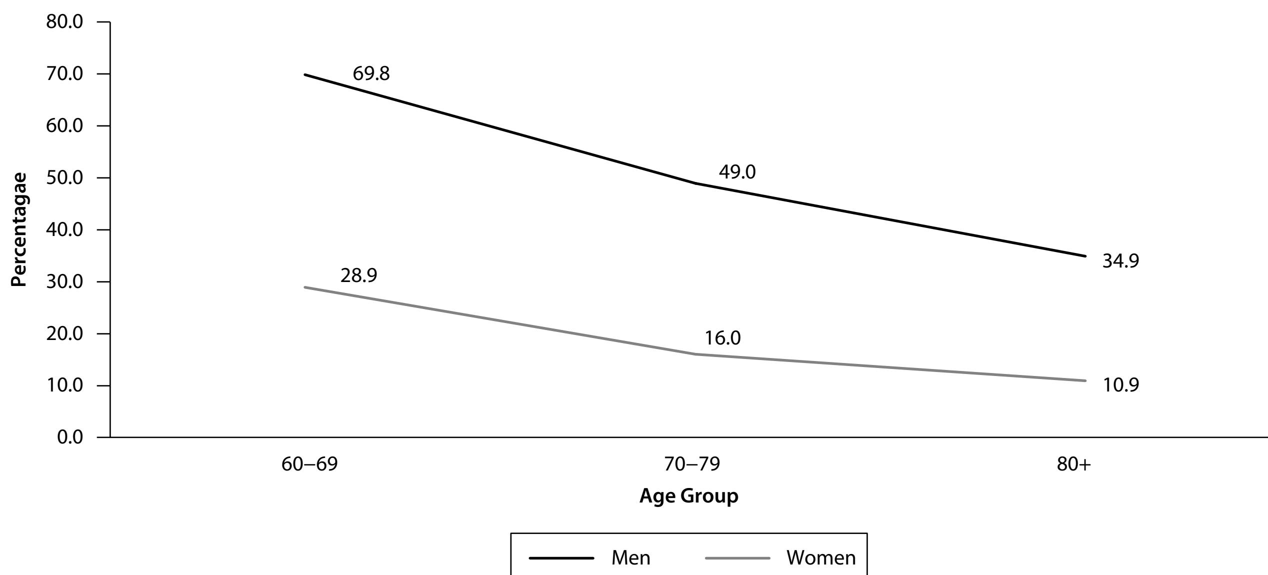

Figure 12.3 Work Participation (Main and Marginal) of Elderly Men and Women by Age, 2011
Source: Computed from Census of India (2011).

bring out the fact that the elderly work not out of choice but out of economic compulsions. For example, nearly three-fourths of the elderly reported economic or other compulsions as the main reason to remain in labour force (Figure 12.4). The compulsive work is particularly striking among the women with nearly 82 per cent of them reporting economic compulsion for continued work participation than elderly men (68 per cent).

The study also observed that household standard of living has direct link with the reporting on the reasons

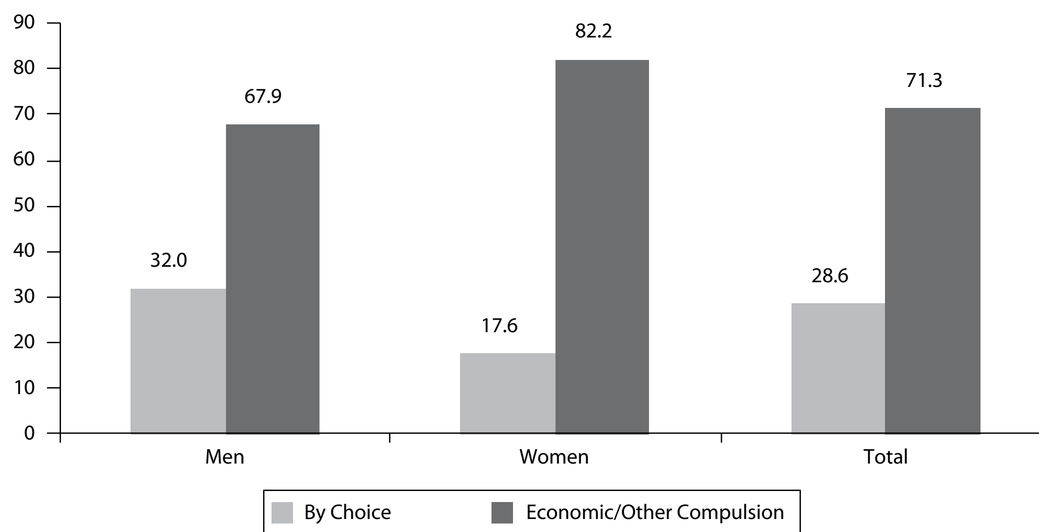

Figure 12.4 Need to Work at Old Age According to Sex in Seven Surveyed States (in per cent) 2011

Source: BKPAI Survey, 2011 (Alam et al., 2012).

for engaging in labour market. The older persons work out of compulsion increases with lowering of standard of living measured based on asset holding and amenities within the household (Alam et al., 2012). These findings indicate the financial burden on elderly among poorest wealth quintiles and in the absence of financial support either from government or children, elderly are left with no option other than to work in order to meet their basic needs.

Meagre Social Security

The old age security system in India can be categorized into two forms either work related pension system provided by the employer (mainly by public sector) or through the provision of social security measures for vulnerable groups.

The BKPAI survey data indicates that retirement benefits and pension benefits are available only for a mere 10 per cent of the elderly in the country (Table 12.1). Thus large majority of the workers in India go without any pension benefits. This is expected given the informal nature of the organization of work. The benefits received by elderly vary greatly between men and women. Around 19 per cent of elderly men receive retirement benefits as against 2 per cent of women.

As the retirement benefits or pension are the privileges of the organized sector workers, the large majority of the unorganized sector workers have no other option but continue to work without any retirement. This is the reasons for very high work participation observed even among those aged 80 years and above. The absence retirement benefits for the unorganized and informal sector workers, thus, poses a serious challenge towards the healthy ageing in Indian context.

There are social security systems for elderly in India but limited to the population below poverty line. These schemes, undoubtedly, help the elderly to improve the quality of life to some extent. The BKPAI survey has

Table 12.1 Elderly Receiving Retirement and Pension Benefits by Sex in Seven Surveyed States in India, 2011

Work related benefits	Men	Women	Total
Retirement	19.0	2.2	10.2
Pension	16.7	3.0	9.5
Both Benefits	14.6	2.0	8.0
None	71.7	94.2	83.5
Number of Elderly	4672	5180	9852

Source: BKPAI Survey, 2011 (Alam et al., 2012).

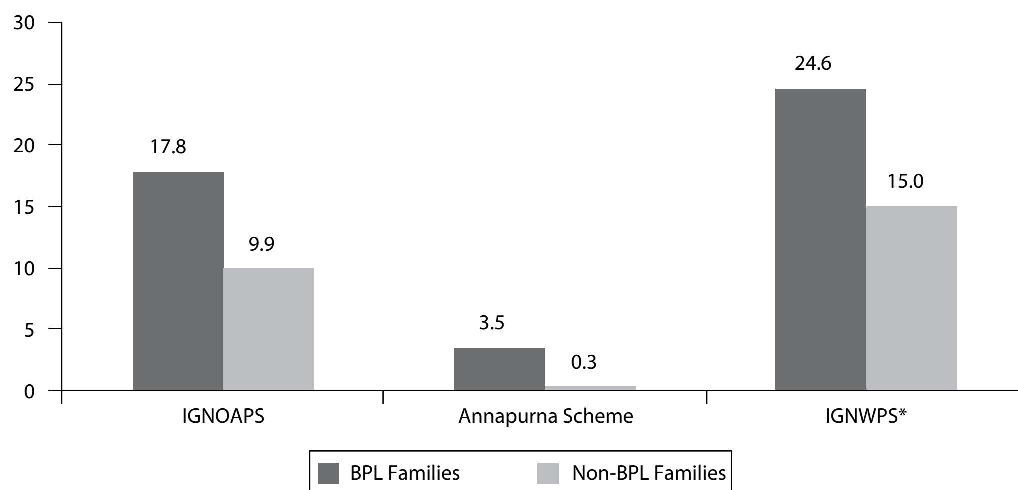

Figure 12.5 Utilization of Social Security Schemes (in per cent) among BPL Elderly in Seven Surveyed States in India, 2011
Source: BKPAI Survey, 2011 (Alam et al., 2012).

collected information on three major social security schemes at the national level: Indira Gandhi National old age pension scheme (IGNOAPS), Annapurna scheme, and Indira Gandhi National Widow Pension Scheme (IGNWPS). Those who are not able to get Indira Gandhi old age pension scheme (IGNOAPS) are eligible for free allocation food through Public Distribution System (Annapurna scheme).

Figure 12.5 indicates the utilization of social security schemes among BPL and Non-BPL card holders. Overall, the penetration of different schemes among the elderly is relatively very weak. Although, the schemes are meant to cover the BPL households, the survey also found that elderly from non-BPL households are also utilizing the schemes which point towards the poor targeting of the scheme. Even the coverage among BPL households is also far from universal. Around 18 per cent and a quarter of elderly among BPL households are utilizing the IGNOAPS and IGNWPS. The low utilization of schemes by elderly from BPL households signifies that the scheme is not able to significantly reduce the financial vulnerability of elderly in the country. Moreover, the monthly emolument available under these schemes is meagre. There are state level variations as state also contributes to the central share but in most cases the amount is less than Rs 1000/- per month. Hence, there is an urgent need to ensure the reach of social security to all the BPL households the amount is enhanced to ensure that the vulnerability of the as elderly is addressed.

Income and Financial dependency

Financial security of an individual greatly depends on the available personal income as well as other assets owned by them. In case of elderly, it is expected that the personal income come from pensions and assets rather than from salary and wages. If the elderly still depends on salary and wages as their primary source of income, it is a clear indication that their financial insecurity.

Table 12.2 highlights the economic dependency of the elderly in the country as nearly 43 per cent of the older persons in India do not have any personal income at all and they are likely to be fully dependant on others economically. The economic dependency is more acute among older women than older men. Around 18 per cent of the older person receive social pension and 11 per cent receive pension from their employer. Hence better coverage of social pension and employer pension is needed to ensure financial security of the older persons.

A greater dependence on agricultural income is also seen in the table with nearly one fourth of the elderly men report dependence on agricultural income. The table also clearly shows the importance of continued employment as an income source especially for elderly men. This is a cause of great concern as economic compulsion as the major motivation for elderly men to work especially from the poorer strata. Overall, the income data show a greater economic dependency among older persons and therefore there is an urgent

Table 12.2 Elderly by Sources of Current Personal Income by Sex in Seven Surveyed States in India, 2011

Sources of Income*	Men	Women	Total
Salary/Wages	17.7	6.9	12.0
Employer's pension (government or other)	16.5	6.8	11.4
Social pension (old age/widow)	13.7	22.4	18.3
Agricultural/Farm income	23.8	3.2	12.9
Other sources of income	14.1	4.9	9.3
No income	26.0	58.7	43.2
Number of elderly	4,672	5,180	9,852

Source: BKPAI Survey, 2011 (Alam et al., 2012).
Note: *Multiple sources of income.

need to strengthen the coverage and reach of social pensions in the country. Further, greater dependence on salary and wages also confirms the economic compulsions as a reason to work during old age.

Person owning or inheriting assets in terms of land, plots, housing, jewels, savings bonds, and shares can generate their own source of income without involving much physical labour through rents, interest, dividends, etc. The assets not only generate income but also provide the elderly a status and respectable position within the household. Figure 12.6 shows that around one-fourth of elderly do not own any sort of assets. The elderly with no income and no assets are likely are the most vulnerable and the figure shows that a significant proportion of elderly particularly women fall on this category.

Elderly people not having personal income or with insufficient income to meet their basic requirements need to look for financial support and depend fully or partially on their family members. Table 12.3 shows that nearly three-fourth of the elderly are either fully or partially dependent on their family for their economic needs.

As expected sons are the major sources of support. This means that the financial burden of the elderly care lies with the family and family member's acts as the safety net for the older persons. But in most cases, the families may not in a position to provide economic support to the elderly members as they themselves belong to the poorer wealth quintiles and the families themselves may be struggling to meet both ends.

The employment status and the economic situation bring out clearly several important aspects of elderly life in the country. First, the elderly workforce participation in India is driven out of poverty and economic

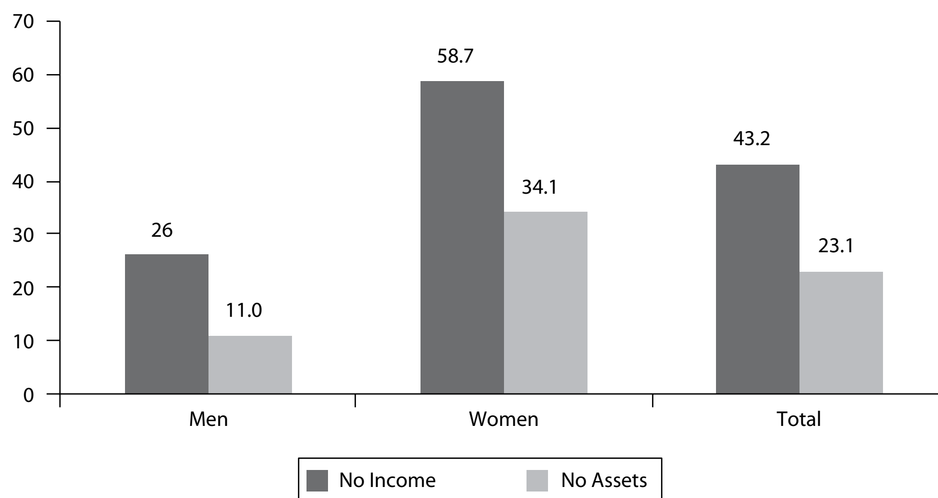

Figure 12.6 Percentage of Elderly with no Income and no Assets by Sex in Seven Surveyed States in India, 2011
Source: BKPAI Survey, 2011 (Alam et al., 2012).

Table 12.3 Percentage of Elderly Based on Financial Dependence and Source of Economic Support by Sex in Seven Surveyed States in India, 2011

Financial dependence	Men	Women	Total
Fully dependent	32.6	66.4	50.4
Partially dependent	31.8	21.0	26.1
Source of economic support			
Son	46.8	52.2	49.7
Spouse	7.3	22.0	15.0
Daughter	2.4	4.8	3.7
Others	5.5	6.0	5.8
Not dependent on anyone	37.9	14.9	25.8
No. of elderly	4,672	5,180	9,852

Source: BKPAI Survey, 2011 (Alam et al., 2012).

compulsions rather than choice. Second, the coverage of social security is meagre and does not adequately support elderly to reduce the financial insecurity. Third, a large majority of the older persons in the country are economically dependent on their families. Fourth, there are significant gender differences in economic vulnerability of elderly with most women economically dependent on their families.

Undoubtedly, in the absence of adequate social security measures, the financial security of the older persons greatly depends on their ability to participate in the labour market. But unfortunately, the work participation of elderly is critically mediated by the health conditions as advancing age also the period of health related vulnerabilities. The studies have pointed out that one of the major reasons for not participating in labour market is the poor health status among elderly (Alam et al., 2012). Older people at advancing ages may have serious functional limitations and they may need assistance to perform their daily activities such as bathing, eating, walking, etc. Disability also increases with increasing age and this often limits their ability to work. Therefore, it is important to look into the health status of elderly for a better understanding of elderly profile in India.

Health and Disability

In general, the old age is also associated with increasing levels of morbidity, disability, and health care costs. The burden of chronic diseases goes up exponentially during old age. The studies have observed that around 65 per cent of the elderly in India have at least one chronic disease which depicts the magnitude of the health issues among elderly (Alam et al., 2012) The capacity to perform daily activities routinely also reduces with ageing necessitating assistance and support. The concept of functionality for the elderly involves the ability to perform self-care, self-maintenance, and physical activity. Functional limitation is also associated with loss of independence and with increased need for both formal and informal care (Fried and Guralnik, 1997).

The 'activities of daily living' or ADLs are the basic tasks of everyday life, such as feeding, bathing, dressing, toileting, mobility (i.e., getting in and out of a bed or chair) and continence (controlling bladder and bowel movement). When people are unable to perform these activities, they need assistance either from others or with the help of mechanical devices or both. The survey assessed their level of independence for six different types of ADL activities covering physical domains of functionality, viz., bathing, dressing, toilet, mobility, continence, and feeding.

Figure 12.7 shows that around 8 per cent of the elderly require assistance to perform one of the daily routine activities. Assistance required to perform various ADL activities is highest for bathing and lowest for feeding. This shows a huge demand for care for the older persons. In the changing circumstances, if families are not able to provide adequate assistance to the elderly, professional home based care may be an alternative to fill the care needs in the future. Further, functional limitations are more for older women than for older men. Therefore in the health font also women seem to more vulnerable than men.

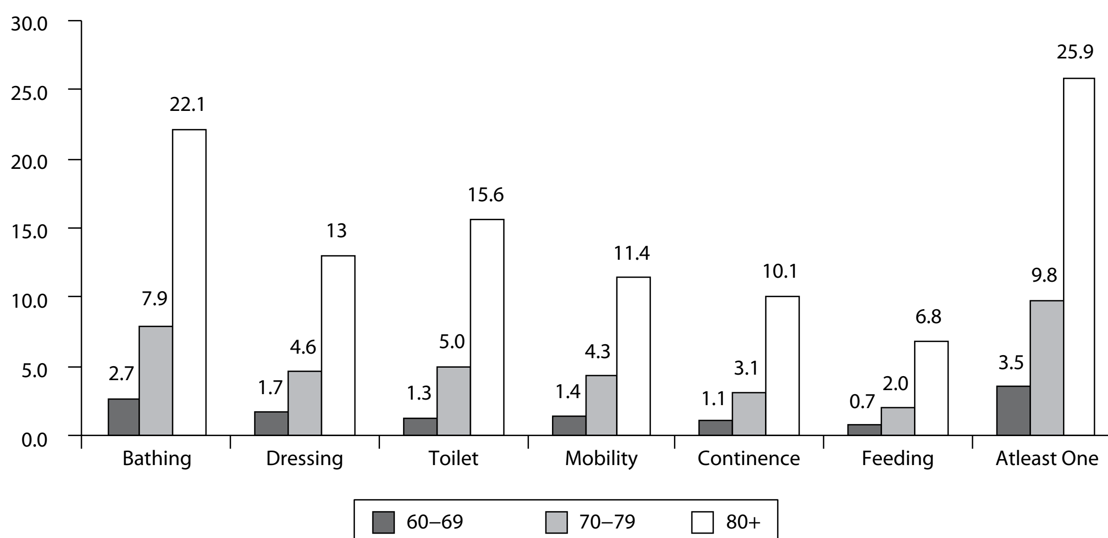

Figure 12.7 Elderly Needing Full/Partial Assistance for ADL Activities by Age, 2011
Source: BKPAI Survey, 2011 (Alam et al. 2012).

Disability is yet another matter of concern for elderly as with the growing age, it can seriously limit their functioning. While the disability rate among the population at large is around 2.2 per cent, for elderly it is around 5.2 per cent in India (United Nations Population Fund, 2011). Disability is also linked to a higher probability of being poor. In many settings, people with a disability have a lack of support and face reduced employment opportunities and earnings. Other household members may have to give up their jobs to care for them. Typically, people with disabilities have higher health-care costs, and may also face social and political marginalisation (Groce et al., 2011).

The BKPAI survey has also collected similar information for various disabilities such as visual, hearing, walking, chewing, speaking and memory. However, the disability rate brought out by the survey is far higher than that of the census figures. The prevalence of disability varies from 59 per cent for vision to about 7 per cent for speech (Figure 12.8).

Figure 12.9 shows the use of aids by elderly with disability. The figure shows that spectacle is the most widely used aid. Usage of other aids such as hearing aid and dentures are negligible among the elderly. The table also shows huge unmet need for aids. Nearly half of the elderly with some visual disabilities are not using

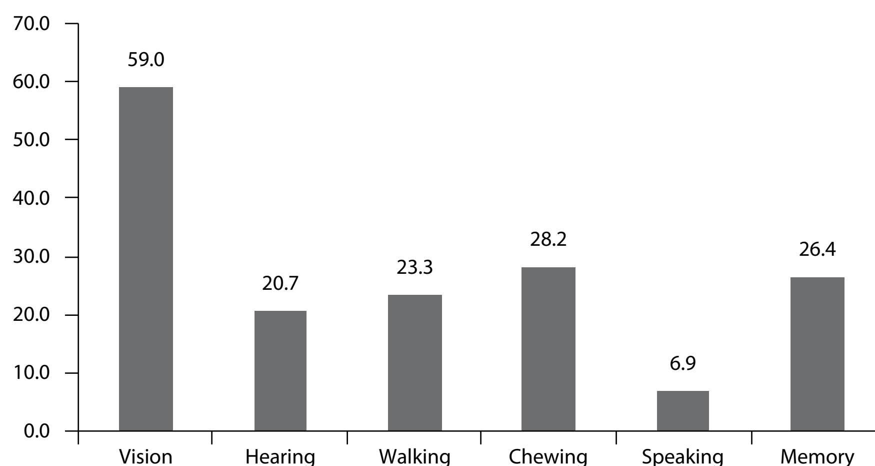

Figure 12.8 Percentage of Elderly by Type of Disability in Seven States of India, 2011
Source: BKPAI Survey, 2011 (Alam et al. 2012).

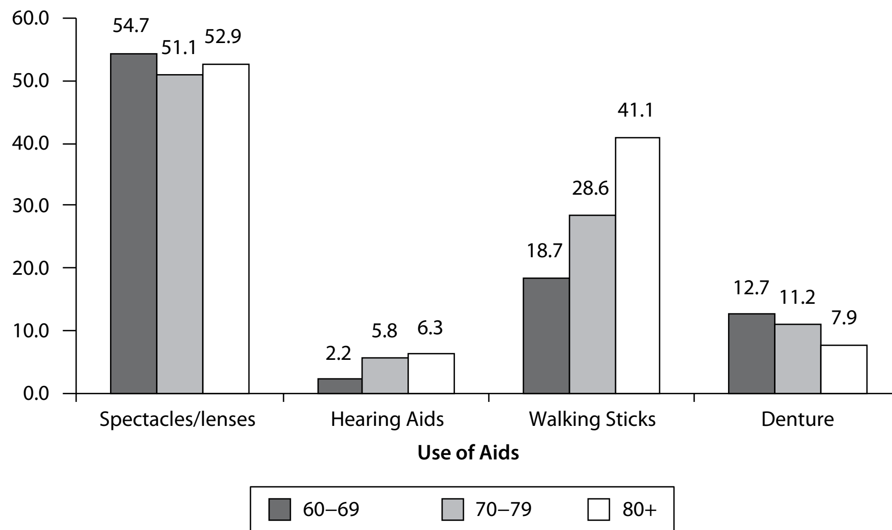

Figure 12.9 Percentage of Disabled Elderly Using any Form of Aids According to Age in Seven States of India, 2011
Source: BKPAI Survey, 2011 (Alam et al. 2012).

spectacles indicating a huge unmet need for aids. The financial dependency of the elderly may be one of the reasons for unmet need for the aids. Further, families may not be able to bear the cost for providing aids to the elderly persons.

The status of older persons in India clearly shows they work out of economic compulsions to meet their basic needs. With low levels of income and assets and mounting health problems, the major challenges faced by the Indian elderly is to ensure income security and also to meet their age-related health problems. With the changing fertility levels and consequent familial changes, sustainability of informal support systems in India is oven doubtful. One of the ways to deal with this problem may be by provisioning of appropriate social security benefits to the older persons. However, the studies have shown that only a small proportion of the older persons are benefitted by the social security schemes, the following section therefore discusses how far the social security schemes have reached the elderly in the country.

Discussion

The chapter provides a profile of elderly in the country with respect to employment, social security, income, functional limitations and disability to depict the status of elderly in India. The profile raises several issues of concern and brings out the implications of changing demographic profile in the country. The demographic changes in India have not been backed significantly by socio-economic changes. As a result, the characteristics of the elderly in India will also be significantly different from that of many other countries. A higher proportion of elderly working in India reflects that the existing resources within the family are not sufficient to meet the basic necessities of elderly and hence required to work at older ages. Most of the elderly work out of compulsion, not out of choice. More than two-fifths of elderly in India do not have any source of income around one-fourth of elderly do not own any sort of assets. Even the salary/wages earned by the elderly are not sufficient to meet their own requirements and hence are dependent mostly on their children. Only one-tenth elderly are covered under pension benefits through the employer. The social security schemes through the government covered only a smaller proportion of elderly below poverty line households. All these call for an immediate need for a sustained social security system for elderly in India. While the country had tremendous achievements in demographic front despite poor standard of living, these achievements might turn out to be a nightmare if the increasing elderly proportions are not taken care by developing adequate institutional structure particularly a well-developed social security system.

Beside the work and income security, the other dimension to focus is their functional health and ability to carry out their day-to-day activities. A quarter of elderly in the oldest old group suffers due to one or other functional disorder and requires some assistance from other family members. The disability burden is high and the use of aids for disabled elderly limited. Not only that the disability care and use of aids are poor, but even

the preventive and promotive health as far as the huge chronic diseases burden are concerned also not adequate.

This chapter highlights the extreme vulnerability and huge care burden exists in the society. It argues the need for social security support for elderly. Unfortunately the burden of care; physical, emotional, or financial, remain with the family. With the current demographic scenario, sustainability of such informal support system is questionable and not promising. Further women, poor and illiterate are more vulnerable with no definite support system either from family or from government. The absence of formal system of retirement income support for unorganized and informal workers highlights the need for strengthening the formal channels of providing the retirement benefits through the government. The government support can bring the economic relief to the elderly. Underlying functional limitations and inability to provide assistance and use of aids to disabled population are vital for developing policies on ageing that address the provision of care through formal sources.

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13

Indispensable Yet Inaccessible

The Paradoxes of Adequate Housing in Urban India

Gautam Bhan and Anushree Deb

The need for quality of basic services and infrastructure in cities remains undisputed. With future projections adding around 100 million people in cities by 2030, ensuring access to these basic services has never been more important for any understanding of social development, inclusive growth or human development, regardless of how one frames the debate (IIHS, 2015). Yet within this broad agreement, adequate and affordable housing hangs precariously. While often recognized and articulated as a basic human need it is never equally recognised as as a public good—let alone a fundamental right—that every urban resident must have meaningful access to. It is within this misrecognition that housing inequalities persist, deepen and reproduce in our cities.

Our goal in this chapter is to understand and frame the ways in which access to affordable and adequate housing remains unfulfilled specifically for income-poor and marginalized urban residents. Given space constraints, we do so focusing on a particular object: housing policy. By this we mean that we are concerned with particular forms of public action on affordable housing, the specific instruments used in order to carry them out, and the actors and institutions tasked with doing so. Such a focus does not imply that we believe that policy actions more powerfully control or direct housing as opposed to, for example, the market or self-built housing by communities. It implies only that our focus is on how and to what ends policy makers and public institutions must act precisely given that they are just one part of the various dynamics influencing urban housing.

The chapter is organized as follows. The first section briefly delineates our understanding of 'housing', and argues that the current trend of defining 'housing shortage' in terms of units does not adequately capture exclusions from adequate and affordable housing. We suggest instead a different frame, looking at housing poverty[1] through three lenses: adequacy, affordability, and viability. Using this framework, the second part of this chapter then highlights four key kinds of exclusions that mark housing poverty: (a) fractured and diverse regimes of (in)secure tenure; (b) inadequate access to basic environmental services; (c) segmentation in the housing market that makes adequate housing unaffordable; and (d) inappropriate policy and planning frameworks at state and national level. Finally, in conclusion, it then concludes with briefly suggesting different ways of approaching the housing question through policy as a way of moving forward.

From 'Housing Shortage' to 'Housing Poverty'

What is the challenge before us? In policy circles today, 'housing shortage' has become an important buzzword used to determine targets for schemes such as Housing for All by 2022. Debates then have centred on *how many* houses of what size or kind, that is, on the quantum of the shortage. This is necessary. Policy landscapes demand targets to guide resource allocation and enable monitoring. Yet, even within those constraints, how one understands the nature of this 'shortage' matters. Framing the question correctly is the first step of effective policy and so it is here that we must begin.

We argue that housing must be judged on three criteria: (a) adequacy, (b) affordability, and (c) viability. The first is a measure of the adequacy of the physical dwelling unit including considerations of size, safety,

and the materials used. The second refers not just to the availability of legal and formal housing stock at certain price points but also to housing finance in order to help households mobilize resources. The third reminds us that housing—especially but not only for income-poor households—is always inter-linked with decisions on employment, proximity to transit, access to basic social infrastructure such as health and education as well as the availability of basic environmental services like water, sanitation, and sewerage. In other words, for an adequate and affordable *dwelling unit* to become viable *housing*, it must be possible to make a life there. Viability in affordable housing is then understood in terms of distance from place of work, mobility in terms of access to public transport, social and physical infrastructure in the form of schools, medical facilities, electricity, roads, and other aspects that make housing liveable (see IIHS 2015 (Deb, 2016).

When we speak of these inter-connected elements, we speak of housing, not 'houses' or 'housing units'. We realize that housing policy must be part of broader urban development even as it is bounded as sector, department or programme. We place housing rightfully as an urban system inter-connected with other aspects of the city and household life. It is then that the true nature and extent of the housing question becomes evident.

Immediately, we face our first challenge: how do we translate this into empirics? Our current ways of collecting and collating housing data offer few means to capture such a reality or way of thinking about housing. The most cited public data on housing that goes some way to capturing these facets is the Kundu Committee Report (2012) commissioned by the Ministry of Housing and Urban Poverty Alleviation. The report argues that the overall housing shortage in India is of the order of 18.78 million units. Figure 13.1 lays out the estimation of this shortage, along with comparisons with both the earlier Kundu Committee Report as well as the Census of 2001 (Census, 2001) (MoHUPA, 2008).

The Committee made a set of important arguments. It said that the housing question in India was not one of large scale homelessness or absolute scarcity of housing. Put simply: households that had 'housing shortage' did not literally lack homes or shelter. The problem, they argued, was that the shelter that people could secure affordable access to was inadequate. They termed this 'housing poverty'. This is important: it marks the nature of our housing shortage as a challenge to deal with already existing housing, not just produce more stock. When housing was affordable, they argued, it was mostly inadequate. When it was adequate, it was mostly unaffordable. Therein lies the nature of our housing problem.

Housing deficit	2001	2007	2012
Total number of households (HH)	55.83	66.3	81.35
Total housing stock (HS)	50.95	58.83	78.48
Housing deficit (HH-HS)	4.88	7.47	2.87
Households requiring new housing			
Upgradation of katcha housing	1.7	Not included	
1. Living in non-servicable kuccha housing	–	2.18	0.99
2. Living in obsolescent housing	2.01	2.39	2.27
3. Living in congested housing	1.97	12.67	14.99
4. Homeless	Not included		0.53
Sub Total (1+2+3+4)	5.68	17.24	18.78
Total housing shortage	10.56	24.71	18.78

Figure 13.1 Estimates of Urban Housing Shortage

All figures are in millions. *Source*: Kundu et al. (2012).

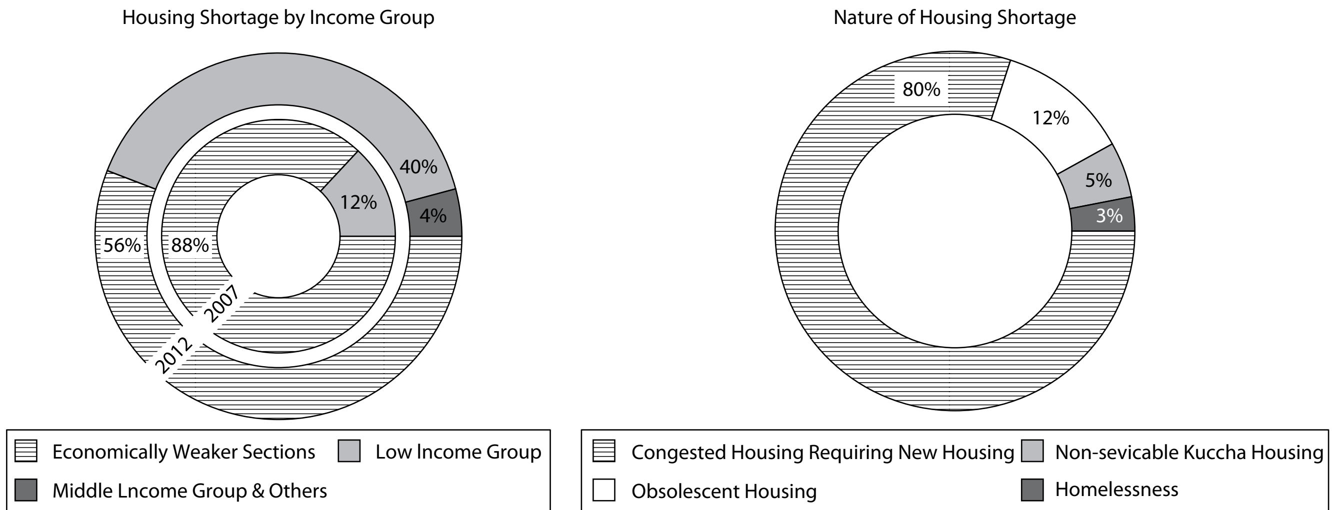

Figure 13.2 Urban Housing Shortage by Income Group
Source: Kundu et al. (2012).

How are we to understand adequacy in this case? The Committee defined 'inadequacy' as being marked by 'unacceptable physical and social conditions'. The former was measured as non-serviceable kutcha housing. The latter by congestion—the presence of married couples in a dwelling unit that had no exclusive room to themselves. These are pragmatic choices—they can be derived and measured from existing public data sets like the Census or the National Sample Surveys. Our interest here is not to debate these thresholds but to point out that such a framing does two things. First, it ensures that measures of adequacy are not reduced just to the materiality and size of the dwelling unit. Second, by using the idea of an 'acceptable' norm, it reminds us that the debate on what constitutes an entitlement to housing as a basic need is not a technical but a political one. The threshold of what is 'acceptable'—20 sq. m or 25 sq. m? One bedroom or two? Concrete or mud walls?—is not a matter of technical expertise but a norm that must be determined through constant deliberation, struggle, and negotiation.

Yet there was much ground that the Committee could not cover. While the notion of 'housing poverty' is very useful, it is pivotal that new scholarship and research build and extend the Committee's formulations. Several key factors of housing poverty are absent from the estimations of housing shortage in the report: access to basic environmental services like water, sanitation and sewerage; accessibility to affordable transit; availability of access to materials or, alternatively, housing finance; and, perhaps most critically, security of tenure. It is not a coincidence that each of these are concerned with our third aspect of housing: viability. Viability remains the most critical factor in determining whether already existing or new housing will be sustainable and occupied in the long term by households. Yet, frustratingly, it also represents the hardest aspect of housing poverty to tangibly grasp and measure. As we have already argued, the challenge of capturing viability in empirics that can underlie policy and programmes is a challenge we must not take lightly.

The Committee's report marked a second important challenge: affordability. Figure 13.2 shows that 96 per cent of housing shortage is almost entirely concentrated in households classified as either Low Income Group (household income between Rs 5,000–10,000 a month) or Economically Weaker Sections (household income under Rs 5,000 a month) (MoUD, 2010).

This is critical. It implies that the character of unmet demand for housing is particular and concentrated rather than generalized. For housing policy, this must act as a starting point in intervening into any imagination of 'Housing for All'—the parts of the 'all' that are excluded from adequate, affordable, and viable housing are those that are most severely income-poor. This is not self-evident. In societies were housing is more publicly regulated and provided, it is not necessary for a paucity of income to translate into equally severe housing shortages. The fact that it does signals the structure of our urban housing markets, an argument that we shall return to later in this chapter. For now, the point we wish to

underline is that the common refrain heard in parts of policy circles that 'even the middle classes cannot afford housing' is not empirically true. They may not be able to afford the housing they want where they want it, but they are not denied a base measure of adequate and affordable housing that is the subject of policy.

What should the limit of what policy considers 'affordable housing' then be? Affordability as defined by the Ministry of Housing and Urban Poverty Alleviation indicates that housing units must be up to 5 times the annual income of households (MoHUPA, 2008). If we accept this premise, then the envelope of what is 'affordable housing' becomes defined more clearly. EWS and LIG households are marked as those with less than Rs 1 and 2 lakhs annual household income. For them, therefore—and for 96 per cent of the housing shortage—the upper limit of affordability is a house worth Rs 5 and 10 lakhs. The challenge for Housing for All therefore is to provide houses under Rs 10 lakhs, with a concentration of supply around Rs 5 lakhs and less that can include EWS households.

In what follows, we look at three key constraints that bind households from accessing housing that is affordable, adequate and viable. The first looks at what makes existing affordable housing both unviable and inadequate: insecurity of tenure and the absence of basic environmental services. The second then looks at segmentation in the housing market that makes adequate housing unaffordable. The third then argues that current housing policy misrecognises the housing problem by trying only to increase the supply of new units that may be affordable but will continue to remain unviable.

Regimes of (In)secure Tenure

Elsewhere, one of the authors has argued that tenure security can be understood as the *de facto* or *de jure* sense of security that one will not be evicted from or dispossessed of one's home (Bhan, Goswami and Revi, 2013). The landscapes of Indian cities are marked by numerous settlements that are, to use a term often used by Brazilian urbanists 'auto-constructed' (Caldeira, 2014). Auto-constructed neighbourhoods and communities are self-built by residents and communities themselves, usually over years of slow, incremental improvements. These communities are built with what Caldeira describes as 'transversal logics' in tension with more formal logics of planning, law, and labour.

An example makes this clear: the squatter settlement or 'slum'. We refer to them here as *bastis,* using the colloquial Hindustani word that is used by residents themselves for their neighbourhoods. Bastis refer to built environments that reflect, in many material ways, the impoverishment of their residents, many of whom are income-poor. They are affordable housing, matching the resources and incomes of their residents. They are often not but have the potential to become adequate as services and dwelling units slowly improve over time. In one sense, they are viable, often built precisely because they enable access to nearby livelihoods and transit. Yet this potential adequacy and viability is constantly under threat.

This is because they are also occupations of land that basti residents claim, use, build and occupy, but often do not own in title. This is not an easily legible distinction. Over the years in most *bastis,* layers of legality are built. Voter ID cards, public services like water and electricity, and often even letters and promises of *pattas*, licenses or just permissions to occupy, are won after difficult and drawn out struggles. As bastis incrementally grow over years and decades, a *de facto* security of tenure grows even as *de jure* legal rights to land may remain elusive. Theorists often speak of this as 'informality' or 'illegality'.[2] What does this tenure do to the potential viability and adequacy of what is existing, affordable housing stock where people are living? We outline two key impacts.

Inadequate Access to Basic Services

The first impact is that insecure tenure compromises access to basic services. Bastis are marked by widespread in adequacies in access to basic environmental services like water and sanitation that, in our understanding of housing, prevent it from becoming viable in the long run.[3] This is not simply due to a lack of income. In many cases, urban local bodies and utilities face *de jure* restrictions from providing public services in unplanned or informal settlements. Often, where such services are provided, residents are offered a different level of service: communal instead of individual connections, for example. Even without explicit restrictions, informal settlements often only achieve services through long duree struggle and political negotiations with the state (executive and judiciary) being able to use illegality as a means to explain either denial or delay in provision of services.

A set of examples can make this clear. In Delhi, the Delhi Jal Board is not obligated to 'provide water supply to any premises which have been constructed in contravention of any law' (Ch. 3, Section 9.1a of the Delhi Jal Board Act).[4] In Mumbai, under the Municipal

Corporation of Greater Mumbai Water Rules, 2002, water connections can only be given 'to a group of hutment dwellers with not less than 15 members', failing which an exceptional case has to be argued for. But more importantly, 'such connections can be granted to only such hutments which were constructed though without proper permission, prior to 1-1-1995'. The exclusion therefore works through a cut-off date. A recent judicial challenge to this exclusion in the Bombay High Court has resulted in its reinforcement. Denying the petition filed by the *Pani Haq Samiti*, the Bombay High Court articulated a common fear underlying the denial of water to basti residents—that services would make residents feel entitled to tenure security: 'you would not want to move away from that place if you have water'.[5]

Yet insecurity of tenure can also result in *de facto* exclusions through the requirements of process. Even if the Bangalore Water Supply and Sewerage Board (BWSSB) does not have *de jure* exclusions for households without tenure, applying for a water connection requires an application along with 'sanctioned plan or Tax Paid Receipt'—a requirement certain to exclude many households, particularly poor households without tenure. Inclusion may also be differentiated with a distinction between what level of amenities can be provided to communities with or without security of tenure. As the BWSSB outlines, it offers 'individual household connections for those with land tenure' and 'community-level services such as shared metered connections' for 'communities without security of tenure'.[6]

Looking at housing and not houses, such inadequacies make affordable basti housing inadequate. Macro-data tells us that only 71 per cent of urban households have access to drinking water within their premises. Even within this 71 per cent, two-thirds (49 per cent) do not get treated tap water (Census, 2011), we must understand this as a problem deeply linked with housing and spatial illegality and not just a market of the limits of household income or government resources.

THE THREAT AND REALITY OF EVICTIONS

The second impact of insecure tenure on housing is that the absence of secure tenure is an exclusion in itself. Residents live in contradictory and uncertain legality often for years, never able to fully invest in their homes. In Bengaluru, slum settlements that have been living on the same stretch of land for over 40 years have nothing more than a piece of paper legitimizing their claim to the land in the form of a 'possession certificate'. The judicial validity of the same possession certificate can be challenged, questioned and even revoked, subject to changing political temperaments of state governments. Therefore, for those already living in insecure tenure, ways for them to claim rights to adequate housing get further restricted.

The threat of eviction that lies behind tenure insecurity is far from empty. Forced evictions have scarred Indian cities in the past two decades in increasing frequency and intensity (see documentations of evictions in Delhi (Bhan, 2015), Mumbai (Ramanathan, 2005), Ahmedabad (Mathur, 2012), Bangalore (PUCK and HLRN, 2013), Chennai (Coelho, Venkat, and Chandrika, 2012) as well as Kolkata (Roy, 2003). Such evictions deplete social and economic gains accumulated over the years by households (Bhan and Shivanand, 2013), and erase incrementally built housing stock. Where it occurs, post-eviction resettlement is often incomplete, covers only one set of residents, and is located far from the city in peripheral locations where land is cheaper. In the case of Delhi, such resettlement has been described as 'permanent poverty' with a generation that is prevented from development by a depletion of assets, a breaking of livelihoods, increased costs due to the distance from work and the city, increased violence, the fracturing of long-built community ties, as well as large-scale dropouts from school education (Bhan & Sen, 2008).

A Segmented Housing Market

Why then do households resort to living in bastis where adequacy and viability of housing are both under threat? The reasons why bastis emerge and remain such a demographically significant part of urban India's housing stock—as well as a majority of the housing of the urban poor—is a complex one we cannot take on this chapter. In brief, however, it is imperative to assert that bastis are also evidence of the nature of land and housing markets in the city. They mark an absence of adequate legal, formal, and affordable housing stock in our cities. Part of the structure of our housing and land markets takes us back to the argument in the beginning of this chapter about affordability. Given the income distribution of urban households, an affordable housing market needs stock at different price points. Who can build this housing?

Private market analysts from Monitor Deloitte that have looked at the possibility of private developers building low-income and affordable housing offer analyses of urban housing markets such as the one presented in Figure 13.3.

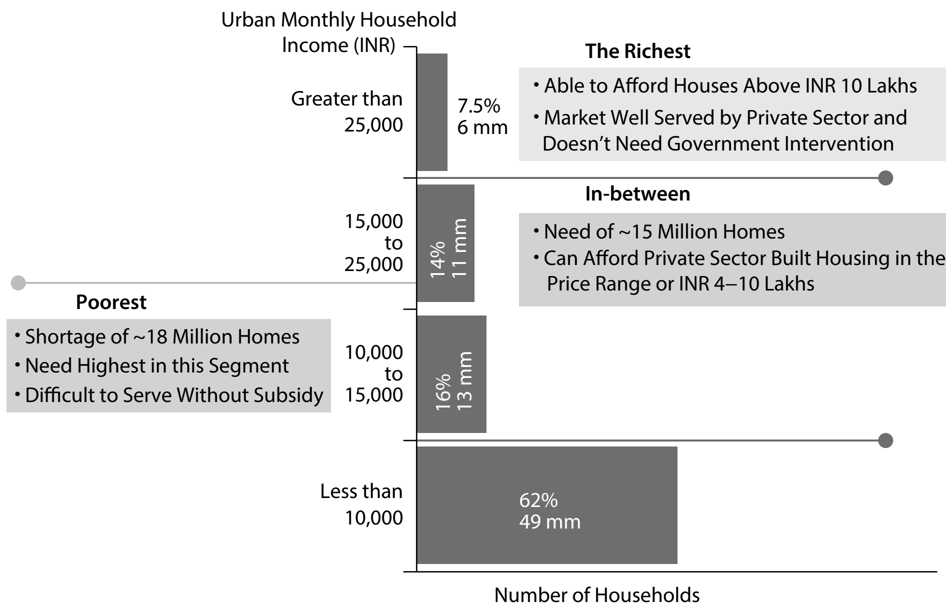

Figure 13.3 The Affordable Housing Market
Source: Aggarwal and Jain (2014).

The figure is telling. As argued earlier in this chapter, the greatest need is for housing below 4 and between 4 and 10 lakhs. Below 4 lakhs, they are clear: 'This segment is difficult, if not impossible, to serve without subsidy or government support.' Even for the segment between 4 and 10 lakhs, the market has potential but remains uncertain. It is only for households that earn more than Rs 3 lakhs a year (so above EWS and LIG definitions, and far above urban poverty lines) that the private market can perhaps make a dent in supply. The segmentation of the existing housing market becomes increasingly apparent if we look at a different empiric: the distribution of housing finance. As Figure 13.4 shows, the National Housing Bank's data suggests that only 3 per cent of loans given for housing are up to Rs 5 lakhs, and only 14 per cent are above 5 lakhs but under Rs 10 lakhs. In an affordable housing market where unmet demand is concentrated below Rs 10 lakhs, the near complete exclusion of low-income households from formal housing finance is quite clear.

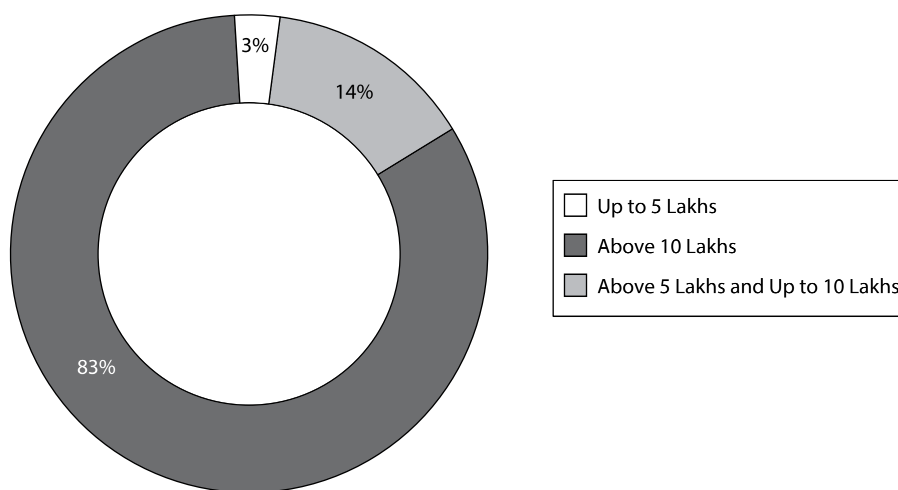

Figure 13.4 Slab-wise Disbursement of Housing Loans to Individuals
Source: NHB Data, 2012.

The skews in available supply in the housing markets are then clear to see. Legal housing stock is simply unaffordable for most urban residents and access to finance to reach what may be possible also doesn't meaningfully exist. If the private market cannot provide at scale and at the right price points, then affordable housing supply must come from either government-led/government-aided housing or housing that is self-built by communities. The latter is precisely what becomes the basti and represents the only set of affordable housing stock built at scale no matter its vulnerabilities, insecurities of tenure and inadequacies. The history of housing exclusions, in many ways, is then precisely the failure of public action to build enough legal, formal affordable housing or to structure land and housing markets to ensure its delivery through other actors. There are complex histories to this failure that are beyond the scope of this chapter.

Briefly, we mark that these diverse histories across different states in India share some patterns. One, resource and capacity constraints across state governments and public development agencies to produce enough affordable housing over time through direct construction. Between 1970 and 2000, public housing production in India averaged at 1 unit per 5000 people. Authorities like the Delhi Development Authority, in particular, did not produce enough affordable housing units despite having acquired sufficient land (Sengupta, 2014). Two, the inability of planning and regulatory frameworks to direct and allocate sufficient land for affordable housing, or to ensure that even the limited reservations were implemented. Three, the absence of sufficient investments in regional and urban infrastructure to expand settlement structures and accommodate migration as well as natural growth (HPEC, 2011), among many others.

Inappropriate Policy Frameworks at State and National Level

The inability of the state to either directly provide or ably regulate the provision of legal affordable housing stock is arguably at least partly linked to housing's uncertain status as a right or entitlement within the terms of the welfare state. The nature of housing in India may have been vastly different had the National Campaign for Housing Rights met with success in its demand to make housing a fundamental constitutional right for all citizens. The absence of a clear rights and entitlement framework for housing has also meant that housing rights have an uncertain judicial record. While the courts have, at points, intervened to expand and protect them, they have just as often refused to halt evictions or hold the state accountable for its failures to meet even its own insufficient targets for adequate housing.

In the absence of a clear entitlement framework, housing then has remained often a discretionary and under-valued part of the state's welfare programmes. Housing is a state subject, and policy histories of housing have varied greatly across the country. On the national level, however, there was no coherent and enabling policy attention until the mid-1980s. The National Housing Policy of 1988 was universally thought to lack teeth, and was almost immediately followed by a National Housing and Habitat Policy that was recently strengthened in 2007. The emergence of national housing policies in this period as opposed to, for example, in the 1960s, however, places them in an entirely different political economy.

From JNNURM onwards, housing policies have found themselves intervening in land markets under extreme pressure to generate rents through high-end urban development and infrastructure projects, as well as urban governance frameworks that see cities as 'engines of growth', to use JNNURM's language. If one were to read the texts of the housing missions from 2005 starting with JNNURM's Basic Services to the Urban Poor (BSUP) to the Rajiv Awas Yojana (RAY) and now to the Prime Minister's Awas Yojana (PMAY), a stark reduction in the role of the state and central governments in the actual provision of housing and moving more into a space to facilitate housing can be clearly interpreted.

There is a second significant shift that is of concern: housing policies are increasingly focusing again on dwelling units—on houses, not housing. From BSUP onwards, housing programmes have sought to create frameworks where the focus is on the delivery of new housing units. The 25 sq. m flat has thus become the sole and single definition of what it means to address housing shortage. Yet as we argued in the beginning of this chapter, housing shortage is distinct from housing poverty. Given the history of the inability of both the state and the market to build housing units at scale, as well as the nature of the segment housing market in our cities, is it possible to build our way out of housing shortage?

The experience of JNNURM and RAY seem to suggest otherwise. There are several concerns: Current urban development policies are unable to regulate the supply of land for affordable housing through either mandatory reservations or through using inclusionary zoning. In such a case, land used to build new housing is often peripheral and far from the city. The viability of such housing is deeply fraught. Since its inception in 2009, out of the 4,571 dwelling units constructed

under RAY till September 2015, only 313 are occupied; indicating an occupancy rate of less than seven per cent. (MoHUPA, 2015). Let alone the fact that the quantum of units constructed is woefully inadequate to meet the housing challenge–even those that are built are not occupied.

Such an imagination crowds out other ways of addressing housing. Specifically, it changes the focus from in-situ upgradation, that is, improving existing affordable but inadequate stock (say in bastis, for example) through the provision of basic services and secure tenure. Any empirically sound analysis cannot deny that the largest stock of affordable housing stock that has been built is within 'informal settlements' of the urban poor. It is here then that any serious intervention to reduce housing poverty must begin, especially given the absence of any likely large scale intervention through either the formal private market or state action.

In-Situ Upgradation—where existing settlements are provided upgraded infrastructure and services—along with secure tenure remains then the single most effective way to make existing affordable housing both adequate and viable. International experience bears evidence to this in the success of Thailand's *Baan Mankong* housing programme that reduced housing poverty significantly within one generation (Boonyabancha, 2009). The success of Ahmedabad's Slum Networking Programme that worked with simply a 'No-Eviction Guarantee' is a domestic example of the benefits of upgradation (Das and Takahashi, 2009)

It is important to be specific here: in-situ upgradation is not the vertical re-development of slums into G+3 vertical housing units but the improvement of the settlement through services and tenure. Upgradation focuses then not on the dwelling unit but the settlement—allowing households to upgrade their own personal dwelling unit over time and incrementally, even as the viability of their housing improves around them. While RAY at least allowed the possibility of upgradation, it is disheartening to see that PMAY focuses entirely on PPPs and developer led building of vertical housing units.

Finally, housing policies have also been singularly ownership focused, thinking only in terms of producing individual and titled homes. While this often expands the formal market at the lower end of the market, experience across Indian cities show that such forms of housing are quickly gentrified and used by non-poor households, or by the upper spectrum of the poor at the expense of those with relatively less capital and resources. Ownership-centric policies have meant a deep neglect, at best, and outright hostility, at worst, to rental housing, for example, or housing forms like dormitories, shelters, communal homes, etc. that play a critical role in responding to the housing needs of the homeless, migrants as well as poor urban residents in general.

Plotted development and individual sites may not be feasible in metropolitan cities like Bengaluru, New Delhi, Mumbai. However, in Tier I & Tier II cities where market forces of urbanization have not yet distorted the land market, regulating the built form through individual house sites is key to building vibrant communities. By allowing households to build housing on individual sites, they incrementally improve their housing and quality of life, converting the adequate and affordable housing unit into viable housing. In Mysore, individual plots with basic services allotted to EWS and LIG households by the City Improvement Trust Board in the 1970s are today vibrant communities that have consolidated themselves over the years and resisted displacement by market forces.

Ways of Moving Forward

How then should we proceed? In conclusion, we offer a set of pathways that emerge from a focus on 'housing and not houses'.

- *Establish Clear Entitlements to Housing*
  Whether it occurs through establishing a justiciable right or through explicit provisions in policies even without such a formal right, it is imperative that affordable housing be conceived of and imagined a public good such as education or food. Such an imagination is necessary in order to mobilize the allocation of public resources to affordable housing, to demand tenure security or changes in land market regulations in ensuring the creation of new adequate, viable, and affordable housing.

- *Upgrade, Not Build*
  The magnitude of affordable housing required in order to meet the current and future housing demand cannot be met by either the state or the market alone. All the empirics suggest that the only affordable housing stock that has been built at scale has been done by communities themselves. In-Situ Upgrading of this existing but inadequate housing–both physically as well as with secure tenure—must be the preferred strategy for housing policy rather than the construction of new units. If political will exists to mobilise tenure rights, then the financial investments in upgrading are also far more within reach than with new construction. International experience from Venezuela to Thailand points to the success of upgrading models as well as domestic experiences in Indore and Ahmedabad. Over

time, upgraded housing has the best chance to become and remain adequate and viable in the long run.

- *Universal Access to Basic Services*
  Successful innovations in the past by municipal bodies have shown that despite 'illegality' in tenure status, urban poor households are willing to pay for services. Recent policy moves from the JNNURM to the National Urban Sanitation Policy have begun to slowly but surely delink the provision of basic services from tenure status. This is a welcome move and, as shown by electricity provision, significantly improves not just access for households but the technical and financial health of the utilities themselves.
- *Protect and Expand Rental Housing*
  A rental housing market through adjustable rents and flexible leases reduces the amount of affordable housing that has to be built. Because of its particular suitability for migrants and seasonal workers in the informal economy, a dynamic rental housing market is a must in developing economies. It represents valuable and secure tenure options, especially for the urban poor as the focus is no longer on titling and ownership. By creating other avenues for secure tenure rental housing adds to the creation of adequate, affordable and viable housing.
- *Regulate the Land Market*
  Directing the use of viable and well located land is crucial in ensuring the success of not just privately built, but also publicly built affordable housing of all forms. Provision of suitably located adequate land either through acquisition or sale, for affordable housing is necessary to ensure that the housing gets built will also remain occupied. Policy intervention will be required to ensure that unviable parcels of land are not used to construct unliveable housing projects. Instead, utilizing existing vacant government land in exchange for incentives is a step towards facilitating viable land for affordable housing.
- *Broaden Housing Finance*
  Even if housing constructed were within affordability limits of its residents, households will still need to access housing finance to mobilize their resources in a manner that leaves them with flexibility in spending and saving. Just like basic services, financial institutions have to de-link notions of tenure, titles and such documentation as a prerequisite for lending. A move towards accepting documents other than titles and sale deeds, in effect, restructuring housing finance on the individual's capacity to pay back and not on the collateral offered and/or required is needed.
- *New Metrics on Housing Poverty*
  Housing poverty needs to be adequately understood and captured through aspects of congestion, ownership/tenure, availability of basic services, location and mobility, employment opportunities, etc. Current data points on housing, urban poverty, employment and basic services look at each of these in isolation despite their interconnections on ground, thereby more often than not, presenting an incomplete picture. A new metrics on understanding housing along our three vectors—affordability, adequacy, and viability—is key if new policy paradigms are to be effectively implemented, locally specific and ably monitored.

Notes

1. We take this term from Kundu (2012) and build upon it.
2. It is clear that such informal production of space is not limited to the *basti* – it defines, in fact, in different ways, the dominant way of producing many Indian cities (Bhan, 2013). To take the example of Delhi: an oft-cited planning empiric states that only 24% of the city lived in 'planned colonies' in 2010. The remainder lives in some form, in other words, of 'informality' ranging from unauthorised colonies to slum designated areas to constricted property regimes in urban villages.
3. It is important to remind ourselves that while bastis mark such inadequacy, they are certainly not the only sites of such exclusions from services in the city. In fact, access to services between 'slum' and 'non-slum' areas shows that increasingly shows a more complex spatiality to urban poverty and exclusion from services. See Bhan and Jana (2013).
4. See here: http://www.delhijalboard.nic.in/djbdocs/about_us/act.htm. Accessed April 1st, 2016.
5. Pani Haq Samiti vs Bombay Municipal Corporation. CWP 10 of 2012
6. From "Services to the Urban Poor" on the BWSSB website. Available here: http://bwssb.org/services/. Accessed May 12th, 2014.

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14

Dispossessed by Development

Mining, Habitations, Lives, and Livelihoods

Sujit Kumar Mishra

The overall development of the Indian economy owes much to the benevolence of its mining sectors (direct and derived), not because it is used as a direct indicator of gross domestic product (GDP), but also the core industries use it as the raw material for their growth and development. As per FICCI (Federation of Indian Chamber of Commerce and Industry) (2013) study 'every one per cent increment in the growth rate of mining and quarrying results in 1.2–1.4 per cent increment in the growth rate of industrial production and correspondingly, an approximate increment of 0.3 per cent in the growth rate of India's GDP'. Mining gives opportunities to mineral rich states/districts to achieve growth through mineral production. For example, Sundargarh district in the Western Odisha (a mineral rich district) has seen tremendous growth on the setting up of mining activities like coal (Mahanadi Coal Field (MCL)), iron, manganese, limestone, dolomite and silica sand. As a result of these industries such as steel plants (e.g. Steel Authority of India Limited), National Thermal Power Corporation (NTPC), Ultra Mega Power Plant, etc. have come up in the area. The local economy of these areas has become enriched in terms of providing livelihood to the local population. In terms of percentage share of gross district domestic product (GDDP) to gross state domestic product (GSDP), Sundargarh contributed maximum to the State's GSDP with 8.84 per cent share (Government of Odisha, 2014). The trend of GSDP of this mineral rich district, over a period of time (from 2004–05 to 2010–11) has been depicted in Figure 14.1.

Indian Mining Industry: A Brief Profile

A large number of small operational mines constitute the mining industry of India. There are about 3,318 mines which reported mineral production (excluding minor minerals, petroleum (crude), natural gas and atomic

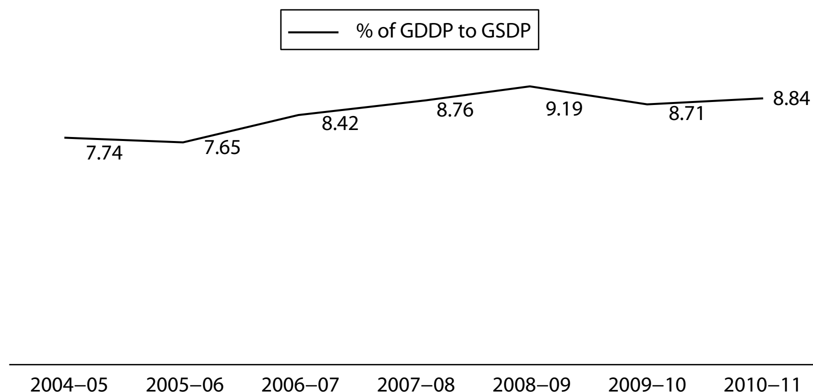

Figure 14.1 Share of GSDP of a Mineral Rich District (Sundargarh of Odisha) in India

Source: Government of Odisha (2014).

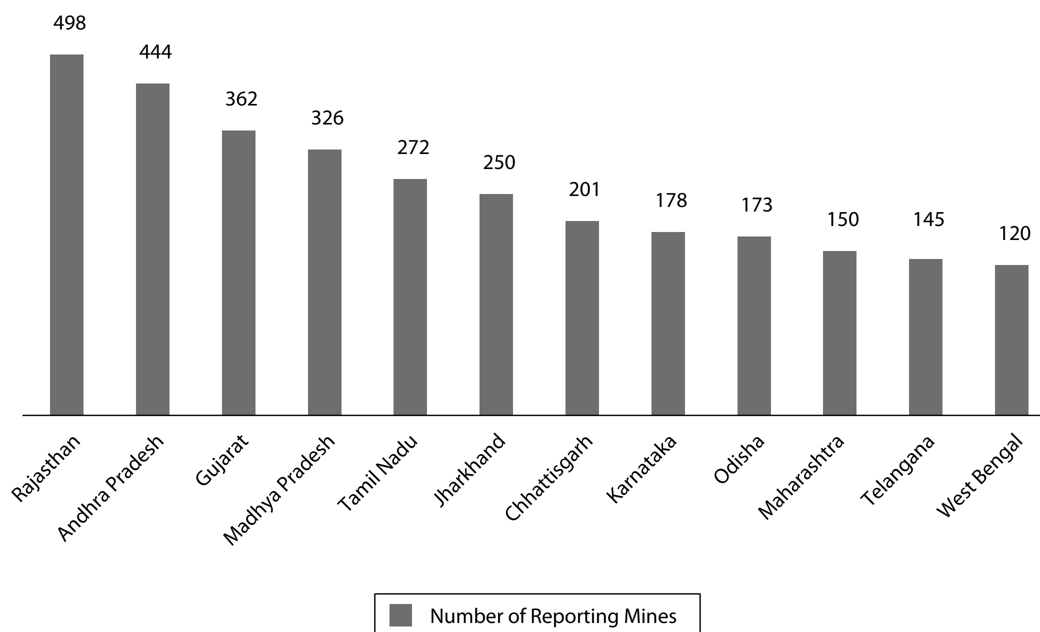

Figure 14.2 Number of Reported Mines in Major States of India

Source: Government of India (2014–15).

minerals) in India in 2014–15 (Government of India, 2014–15). The mining sector (excluding atomic and minor minerals and petroleum (crude) and natural gas) provides daily employment to 5,12,270 persons of which 78 per cent is under the public sector and 22 per cent in the private sector. Apart from this there are lakhs of people who derive their livelihoods indirectly from the mines, for which official statistics are not available. Out of the total reported mines in India, 17.3 per cent are coal (including Lignite), 17.9 per cent are metallic minerals and rest 64.7 per cent are non-metallic minerals. Figure 14.2 presents the reported mines in the 12 states of the country, which accounted for 94 per cent of total number of mines in the country in 2014–15. Rajasthan tops among all other states with having 498 mines in it.

The Ministry of Mines has divided mining leases into seven different categories based on the area (Government of India, 2014–15). The details excluding fuel, atomic and minor minerals are presented in Table 14.1. The percentage of very small leases (i.e. an area below 10 hectares) constitute 64 per cent of the total leases (with 6 per cent of the total area). The number of leases reported with an area above 100 hecares are 954 with 70 per cent of the total area (100 to 200 hectares with 11 per cent, 200 to 500 hectares with 18 per cent and above 500 hectares with 41 per cent of the total area) (Table 14.1).

Table 14.1 Area-wise Distribution of Mining Leases in India (As on 31–03–2013)

S. No.	Frequency group (area in hectare)	Number of mining leases	Percentage of total leases	Area in '000 hectares	Percentage of total area
1	All groups	11,104	100	498	100
2	0 to 10	7122	64	28	06
3	10 to 20	1003	09	15	03
4	20 to 50	1243	11	41	08
5	50 to 100	844	08	63	13
6	100 to 200	449	04	57	11
7	200 to 500	300	02	89	18
8	Above 500	205	02	205	41

Note: **Excluding fuel, atomic and minor minerals*

Source: Government of India (2014–15).

Table 14.2 Production of Selected Minerals

S. No.	Minerals	2013–14 (P)	2014–15 (E)
1	Fuel	1,76,081.29	1,71,013.82
2	Metallic minerals	42,653.97	36,772.60
3	Non-metallic minerals	6924.42	7359.60
4	Minor minerals	52490.49	52,490.49
	All minerals	2,78,150.17	2,67,636.51

Source: Government of India (2014–15).

MINERAL PRODUCTION

The estimated figure of the index of mineral production (base 2004–05) for the year 2014–15 is 127.7 as compared to 124.7 for 2013–14 showing a positive growth of 2.4 per cent. The total value of mineral production (excluding atomic minerals) during 2013–14 was Rs. 2,78,150.17 crore (provisional). However, 2014–15 saw a 3.78 per cent decrease in the production compared to the previous year (Government of India, 2014–15). Out of the all mineral production, fuel mineral constituted the lion share that is, 63.9 per cent, followed by minor minerals with 19.6 per cent and metallic minerals (13.7 per cent). Non-metallic minerals are only 2.7 per cent of the total mineral production (Table 14.2).

94.2 per cent of the estimated mineral production has been concentrated within 13 states (including off shore areas) only. Mineral production wise offshore areas' proportion is more (20.3 per cent), followed by Rajasthan with a share of 11.49 per cent, Gujarat (8.85 per cent), Andhra Pradesh (8.25 per cent), Chhattisgarh (7.48 per cent), Jharkhand (7.37 per cent), Odisha (6.38 per cent), Maharashtra (5.35 per cent), Madhya Pradesh (4.70 per cent), West Bengal (4.32 per cent), Assam (4.04 per cent), Karnataka (2.96 per cent), and Uttar Pradesh (2.72 per cent) in the total value of mineral production.

In 2013, India stood at second in barytes and talc/steatite/pyrophyllite, third in chromite, fourth in coal and lignite, iron ore, kyanite/sillimanite and steel (crude), fifth in bauxite and zinc, sixth in manganese ore, seventh in aluminium, eighth in refined copper and twelth in magnesite (Government of India, 2016). The detailed statistics on of principal minerals production and metals at both domestic and world levels are given in Table 14.3.

In India, the GDP share of Mining and Quarrying Sector stands at 2.13 per cent in 2013–14. Within this, the role of public sector accounts 59 per cent in total value (Government of India, 2016). The rest is accounted by private sector mostly dominated with small mines and it is continued to be operated manually as either proprietary or partnership ventures. The minerals of copper ore, diamond, fluorite (conc. and graded), selenite, and sulphur are wholly mined/recovered by the Public/Joint Sector. Public Sector, almost entirely produces lignite, gold (primary), tin concentrates, gypsum, and sand (others). Coal India Limited (CIL) as an apex body, operates through 81 mining areas with 7 wholly owned coal producing subsidiaries spread over 8 provincial states of India.

Issues That Confront Mining Communities

The potential of the mining sector to make huge revenue, has been interlinked with a large number of negative impacts in the form of externalities (Mishra, 2012). The social impacts on the communities are rarely taken into account. One of the most adverse impacts is displacement. Rao (2005) depicted of a case study of mining areas of Jharkhand where the mining communities lost their traditional occupation and started scavenging in the area. Another case is the MCL, Odisha (Mishra and Mishra, 2014), where many people died in a mining accident while collecting raw coal for sustaining their livelihood. These were basically mining communities, staying in the vicinity of the mining areas. Setting up of the industries led to the loss of their traditional livelihood. Hence this was the only alternative left to them. The state tagged these victims under the category of 'illegal mining'. As per the Shah Committee Report (2013), the term 'illegal mining' exists in the following cases:

(a) mining without a licence; (b) mining outside the lease area; (c) undertaking mining in a lease area without taking approval of the concerned State Government for transfer of concession; (d) raising of minerals without lawful authority; (e) raising of minerals without paying royalty in accordance

Table 14.3 Contribution and Rank of India in World Production of Principal Minerals & Metals, 2013

S. No.	Commodity	Unit of quantity	Production		Contribution	India's rank in order of quantum of production
			World	India		
1	Mineral fuels					
	coal & lignite	Million tonnes	7906	610	7.7	4th
	petroleum (crude)	Million tonnes	4425	38	0.9	25th
2	Metallic minerals					
	Bauxite	000 tonnes	2,96000	21666	7.3	5th
	Chromite	000 tonnes	28,800	2853	9.9	3rd
	Iron ore	Million tonnes	3,157	152	4.8	4th
	Manganese ore	000 tonnes	52,800	2588	4.9	6th
3	Industrial minerals					
	Barytes	000 tonnes	8,400	1137	13.5	2nd
	Kyanite, andalusite and sillimanite	000 tonnes	464	63	13.6	4th
	Magnesite	000 tonnes	46,900	195	0.4	12th
	Apatite and rock phosphate	000 tonnes	2,35,000	1385	0.6	17th
	Talc/steatite/soapstone/pyrophyllite	000 tonnes	8000	1074	13.4	2nd
	Mica (crude)	Tonnes	3,50000	1610	0.5	16th
4	Metals					
	Aluminium	000 tonnes	47,100	1667	3.5	7th
	Copper (refined)	000 tonnes	21,000	644	3.0	8th
	Steel (crude/liquid)	Million tonnes	1,607	81.7	5.1	4th
	Lead (refined)	000 tonnes	10,500	122	1.2	15th
	Zinc (slab)	000 tonnes	13,500	766	5.7	5th

Source: Government of India (2016).

with the quantities and grade; (f) mining in contravention of a mining plan; (g) transportation of raised mineral without lawful authority; (h) mining and transportation of raised mineral in contravention of applicable Central and State Acts and rules there under; (i) conducting of multiple trade transactions to obfuscate the origin and source of minerals in order to facilitate their disposal; (j) tampering with land records and obliteration of inter–State boundaries with a view to conceal mining outside lease areas; (k) forging or misusing valid transportation permits and using forged transport permits and other documents to raise, transport, trade and export minerals.

The MCL mining community does not fit into these above criteria. In this case, despite the fact that livelihood losers are not entitled for any benefit, the state agencies misrepresented their case in order to exclude them from availing the benefit of institutional mechanisms. However this important issue of 'illegal mining' needs urgent attention of the government at all levels. Table 14.4 presents the state-wise details of the cases illegal mining in India from 2010–11 to 2014–15. There has been a steady increase in the number of illegal mines from 2010–11 to 2012–13. Although the year 2013–14 saw a slight fall in the numbers, the actual number is quite large, that is, 88,689. There are actions taken to check illegal mining and curtail it. In spite of these actions, the data shown in Table 14.4 depicts a steady increase in its number. There are possibilities of some unidentified/unreported mines also in this category.

The collective mobilization by mining communities against exploitation by the mining sector has contributed to the global spread and institutionalization of norms. Since independence, these communities have been fighting against the construction of development projects especially mines at the cost of their livelihoods. The most important recent examples are Pohang Steel Company (POSCO), Calcite mining in Andhra Pradesh, Vedanta's bauxite mining project in Odisha, Bauxite mining in Kashipur, Utkal Alumina project, Uranium Corporation of India Ltd, Limestone mining in Himachal Pradesh, to name a few. Vagholikar et al. (2003) observe that there should be a sound relationship between development activities and ecological security (which include conservation of eco system and species). According to the Kalpavriksh report 'At least 90 wildlife sanctuaries and national parks and hundreds of other

Table 14.4 Number of Illegal Mines in India-State-wise

S. No.	Illegal mining cases						Action taken from 2010–11 to 2014–15 (Qtr ending June 2014)			
	State	2010–11	2011–12	2012–13	2013–14	2014–15 (Qtr ending June 2014)	FIR lodged (No)	Court cases filed (No)	Vehicle seized (No)	Fine realised by state government (Rs. Lakh)
1	Andhra Pradesh	13,939	19,913	16,592	7692	2786	2	16,594	2	11,353.079
2	Chhattisgarh	2017	2946	3238	3996	1332	89	3327	1	1684.193
3	Goa	13	1	0	1	0	0	0	1	1.91
4	Gujarat	2184	3485	6023	5447	n.r.	293	6316	7307	
5	Haryana	3446	2022	3517	3589	n.r.	600	4117	0	41938.66
6	Himachal Pradesh	1213	1289	0	n.r.	n.r.	186	186	0	1972.64
7	Jharkhand	199	364	663	901	n.r.	1030	1693	697	71.46
8	Karnataka	6476	6691	6677	8509	1993	536	7213	13323	262.61
9	Kerala	2028	3175	4550	4448	1153	0	4550	0	8358.95
10	Madhya Pradesh	4245	7147	7169	6752	1728	61	7230	528	1932.63
11	Maharashtra	34,265	40,642	42,918	36,476	0	0	42,918	138220	12,165.84
12	Odisha	420	309	314	76	n.r.	8	322	691	18,371.29
13	Punjab	754	314	19	n.r.	n.r.	86	105	61	3411.85
14	Rajasthan	1833	1201	2861	2953	889	2387	5248	1537	145.16
15	Tamil Nadu	277	123	295	1078	17	3963	4258	39911	3627.238
16	Uttar Pradesh	4641	4708	3266	6777	3111	0	3266	0	10,642.848
17	West Bengal	239	269	479	n.r.	n.r.	1128	1607	1116	6352.03
Grand Total		78,189	94,604	98,597	88,689	13,009	10,369	1,08,966	2,03,395	1,22,293.729

Source: Government of India (2014).

ecologically sensitive areas with unique biodiversity and wildlife are threatened....The affected species include elephants, tigers, gaur (wild cattle) and other ungulates, as well as many small mammals, bird, amphibians, reptiles and macro-invertebrates' (Vagholikar et al., 2003). Sharma (2003) cited a case of Jamwa Ramgarh Wildlife Sanctuary (basically a tiger habitat) and its difficulties with commercial soapstone and marble mining operation in the state of Rajasthan. Banik (2007) in his study pointed out that the number of trees and shrub species drastically decreased due to mining, which has had an adverse effect on land use pattern too.

There are three different stages in 'Development' and 'Making Development Sustainable'. With specific reference to mining sector development and the mining communities, these are: (a) identification of place, cost benefit analysis, land acquisition, displacement and rehabilitation; (b) externalities in the form of livelihood, agriculture, health and accident; (c) closure in case of mining project and the issue of livelihood.

The idea of any project begins with the Cost-Benefit Analysis (hereafter CBA). It is a set of practical procedures which look into the aggregate cost and aggregate benefit of the concerned project. A project evaluation basically requires a comparison between costs and benefits of different time periods. A project is regarded as feasible only when the benefit incurred from the project outweighs the cost. In other words the benefit and cost ratio should be greater than one.

So far as its aims and objectives are concerned, CBA looks rich. However, past experiences suggest that CBA basically overlooks the distribution pattern of CBA. It considers only the total effect. While doing so, it overlooks the sections of people who in fact pay the cost for it. CBA generally does not address issues of the various subsets of individuals. Cernea (1999) argues that the impoverishment risks are distributed differently

from project benefits. Aggregate benefits may look real, but they do not automatically offset the costs of each individual.

As we discuss the first stage, it is quite a notable phenomenon that in India the laws regulating the acquisition of privately owned lands exist, whereas there is no such law existing to deal with resettlement (Mathur, 2011). In the study area, the Land Acquisition Act (LAA), 1894 was the commonly available act in India to deal with the acquisition of the affected/displaced people. The guiding principle of the act is the concept of 'Eminent Domain'.

Land plays a major role in the rural economy since large sections of people rely upon their agricultural lands, either directly or indirectly, to earn their livelihood. The doctrine of 'Eminent Domain' still enables the state to acquire any type of private land for public purpose (Desai, 2011; Ramanathan, 2011). Following this theory, the state can acquire any land for a larger public interest. This concept has three important components: (i) acquisition of privately owned land; (ii) for larger interest; and (iii) compensation for acquisition (see Desai, 2011). Compensation is only available for those who have lost land, not for those who have lost livelihoods.

Sections 23 and 24 of the LAA provide the guidelines to the state for determining the compensation amount. The LAA 1894 cites that the compensation for land operates as a function of its market value, which should be essentially based on the previous sale deed of a similar land.

In three mining regions of India (Kannabiran and Mishra, 2016)—MCL, Jharsuguda, Odisha, NTPC, Korba, Chattisgarh and Singareni Collieries, Khammam, Telangana, the doctrine of 'Eminent Domain' is the only mechanism that has been used to acquire land for the larger interest of the state using the archaic LAA 1894. The rehabilitation policies of the three projects had no match with one another. They were not at all homogeneous in nature even though the displaced communities, for whom they were meant, were very much homogeneous. For instance, the displaced people of MCL, Jharsuguda, Odisha, were provided jobs in MCL, whereas the same did not happen to the displaced people of NTPC, Korba, Chhattisgarh and Singareni Collieries, Khammam, Telangana state. The nature and scope of rehabilitation was discovered to be quite dissimilar for different villagers within the same project, e.g., in Singareni project, 2 acres of land were allotted to each villager in one village whereas the same was not true for the remaining three villages studied, which also fell under the same project. Dispossession due to the acquisition of land was the only common factor shared by these three projects, i.e. 2.17 acres to 0.15 acre in the case of MCL, Jharsuguda, 7.30 acres to 0.61 acre in the case of NTPC, Korba and 4.60 acres to 2.98 acres in Singareni project Khammam. The severity of landlessness is not found in case of Singareni project since a few villagers were allotted as much as 2 acres of land. However, the operational land holding of the affected people was actually reduced to a smaller size as and what they received was infertile and uncultivable land. Apart from this, the dust particles from coal and water pollution multiply the suffering of the displaced people in addition to adversely affecting the agricultural production in these areas. As far as homestead land is concerned, there were certain provisions for this in all the three projects. However, a discrepancy arose when they introduced two provisions in the allotment of homestead land: either land or money in lieu of the homestead land. But there was yet another problem: the money given in lieu of homestead land was not adequate to buy a piece of land adjacent to the project site. On enquiry, it was learnt that they wanted to live a community life along with their own people and therefore they did not opt for living in rehabilitation colonies. In addition to this, the victims of all the three projects were completely ignorant about the provisions contained in the different sections of the rehabilitation policy. So, they had no other way out except accepting whatever was offered to them.

Clause 7.21.3 of National Rehabilitation and Resettlement Policy (NRRP) 2007 provides that the Scheduled Tribe (ST), followed by the Scheduled Caste (SC) will be given preference in allotment of land for land, if government land is available in the resettlement area. According to clause 7.21.6, 'they will be resettled, as far as possible, in the same Schedule Area in a compact block, so as to retain their ethnic, linguistic and cultural identity. Only in rare cases, exceptions would be allowed where the requiring body in case of a project involved land acquisition, or the State Government, whereas in other cases of involuntary displacement, is unable to offer such land due to reasons beyond its control'. However, the land frontier is constant and the past history is the eye-witness to the failure of land-for- land policy in all the development projects. The proviso 'as far as possible' has ensured the continuation of the opposite in Indian context (Oskarsson, 2011).

There is also a provision of paying one-third of the compensation amount as the first instalment and the rest at the time of taking the possession of the land (clause 7.21.4). However, if the land is acquired for a project on behalf of an acquiring body, there is a provision of one-

time compensation payment equivalent to five hundred days minimum agricultural wages for loss of customary rights or usage of forest produce.

Past studies on the condition of displaced people of MCL Odisha, NTPC Korba, Chhattisgarh, Singareni project, Telangana, Ultra Mega Power Plant and Hindustan Zink Limited, Odisha, etc tell us that people have extensively used the received cash in various unproductive ways. It happened so since they were suddenly exposed to a monetary economy where the mode of exchange was only money. Having no idea of where and how to invest their money the ready availability of cash led to a rise in alcohol addiction and early mortality. There is little evidence in the policy document about providing orientation on financial planning to communities unused to handling large amounts of cash.

The subsequent or second stage mainly takes note of the externalities in the forms of agriculture, health and livelihood, particularly among development communities (i.e. affected/displaced people) who suffer the negative impacts/externalities in terms of ill health (Mishra, 2010; Mishra, 2014), loss of valuable produce like food grains, and facing problems in finding a suitable employment (Mishra and Pujari, 2008; Mishra, 2012). There is negligible scope for these mining communities to have their issues addressed by established institutional mechanisms. Mishra and Mishra (2014) focus on the mining accidents and the resultant deaths of people in MCL of Odisha. The health of the local inhabitants (mining communities) is badly affected as well as they are uprooted thus causing loss of their livelihood, only because of the mismanagement of the mines. The rehabilitation policy of the mining authority gives scope to a member from each agricultural family that loses land to have a job in the mine. Allocating a job to a member from each family makes other members of the family dependent on the job holder since they neither have a piece of land nor a job for themselves. The other groups of people are the landless who were cultivators till the patches of land they worked on were also now taken away from them. Hence, on account of non-availability of other livelihood options for the mining communities, they have adopted an immediate alternative, i.e., collecting coal. The Indian Mines Act, 1952 has provided a few guidelines for the health and safety of the workers. The Act, however, does not give any clear reference to the people (especially mining communities) living in the vicinity of the mines. So, if there is an accident/death of an employee of the mine, one of the family members is offered a job in the mine. The others have no claim at all. By and large, the only possible redress available for the villagers is an ex gratia payment.

In India, a major issue (third stage) which has not yet received required attention is 'mining closure and the issue of livelihood'. It is only the mining communities who have to bear the brunt of the closure since they derive their livelihood either directly or indirectly from it. However, the local economy in the vicinity also relies immensely on the mining activities. Therefore, the closing of the mine badly affects the communities in a number of different ways. The first National Mineral Policy 1993 (National Mineral Policy, 1993) of Government of India puts stress on the issues of rehabilitation and mine closure-an important phase of a mine's life cycle.

> Mineral deposits being exhaustible, once the process of economical extraction of a mine is complete, there is need for its closure. Especially where the mining activities have been spread over a few decades, mining communities get established and closure of the mine means not only loss of jobs but also disruption of community life. Whenever mine closure becomes necessary, it should be orderly and systematic and so planned as to help the workers and the dependent community rehabilitate themselves without undue hardship.

Government of India announced in March 2008 a new policy in order to replace the 1993 one. In the new National Mineral Policy 2008 (Government of India, 2008), there is also a paragraph mentioning mine closure.

> Once the process of economical extraction of a mine of a mine is complete there is need for scientific mine closure which will not only restore ecology and regenerate biomass but also take into account the socio economic aspects of such closure. Where mining activities have been spread over a few decades, mining communities get established and closure of the mine means not only loss of job but also disruption of community life. Whenever mine closure becomes necessary, it should be orderly and systematic and so planned as to help the workers and the dependent community rehabilitate themselves without undue hardship.

Both the policies are silent about the mining communities (although they refer in passing to 'dependent communities'). The Central Government vide Notification No. GSR 329 (E) dated April 10, 2003 and No. GSR 330 (E) dated 10 April, 2003 (Government of India 2013) amended the Mineral Concession Rules, 1960 and Mineral Conservation and Development Rules 1988 respectively. According to these amendments, all the existing mining lessees are required to submit a 'Final Mines Closure Plan' one year before the actual closure.

Moreover, it was also mentioned in the notification that the 'Progressive Closure Plan' and 'Final Closure Plan' should be done in compliance with the guidelines issued by the Indian Bureau of Mines. According to the guidelines (Government of India, 2013):

5 Economic Repercussions of Closure of Mine and Manpower Retrenchments:

Manpower retrenchment, compensation to be given, socio-economic repercussions and remedial measures consequent to the closure of mines should be described, specifically stating the following:

5.1 Number of local residents employed in the mine, status of the continuation of family occupation and scope of joining the occupation back; 5.2 Compensation given or to be given to the employees connecting with sustenance of himself and their family members; 5.3 Satellite occupations connected to the mining industry–number of persons engaged therein-continuance of such business after mine closes; 5.4 Continued engagements of employees in the rehabilitated status of mining lease area and any other remnant activities; and 5.5 Envisaged repercussions on the expectation of the society around due to closure of mine.

The guidelines to conduct the mine closure are silent the 'dependent communities' or the 'mining communities'. On the whole, the mining communities are the people who always bear the cost of 'development'. These communities generally suffer dispossession in at least two different stages: in the first stage, when the land is acquired for the setting up of the project and secondly, when the project is closed down. In a nutshell, these communities are dispossessed by development.

Lives and Livelihoods

The word 'development' is a composite concept, where creation of livelihood is one of the main indicators. This above perspective is largely state-centric. When we start visualizing development from the community perspective, the basic answer would start from the concept of impoverishment. Indian government does not have official records to furnish the details of the mining communities on a regular basis. Apart from this, the institutional mechanisms are also designed in such a manner that it always try to maximize the profit of the state at the cost of mining communities. As Lahiri-Dutt (2007) rightly observes, 'the legal instruments are colonial vintage, anti-poor and are unable to deal with contemporary realities'. From past experiences of the development projects, we have seen vast majority of the mining communities rendered totally vulnerable as they could not restore any semblance of their previous quality of life.

Selected Empirical Evidence

Below are the examples of three different types of cases to depict the issue of livelihood associated with mining activities. Despite the fact that mines earn huge revenue for the country, the implementation of these mining projects in the rural areas has large number of externalities. The most important issue is in the form of livelihood of the communities in different form.

Case 1: Agriculture and Allied Activities

The result based on The Basundhara Coal Mining area has primarily been an agrarian economy (Mishra, 2012). Majority of people derive their livelihood from agriculture. After the establishment of the mine, there has been a gradual shift from agriculture to non-agricultural activities in the mining villages. Rice is the dominant crop in both types of the surveyed villages. The area under rice crop constitutes nearly 73.8 to 89.1 per cent in these villages. The production of paddy per acre of land is 6.3 quintals in the mining villages and 9.2 quintals in non-mining village. In mining villages, one notices significant decline in production of paddy. Compared to 2001 (before mining started), the current year production levels are 60.6 per cent and 98.7 per cent, respectively, in mining and non-mining villages, showing 29.4 per cent production loss in the mining villages. At the level of cultivating households, the loss of production is 100 per cent for more than 28.6 per cent cultivators in mining villages, whereas in non-mining village it is found to be nil (Table 14.5). The main reason is the deposition of coal dust on the vegetation, which prevents proper growth of the crops.

Area under cultivation shows that now agriculture is not an important activity in the mining villages. And the yield per acre shows the losses are substantial (as it is 9.2 quintal in non-mining village and 6.3 quintal in the mining villages). Hence the difference in yield between these two types of villages is found to be 2.9 quintals. The market value of one quintal of paddy is around Rs. 850. So the loss of income in mining villages is Rs. 2465 per acre.

A substantial loss of common property has occurred in the post-project period in NTPC, Korba (Kannabiran and Mishra, 2016). In pre-project situation, each and every household had an indiscriminate access to grazing land, but in the rehabilitated place, this facility was denied, except a few enjoying the same. Earlier, the affected villages used to be situated adjacent to the forest. Therefore, it enabled people to take opportunity

Table 14.5 Extent of Production in the Study Villages

S. No.	Detail	Villages	
		Mining	Non-mining
1	Percentage of paddy area	73.8	89.1
2	Average production of paddy per acre	6.3	9.2
3	Percentage of current year production to before mining production	60.6	98.7
4	Percentage of households with 100 per cent loss	28.6	Nil

Source: Field Survey.

of the forest by collecting various objects from there. In addition, there is a problem of not having any common burial ground in the new settlement area. It is the same with MCL, Jharsuguda, and Singareni, Khammam. Apart from that, the villagers used to have free access to the forest in the pre-displacement situation, whereas the same is highly restricted in the new location. Rainfall had become scanty in all the three study areas during the last few years before the study. The cumulative effect was seen in the form of absence of grass and pasture and failure of crop. Because of scanty rainfall, even paddy stalk, the staple food for cattle, also came to a failure.

Case 2: Unemployment and Livelihood Loss

A study of a sample of 197 households of 3 mining villages NTPC, Korba, Chhattisgarh has taken four indicators to assess to what extent joblessness has been overcome and how much the displaced people at the relocated sites have been benefited out of the development schemes (Kannabiran and Mishra, 2016). The details are given in Table 14.6.

The same exercise has been tried out alternatively with a reference to gender. The reduction in the number of days of work from 200 days to 90 days has brought a great change in the lives of women. Similarly, the distance of workplace has also increased on an average from 2 km. to 7 km. Even though wage is paid in time, it never matches with their male counterparts (Table 14.7).

Case 3: Forms of Livelihood and the Local Economy

The observations in this section are based on the data collected from a sample of 422 households of 24 mining villages from the closed Lead Mines called The Hindustan Zinc Limited (HZL) Sargipalli of the state Odisha

Table 14.6 Status of Livelihood of Men

S. No.	Parameters	Status	
		Before	After
1	Average number of days a man gets work	300 days	300 days
2	Per cent of households cultivating their own land	77.2	2.5
4	Per cent of households engaged in unskilled wage work	8.1	73.6
5	Farm wage earners	10.2	11.2

Source: Field Survey.

Table 14.7 Status of Livelihood of Women

S. No.	Parameters	Status	
		Before	After
1	Average number of days a woman gets work	200 days	90 days
2	Average distance of workplace in km	02	07
3	Women are paid on time	Yes	Yes
4	Women get wage rate equal with male	No	No

Source: Field Survey.

Table 14.8 Local Economy and Livelihoods in the Study Area

S. No	Types	The forms of livelihoods provided by the local economy	
		During mining	Post closure
1	Mining communities	Agriculture and allied activities, daily wage worker, milk business, tailoring, carpentry, vegetable business, rice business, poultry firm, providing water in the gardens of mining employees, grocery shop, *gupchup* business, hotel, *mistry*, *pan* shop, saloon, *mumura* business	Agriculture and allied activities, daily wage worker
2	Mining workers	Mining work (both permanent and temporary), agriculture	Agriculture and allied activities, unskilled wage work on daily basis, business, migration to Goa and Gujarat

Source: Field Survey.

(Mishra, 2015). 'Local economy' means the array of livelihood activities of the environment where one survive with these options, for example, the local economy of the study mining area (of Sundargarh district of Odisha) are heavily dependent on agriculture. However apart from agriculture there were plenty of derived-livelihood options provided by the local economy during the mining period (Table 14.8).

The closing down of mining activities influenced the local economy adversely. The weekly market to Sargipalli was the biggest weekly market of the area. The purchasing power of the people decreased because of the closure of the mining activities. People took loans under Integrated Rural Development Programme (IRDP) scheme and produced lot of milk for their livelihood. However the sudden closure made them vulnerable as they could not repay the loan properly. Due to lack of proper care, the cattle also died after sometime and they entered into indebtedness. Many more migrated to Goa to get engaged in fishing and the other migrated to Gujarat to work in textile industries and remain there for 6 to 7 months each year.

Importance of Information/Consultation for Mining Community

The key requirements for development approvals in many legislatures are community consultation, engagement and increasing participation. Undoubtedly, consultation and engagement are two prerequisites for mining companies to gain and maintain a 'social license to operate'. Likewise, to understand community perceptions about development project is highly essential for an operation to manage expectations, understand perceived impacts and respond to community needs and priorities (CSRM nd). One of the root causes of policy failure was the dysfunctional relationship between the planners and the displaced communities and thereby resulting in disaster.

The state has included the concept 'consultation' with the affected people/victims in various places of the NRRP 2007. Let us scrutinize the term 'consultation' used in various places of the policy document in favour of the victims.

Clause 5.5: Subject to any general or special order of the appropriate Government, the Administrator for Rehabilitation and Resettlement shall perform the following functions and duties: (ii): hold consultation with the affected families while preparing a rehabilitation and resettlement scheme or plan; (v) prepare a budget including estimated expenditure of various components of acquisition of land, rehabilitation and resettlement activities or programmes in consultation with representatives of the affected families and the requiring body;

Clause 6.14.1: After completion of baseline survey and census of the affected families and assessment of the requirement of land for resettlement, as mentioned in paragraphs 6.3 and 6.12, the Administrator for Rehabilitation and Resettlement shall prepare a draft scheme or plan for the rehabilitation and resettlement of the affected families after consultation with the representatives of the affected families including women and the representative of the requiring body

Clause 6.15.2: The consultation with the gram sabha or the panchayats at the appropriate level in. the Scheduled Areas under' Schedule V of the Constitution shall be in accordance with the provisions of the Provisions of the Panchayats (Extension to the Scheduled Areas) Act, 1996 (40 of 1996).

Clause 7.21.2: The concerned gram Sabha or the panchayats at the appropriate level in the Scheduled Areas under Schedule V of the Constitution or as the case may be, Councils in the Schedule VI Areas shall be consulted in all Cases of land acquisition in such areas including land acquisition in cases of urgency, before issue of a notification under the Land Acquisition Act, 1894 or any other Act of the Union or a State for the time being in force under which land acquisition is undertaken, and the consultation shall be in accordance with the provisions of the Provisions of the Panchayats (Extension

to the Scheduled Areas) Act, 1996 and other relevant laws. Further, in cases of involuntary displacement of two hundred or more Scheduled Tribes families from the Scheduled Areas, the concerned Tribes Advisory Councils (TACs) may also be consulted.

This concept has been used in all the four places as a 'demand side' parameter. 'Consultation' and 'Consent' are completely two different concepts. The victims own no right to say 'no' when the project site is identified.

SELECTED EMPIRICAL EVIDENCE

In MCL, Jharsuguda, Odisha, Rs. 20,000 per acre has been fixed as the market value of the lost agricultural land. Apart from that, a shifting allowance worth Rs. 2000 has been given to each affected household. The survey reveals that only 25 households (i. e. 16.3 per cent) had the knowledge of the valuation process and the rest were ignorant. In the case of NTPC, Korba, Chhattisgarh, only a marginal 7 households (i.e. 3.6 per cent) had some knowledge of the valuation of process of the land and the rest were ignorant. The case of Mr. Yerraiah Kalam from Kotha-Kondapuram village of the Singareni project, Telangana is illustrative.

This is Mr. Yerraiah Kalam (Koya tribe) from Kotha Kondapuram rehabilitation colony of Singareni project. Pata Kondapuram was my old village where I possessed 10 acres of cultivable land. My family and I worked on the field and our days were passing happily. I had 6 cows and 11 goats. I used to take my livestock to the nearby forest to feed them. There was no problem I ever faced in my old village. A strong social cohesion was established among the villagers. Suddenly, one day, the villagers started talking about the project and certain possibilities of loss of land. I got scared about my future. Thereafter, they started talking about alternative land for the land losers. I was under shock when I was told that I would be given 2 acres of land in lieu of my 10 acres of land. I found it absolutely illogical. What was the base of this? I kept on asking a number of people and eventually felt like helpless. Finally, I accepted whatever they offered me. The 2 acres of land I was provided was un-irrigated and of low quality. Apart from that, the new land was situated 5 kms away from my village. I am not in a position to cultivate the entire 2 acres of land because of its quality. The money I received from them was not enough to even construct a small house. I heard that a few people received money even for the construction of toilet. I did not know that. When enquired, I was told that the compensation amount I received was inclusive of all the components. I even could not got a proper toilet built in my house and therefore even now we are depending upon open defecation. Now, I don't have anything except this poor quality and un-irrigated land. I am 65 and my wife is 60. Both of us are working as daily wage labourer. I could not help send my 3 sons go to school and now they are also working as daily wage labourers. My family and I are made highly vulnerable by this project.

Here is another and very different example which explains about the issue of consultation in the case of closure of HZL, Sargipalli, Odisha. The closure process of the HZL, Sargipalli, was very sudden in nature as a result the people were not ready to take a proper decision about their livelihood issues and whatever steps they took were not planned. The labour union as well as the federation tried their level best to make people to agree for the proposal of closure and accept the compensation. They instigated people by saying that the status of underground is not okay. The pillars inside the mine had become weak and collapse any time, causing risk to life. So it would be wise for them to take the redundancy amount, keep it in the bank and save their lives. They further argued that they were not aware of the opportunity of voluntary retirement scheme (VRS) will be abandoned and thereof, natural closure comes and the employees would not get the redundancy amount. Furthermore they argued that the employees had already worked in hazardous for health and unhygienic condition. Their health would sooner or later exposed to disease. So it was argued by them that it was golden opportunity for them to opt for VRS, deposit the amount in the bank and receive bank interest. On other side the people were not aware about anything about the institutional mechanisms provided to them for the acceptance for VRS. From the above selected empirical evidences, it became clear that consultation was just the spreading of information about the project in a monopolised manner to the affected people.

* * *

This study has attempted to foreground a multiplicity of issues related to mineral sector. These issues have been addressed through the help of selected empirical studies and published literature. Mining community is the only thread that connects all the issues as they feature in the entire discussion. In this context, a pertinent question immediately comes into mind, that is, can there be 'a sustainable mining community'? In this connection, the concept of 'equity' and 'intergenerational equity' can be thought of to turn a simple mining community into a sustainable mining community. While Equity refers to equality in terms of quality of life and standard of living, Intergenerational Equity is sustaining equality in the future in a changed situation, which means nobody,

will have to suffer any sort of misery for the cause of development or change. The entire discussion in the present chapter has given rise to two different perspective of development—(i) state perspective of development; and (ii) community perspective of development.

To begin with the issue of institutional mechanisms, the National Mineral Policy (NMP), Rehabilitation Policy, Mine Act, Land Acquisition Act, Cost Benefit Analysis, Closure Policy, etc. are meant for a sound and sustainable mineral production and to create wealth of the country. The NMP (1993 and 2008) is concentrated mainly on the mineral production and the factors associated with larger and sustained production. In order to achieve this, the investment of material and intellectual properties is also found to have increased manifold. Because of this, the country is earning huge amount of revenue. Clause 7.10 of the NMP 2008 talks about the mineral development and protection of environment with an objective of sustainable development. To this, as per the clause, mining operations shall not ordinarily be taken up in identified ecologically fragile and biologically rich areas'. However there are instances cited earlier in the paper from the study of Kalpavriksh and the subsequent vulnerability faced by the 90 wildlife sanctuaries and national parks and hundreds of other ecologically sensitive areas with unique biodiversity and wildlife due to mining activities. Clause 7.11 of NMP 2008 deals with relief and rehabilitation of displaced and affected persons:

> In areas in which minerals occur and which are inhabited by tribal communities and weaker sections it is imperative to recognize resettlement and rehabilitation issues as intrinsic to the development process of the affected zone. Thus all measures proposed to be taken will be formulated with the active participation of the affected persons, rather than externally imposed. A careful assessment of the economic, environmental and social impact on the affected persons will be made. A mechanism will be evolved which would actually improve the living standards of the affected population and ensure for them a sustainable income above the poverty line. For this purpose, all the provisions of the National Rehabilitation and Resettlement Policy (NRRP) or any revised Policy or Statute that may come into operation, will be followed.

It is interesting note that when there is a question of welfare of the communities in the mining area, the government passes the concerned legal instrument to some other head. Here the instruction is to follow the NRRP to improvise the standard of living of the communities. NRRP follows largely the age old legal instrument called as Land Acquisition Act. Notwithstanding increased policies and acts, the status of the mining communities has taken a turn for the worse with severe adverse impacts on a large scale.

There is a weak link between the community and the state in terms of participation in the development process, the capacity to negotiate with the state to determine the level of acceptance and so on. Furthermore, the term 'consultation' used in the policy document is nothing but arbitrarily passing the information to the people about the project. Even the communities do not have any right to say 'no' to the project. It means that the 'consent' of the people does not have any role to play in the process of 'consultation'. As per the views of the mining communities, consultation is a composite term which possesses the cumulative impact of two important factors: (i) right to consent about the project; and (ii) possession of bargaining power over their economy (both for land-owning and landless people). Apart from this, there were two other issues came out from the discussions with the communities: (i) proper implementation of the policy keeping equity as the major objective; and (ii) effective monitoring and evaluation of the process. Needless to mention that the present monitoring system is highly outdated. And also, it is not an inbuilt process within the process. Therefore a need for creating a system arises which will negotiate with the state after exploring how community perception and concerns reflect in the development policy in India and what mechanisms are required to be evolved to make the current policies sustainable with special focus on social justice and equity.

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15

Waiting for Swachh Bharat

A Close Look at the Question of Caste, Sanitation, and Policy Approaches

Subhash Gatade

Campaigns initiated by governments have a dynamics of their own. They start with a bang, are able to raise lot of expectations and with passage of time—when reality seems to catch up—tend to end in whimper. The *Swachh Bharat Abhiyan* (Clean India Campaign, hereafter SBA) started by the BJP (Bharatiya Janata Party) government at the centre led by Prime Minister Narendra Modi seems to be little different.[1] No doubt the 'Navratnas'—the celebrities chosen for spreading the 'Clean India' message—are nowhere to be seen now, the campaign is still being debated and discussed and has managed to remain in the news.

Undoubtedly it is difficult to hazard a guess about its continuing newsworthyness but one tends to think that the manner in which the whole campaign was envisaged and processes were initiated to facilitate continuous participation of masses at various levels, has proved to be a key factor. One still remembers the *Swacchta* Pledge administered to millions of students spread in thousands of schools spread across the country exhorting them to fulfill Gandhi's supposed dream of a 'Clean India'.[2]

Perhaps it has also to do with the growing realisation about importance of sanitation in people's lives—in terms of health, economy and dignity of life and a reflection of the concerns of the world community vis-a-vis sanitation.[3]

During his Independence Day speech—around a year after the campaign was launched—Prime Minister M Modi said:

> A total of 31.83 lakh toilets were built between April 2014 and January 2015 under this campaign, which is 25.4% of the target for 2014–15. Over the next 5 years, the government plans to invest nearly Rs 2 lakh crore to construct 12 crore toilets across India.[4]

Similarly the official position put forward by the Indian delegation before the sixth SACOSAN (South Asia Conference on Sanitation) Forum held in Dhaka from 11–13 January 2016 also had many positive things to say about the advances in sanitation thanks to the 'turning point in the sanitation history of India' signified by the *Swacch Bharat Abhiyan*. It said:

> Progress of sanitation has witnessed a spurt since the launch of the *Swacch Bharat Mission*. In the first year i.e. from 2.10.2014 to 2.10.2015, 8.8 million toilets were constructed, against an expected outcome of 6.6 million toilets…The sanitation coverage, which stood at 40.60% as per the National Sample Survey Organisation (NSSO) has increased to around 48.3%.[5]

It is a different matter that an impact assessment study conducted by the National Sample Survey Organisation (NSSO) itself had revealed that 'toilets built in rural areas were lying unused, as the villagers were wary of using them.'[6]

Commenting on this study another newspaper even added that how after review by Prime Minister's Office (PMO) the results were delayed for publication as the government feared that they would be used by the opposition to slam the government over its cleanliness initiative.[7]

Keeping such a differing opinion on the issue in focus, what we intend to do in the following note is to evaluate the situation on the ground about few of the promises of the campaign and see for oneself whether any pattern emerges out of it or not.

To begin with we can have a look at one of the most visible manifestation of 'unclean India'—the question of manual scavenging—which involves practices of cleaning human excreta in ways which require direct

contact and is considered worst surviving symbol of caste untouchability.[8] Perhaps it also needs emphasising that '99 per cent of the people forced to do this work are Dalit, and 95 per cent of them are women, reflecting the many layers of shame and oppression imposed by caste, patriarchy and untouchability on this despised livelihood'.

Elimination of Manual Scavenging: Journey to a Blind Alley?

CHENNAI: A highly modernized airport is the last place where one would expect to encounter manual scavenging. But the practice that is banned in the State reportedly takes place at the Chennai airport that has been modernised at a cost of about Rs. 2,000 crore. Airport sources said that they had on many occasions witnessed workers cleaning the manholes on the premises of the airport without even any protective gear…Only last month, four people, including three manual scavengers were asphyxiated while cleaning a septic tank in Okkiyum Thoraipakkam. It is to be noted that over 200 workers have reportedly died in the State over the last two decades from falling inside sewer manholes and septic tanks.[9]

There is nothing surprising about this news which talks about a recently modernized airport accompanied by 'manual scavenging' because as far as India is concerned this situation exists everywhere. Delhi, which happens to be the capital of the country which has spent billions of rupees on establishing Metrorail also has scores of people who are engaged in the work of manual scavenging.

The situation in the national Capital itself is very bad. The Delhi High Court early this month rebuked municipal authorities and asked them to finish a survey of manual scavengers in the city in two months. The 2011 census figures showed Delhi had 583 toilets cleaned by manual scavengers and 633 'serviced by animals'.[10]

It was only the year 2015 when the socio-economic caste census data released by the government yet again acknowledged the fact that manual scavenging 'officially banned since decades in India, continues with impunity in several states' and that there are

1,80,657 households still engaged in this degrading work for a livelihood…Maharashtra, with 63,713, tops the list with the largest number of manual scavenger households, followed by Madhya Pradesh, Uttar Pradesh, Tripura and Karnataka, as per Census data.[11]

The official figures definitely tell a different story but unofficial figures collated by civil society organisations/ movements engaged in sensitizing people about it or eradicating it tell us an altogether different story. According to them the actual figure reaches around 13 lakhs. Even if one sticks to official figures, it does not lessen the gravity of the situation.[12]

According to the 2011 census, there are more than 2.6 million dry latrines in the country. There are 13,14,652 toilets where human excreta is flushed in open drains, 7,94,390 dry latrines where the human excreta is cleaned manually. About 73 per cent of these are in rural areas and 27 per cent are in urban areas.[13] Question arises why manual scavenging persists despite advances in technology and material progress? Is it '..[b]ecause of a lack of water-serviced latrines' (as concluded by a review of the [now defunct] Planning Commission?[14] Or there are deeper reasons involved in it?

Not that there have not been attempts at the level of parliament or at the level of executive to rid this practice but they have been half-hearted and exhibited indifference of the rulers. Ranging from the Barve Committee (1948) formed immediately after independence by the Maharashtra government to end manual scavenging—whose recommendations were accepted by the central government then—ollowed by the Malkani Committee to many other similar policy interventions or legislative actions to two major acts within a span of two decades the journey to do away with the medieval practice still continues.[15]

The Government of India promulgated 'The Employment of Manual Scavengers and Construction of Dry Latrines (Prohibition) Act' in 1993 but it took four years for it to notify it in the Gazette of India (1997). No state bothered to promulgate the act till 2000. Within twenty years of its existence there was no conviction of any government official, nor were executives of any company/ firm penalized for continuing with this practice. In fact, it was observed that the main violators of the law included government authorities only. Indian Railways continued to resist its implementation under the specious plea that cost factor has to be taken into consideration if the practice is to be eliminated.

As if to acknowledge the failure of this act the government passed a new legislation in September 2013 called The Prohibition of Employment as Manual Scavengers and their Rehabilitation Act 2013 and issued government notification for the same. It must be emphasized that an escape clause for local and railway authorities to continue to deploy workers in manual scavenging has also been provided in the beginning itself. This legislation looks at protective gear and safety precautions for the workers as an alternative to mechanisation. And for the purposes of the Act, those using protective gear and devices as may

be notified by the Central government would not come under the definition of a 'manual scavenger.'

The 'Resource Handbook to End Manual Scavenging' (Mander, 2015: 13) throws light on the persistence of the practice. According to the handbook manual scavenging continues because of

- Endurance of cultural notions of caste pollution and purity and assignment of persons to the despised work based on their birth
- Caste inequalities layered with gender discrimination (as most dry toilet cleaners are women)
- Apathy and failure of the state administrations throughout India to implement the law banning manual scavenging and implementation of official rehabilitation schemes
- Culture of impunity and the absence of state accountability, answerability and public sincerity to end caste discrimination resulting in its continuance.

As if to underline the fact that this degrading practice continues unabated despite legislative interventions a three judge Bench of the Supreme Court led by the then Chief Justice P. Sathasivam—while responding to a writ petition filed by Safai Karmchari Andolan and others—directed all the states to abolish manual scavenging and take steps for rehabilitation of such workers. It said

> Manual scavengers are considered as untouchables by other mainstream castes and are thrown into a vortex of severe social and economic exploitation. Dry latrines have not only continued to exist till date in several States, but have increased to 96 lakh and are still being cleaned manually by scavengers belonging to the Scheduled Castes.[16]

For sewer deaths it announced a compensation of Rs 10 lakh for the family of the deceased and directed that entering sewer lines without safety gears should be made a crime even in emergency situations.[17]

A report brought out by Human Rights Watch 'Cleaning Human Waste' (2014) provides details of these two major laws enacted by the Indian government within last two and half decades to end this practice and reviews their implementation. Underlining the failure of central and state governments in protecting the manual scavenging communities from threats of displacement and violence when they attempt to leave this practice and apathy of various governments towards helping them enter labour market and complicity of the authorities at the local level in perpetuation of this practice, in its recommendations to Indian Central and State Authorities asks it to

– Identify all individuals currently engaged in manual scavenging.
– Ensure that rehabilitation entitlements under the 2013 Act are available to manual scavenging communities.
– Take immediate steps to ensure that officials effectively intervene to stop communities from being coerced to practice manual scavenging.
– Strictly enforce the law against local government officials who themselves employ people to work as manual scavengers.
– Enact The Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Amendment Ordinance, 2014, No. 1 of 2014.[18]

In this particular study it also observes that women are often compelled to continue this work not for wages but for food and community resources. The question remains whether *Swachh Bharat Abhiyan* would be able to make a dent in this situation?

It would be decided by its difference from earlier interventions. Whether it is following the same path already traversed or has taken a radical rupture from earlier programmes?

We can have more clarity on the issue if we move towards another objective of Swachh Bharat Abhiyan, namely elimination of open defecation, the practice of defecating in the open without using the designated toilets, a practice which provides further rationale to manual scavenging.

Global Capital of Open Defecation

> …[t]he problem of persisting manual scavenging is much more that these figures suggests. It is a form of social exclusion. … The lack of water in public toilets leads to manual scavenging. Defecation along the railway lines leads to manual scavenging as it has to be lifted. The practice of collection of *tikaris*—i.e. collection of excreta from footpath and open spaces—adds to manual scavenging. As in public toilets old people cannot sit in latrines and therefore they stand while defecating, therefore, there is night soil to be cleaned in the morning from the walls' (Bansode).

Defecation habits of Indians are a cause of concern—worldwide.

The practice of open defecation, which is responsible for many health emergencies and is an affront to human dignity may have eclipsed in most of the western world and seems to be on serious decline in many of the third world countries even continues unabated here. A report prepared jointly by UNICEF and WHO—Progress on Drinking Water and Sanitation, 2014 update—had

Table 15.1 India's Proportion of Open Defecation in the World

2006	2008	2013
55%	58%	61%

Source: Medeazza and Chambers (2013).

already sounded the bugle when underlining 'increases in sanitation coverage' although the 'progress has been slow' it had noted how India has the largest number of people defecating in open.[19] The report had pointed out that 82 per cent of the one billion people practising open defecation live in just ten countries, namely India, (597 million); Indonesia, (54 million); Pakistan, (41 million); Nigeria, (39 million); Ethiopia, (34 million); Sudan, (17 million); Niger, (13 million); Nepal, (11 million); China, (10 million); Mozambique, (10 million) ; Rest of the world (182 million). Another report prepared by WHO and UNICEF a year earlier had underlined another notable fact. India's proportion in the world is also increasing (Table 15.1).[20]

The period under consideration (2006 to 2013) happens to be the period where growth rate of Indian economy was even a matter of envy in the western world. If we probe India's own sanitation journey further we find that open defecation is decreasing at a very slow rate—around 2 per cent per year from 1990 to 2015, whereas in the same period Bangladesh nearly eliminated its open defecation where it decreased from 34 per cent to 1 per cent.[21]

Persistence of this practice in a country which claims to be a leading scientific-technological human power in the world and is in a position to launch satellites into space or can build nuclear weapons has continued to baffle social scientists, development economists. A very commonsensical understanding is that since India happens to be a developing country with 1.25 billion population and not a very high per capita GDP that it is not able to move ahead on this front. A perusal of JMP data throws light on this aspect and demonstrates how countries far poorer than India stand far better when open defecation is concerned (Table 15.2).

A cursory glance at the above report makes few things clear.

- There is no relation between the country's Per Capita GDP PPP figures and prevalence of Open Defecation. Let us randomly take the case of three African countries: Democratic Republic of Congo, Malawi and Burundi who have Per Capita GDP PPP figures as 439, 739, and 737 respectively but where percentage open defecation rate is 9, 7, and 3 per cent respectively.
- Three neighbouring countries namely Afghanistan (Per Capita GDP PPP figures 1,892, % OD rate 15), Bangladesh (Per Capita GDP PPP figures 2,364, % OD rate 3) and Pakistan (Per Capita GDP PPP figures 4,360, % OD 23) are also in better position than India.
- India figures worst on the middle column also (per cent shared or unimproved), none of the country's mentioned there have such low figures like India. It just goes to show typical preference of Indians—where they would build enormous open pit latrines—as they are worried about the 'polluting' aspects in caste terms of emptying them–or will go for open defecation.

One is reminded of Sangita Vyas's talk on Ted X where she explores why pit latrines built by Indians are very deep and also cross the limits set by UNICEF. She compares the height of the septic tank in different countries. According to her whereas in other countries the septic tank is normally cleared every 5–6 months whereas in India the height of the septic tank is more than UN standards. She analyses it and tells whereas there is stigma attached to it in India because of caste other countries do not suffer from such stigma.[22]

Only in a society where excreta avoidance is ritualised we can find that open defecation can continue unabated or you build pit latrines which can continue for lifetime. Gita Ramaswamy (2011), throws light on this situation:

> In large parts of western world, the connection between human excreta and disease is well established. Human excreta is the principal vehicle for the transmission and spread of a wide range of communicable diseases…. In India, excreta is seen as impure…. Traditional practice has failed to keep up with scientific disposal of excreta, leading to skewed practices, particularly in the matter of having someone else to clean up behind us.
>
> Excreta avoidance is ritualised: the bath is taken after defecation…Caste Hindu society did not ever mind that public places were soiled by excreta but insisted that inside of the house should be free of excretions…
>
> Given such ritual avoidance of excreta, and the reality that excreta cannot be avoided after all, caste Hindu society, not surprisingly, found the solution in 'polluted' castes who would manually handle excreta. Scavenging and caste are thus intimately linked. (Ramaswamy, 2011: 14).

Table 15.2 Open Defecation is More Common in India than in Poorer Countries, 2012 JMP Data

Country	Percentage of open defecation	Percentage shared or unimproved	Percentage of improved sanitation	GDP per capita
India (2011 census)	49.8			
India (JMP)	48	16	36	5,050
Southern Asia	38	20	42	4,666
Sub-Saharan Africa	25	45	30	3,171
Pakistan	23	29	48	4,360
Haiti	21	55	24	1,575
Low-income Countries	21	42	37	1,569
Ghana	19	67	14	3,638
Senegal	17	31	52	2,174
Zambia	16	41	43	2,990
Afghanistan	15	56	29	1,892
Swaziland	14	29	57	5,912
Kenya	13	57	30	2,109
Southern Asia without India	12	31	57	–
Nicaragua	10	38	52	4,254
Democratic republic of Congo	9	60	31	451
Republic of Congo	8	77	15	5,631
Uganda	8	58	34	1,134
Malawi	7	83	10	739
Cameroon	6	59	45	2,551
Myanmar	5	18	77	–
Bangladesh	3	40	57	2,364
Burundi	3	50	47	737
Rwanda	3	33	64	1,379
Gambia	2	38	60	1,565
Vietnam	2	23	75	4,912
China	1	34	65	10,771

Source: Coffey et al. 2014.
Note: Distribution of the population into each sanitation category (% of population) from WHO and UNICEF (2014).
India figures from Census 2011 from Government of India (2012) and relate to proportion of households not having a toilet in their house and not using a public toilet. Per Capita GDP PPP figures from World Bank (2014).
*Categories are defined by the World Bank; low-income includes countries with GNI per capita, calculated using the World Bank Atlas method, of $1,035 or less in 2012 (World Bank 2014).

At a general level one can say that the Hindu notions of purity and pollution, inextricably linked with the caste system and the practice of untouchability, underlie the unsanitary practices in Indian society. These beliefs in fact perpetuate the oppression of the 'polluted castes', who are then forced to undertake manual scavenging, unclog manholes and clean other people's filth. (These ideas have also impacted practice of other religious groupings in India and we similarly encounter 'polluted' castes among them also.[23]) The availability of cheap Dalit labour to do these dehumanizing jobs can be cited as one of the reasons why open defecation still persists and development of toilet facilities and a modern garbage and sewage management system have been neglected so far.

Can we say that policymakers have given serious thought about this particularity of Indian situation and formulate policies accordingly.

Ending Open Defecation: The Toilet Route!

Toilets…and more toilets. The only answer available before the policy makers to end Open Defecation seems to be building toilets only. And it has been a ruling *mantra* of the sanitation campaigns organised earlier also. This extract from a review of the Total Sanitation Campaign-which began in 1999 and later metamorphosed into Nirmal Bharat Abhiyan—by Programme Evaluation Organisation of the (now defunct) Planning Commission explains its understanding:

> The practice of open defecation is supposed to be stopped by providing all individual households access to the toilets (target by 2012), toilet facilities to all schools and anganwadi centres (target by 2009) and Community Sanitary Complex/ Women Sanitary Complex in case there is no space or there exist financial constraints. In 2003 Government of India has added one new component 'Nirmal Gram Puraskar' to give fillip to the campaign. Unavailability of the toilets is the main reason for the huge percentage of households still defecating openly. According to our estimates, out of 73 households per 100 rural households where at least one member of the family practices open defecation, 66 households are forced to do so due to unavailability of toilets, 1 household is forced to do so due to inadequacy of number of toilets and 6 households are doing so in spite of having toilets.[24]

How has it performed as far as building toilets is concerned.

According to government records, in the past one decade, India has been building more than 3.5 million toilets a year (www.downtoearth.org.in/news/where-do-indians-defecate-42741). To put it in perspective: 9,589/ day, 400/hour or seven toilets/minute. Despite this, government has been changing its goal post to attain universal sanitation coverage. Earlier it said all Indians should have a toilet by March 2012. Now the government says it will be in March 2022 (Mahapatra, 2013).

The ongoing *Swacch Bharat Abhiyan* also talks of providing toilets to every household and community latrines to control Open Defecation. If earlier there were plans to build seven toilets per minute, under this new campaign the target has around quadrupled and there are plans to have thirty toilets per minute or one toilet every two seconds.[25] It is important to underline that there have been dissenting voices to this toilet *mantra* from within the establishment itself. Much like the NSSO assessment quoted earlier which talked about 'toilets remaining unused', a report prepared by country's auditor general indicted it in no uncertain terms: '… audit clearly reveals the failure of the sanitation programmes in achieving the envisaged targets', the CAG report on performance audit of total sanitation campaign/Nirmal Bharat Abhiyan tabled in Parliament said. The CAG pointed out that while the Swachh Bharat Mission was launched by the Prime Minister on October 2, 2014 with an aim of 100 per cent open defecation-free India by 2019, before this similar targets for eradication of open defecation were set out for 2012, revised to 2017 and again set out for 2022.

> The conceptual frame-work kept changing from supply driven to demand driven and finally to 'saturation and convergence' approach, yet the lessons learnt and experimentations through this long journey do not seem to have made much impact on the sanitation status in the country.[26]

The report also underlined how 'more than 30 per cent of individual household latrines were defunct/ non-functional for reasons of poor quality of construction, incomplete structure, non-maintenance' and said that '[u]nless implementation is based on realistic planning and is backed by large scale information, education and communication campaigns to bring about behavioural changes in the target population and overall governance at the grass root level improves, mere deployment of resources may not have any significant impact'.[27] It would be revealing to know the story of the 'missing toilets' from the earlier campaign just to comprehend how this 'tsunami of toilets' can unfold itself on the ground.

'Missing Toilets: Is India's Sanitation Drive 'In Deep Shit'?

A new report from Right to Sanitation Campaign in India entitled: *In Deep Shit* paints a gloomy picture about the position of India's sanitation, and simultaneously draws our attention to the case of 'missing' and 'dead' toilets. The report has questioned the claims made by the Ministry of Drinking Water and Sanitation (MDWS) that India is making great strides in availing toilets to its rural population through the Nirmal Bharat Abhiyan (NBA).

The report *In Deep Shit* exposes the discrepancy in toilet data in the rural areas as provided by the MDWS, which is 3.76 crore toilets higher than the one provided by Census 2011. 'The MDWS claims that 53.09 per cent of rural households were covered by the sanitation drive by December 2010 while the Census rural toilet data (as collected by September 2010) was 22.39 per cent lesser than the former's coverage. There is a variation of about 25 per cent in the rural HH toilet coverage reported

between the MDWS (Census 2011 projected HH coverage) and actual Census 2011 toilet coverage.'[28]

Whatever Happened to the Sanitation Chain

Focus on toilets has another unsavoury effect. There is a deliberate or (one can say) inadvertent neglect of subsequent stages of waste management which together form what is known as sanitation chain. The sanitation chain includes toilet (initial collection point of excreta) followed by removal and transport of faecal sludge, subsequent treatment, and final safe disposal. If the excreta is not properly disposed then sanitation chain remains incomplete and it can further contaminate land as well as water leading to health problems of different kinds.

In India, not only the toilet situation is bad—which is supposedly being corrected under SBA—subsequent waste management is equally bad or even worse leading to untreated sewage being dumped into water bodies or open grounds. It is worth noting that under SBA, there is emphasis on constructing toilets—individual household, community and public—and there is enough budgetary outlay for the same, but it does not include additional sewage treatment facilities despite the fact that only about a third of urban Indian households are connected to piped sewer systems (Census, 2011). Thus even when we use toilets, we inadvertently or unsuspectingly continue to contaminate our drinking water sources as well as our land—thanks to the government's apathy and its neglect of the total picture.

Geetika Anand and Vishnu direct our attention to a recent report released by the Central Pollution Control Board (CPCB), which 'estimates that there are 522 operational Sewage Treatment Plants (STPs) in India with a total capacity of 18,883 MLD. Another 294 STPs are either non-operational or under-construction or proposed...The operational STPs cover a total of 214 urban centres (CPCB, 2015) that house approximately 142 million people, or almost 38 per cent of India's total urban population (Census, 2011). This implies that the remaining 62 per cent do not have any access to sewage treatment facilities'.[29]

A report on sewer workers and the hazardous working condition under which they work, also throws light on the way in which India is 'literally drowning in its sewage'. According to the Delhi based Centre for Science and Environment, India is literally drowning in its sewage. Indian cities generate about 33,212 million litres per day (MLD) of sewage but the country has a capacity to treat only 6,190 MLD. Delhi, the rapidly growing capital of India, is also facing severe problems of untreated sewage. It has roughly 5 per cent of the country's urban population and 40 per cent of its sewage treatment capacity. Yet, this infrastructure is failing to keep the river clean (Singh, 2010). Interestingly this report also found mention in the parliament. Quoting from it, the then minister for Water Supplies had discussed the 'sewage crisis in making in urban cities,'

The key problem is Indian cities do not have drainage to convey excreta to the Sewage Treatment Plants (STPs). It is expensive to build sewage drainage but even more expensive to maintain it. And city Governments will keep behind all plans to build more. Cities also find they can never repair enough. The end result is that where there is an STP, there is no waste to treat. All cities forget that the majority lives unconnected to underground drainage or lives in what is officially called unauthorized and illegal colonies. In this way the city forgets these areas generate sewage, which flows into open drains that crisscross the cityscape. But these are the very drains, flowing past legal colonies, in which the STP disposes off its expensively treated effluents.[30]

It is clear that if the government continues to focus on building toilets and putting the question of subsequent waste management in cold storage, then perhaps it may have the satisfaction of fulfilling the target as far as no of toilets are concerned but it would still be far away from ushering us into a real 'Clean India'.

Sewer Workers: The Strange Silence

'Dirt', British anthropologist Mary Douglas famously explained, is 'matter out of place'. Dirt, on its own, does not mean impurity, contamination or pollutants. Dirt is what we, as a society, designate as 'unclean', thereby giving birth to a social order and its boundaries. Outside the boundary is 'dirt' or 'dirty', marking the purity of what lies within the boundary. We treat sanitation workers who clean this dirt no differently. We ostracise them as 'matter out of place'. (Bhasin, 2013).

The inadvertent or conscious neglect of the whole sanitation scenario and the hurried manner in which 'Clean India' is being envisaged also gets reflected in the way workers engaged in the work at various levels are dealt with.

The dangerous and hazardous working conditions of a section of these workers were brought to the notice of the Upper House when a member of the ruling coalition quoted an estimate of 22000 deaths annually while cleaning sewers in the country, drawing on the records of the National Commission of Safai Karmacharis.[31]

He called them 'cleanliness martyrs' who do not get any attention.

It is important to note that the figures quoted exactly matched the details of a story in a magazine which had appeared nine years back. The said story titled 'Life Inside a Black Hole', discussed how 'beneath the glitter of India are dark alleys in which are trapped poisonous gases and millions of Dalits who do our dirty job in return for disease and untouchability'. According to the author Siriyan Anand,

> At least 22,327 Dalits of a sub-community die doing sanitation work every year. Safai Kamgar Vikas Sangh, a body representing sanitation workers of the Brihanmumbai Municipal Corporation (BMC), sought data under the Right to Information Act in 2006, and found that 288 workers had died in 2004–05, 316 in 2003–04, and 320 in 2002–03, in just 14 of the 24 wards of the BMC. About 25 deaths every month. These figures do not include civic hospital workers, gutter cleaners or sanitation workers on contract. Compare this with the 5,100 soldiers—army, police, paramilitaries—who have died between 1990 and 2007 combating militancy in Jammu and Kashmir (Siriyavan, 2007).

It had also underlined the fact that most of the workers who work in sewers die before retirement. The average lifespan of a manhole worker is about 45 years. If a worker does not die inside a manhole but due to illnesses contracted while doing the job, then there is no monetary compensation. For undertaking the hazardous job, the worker gets a paltry 'risk allowance', which for example, is Rs 50 in Delhi. Quoting Ashish Mittal, an occupational health physician who co-authored Hole to Hell, a 2005 study of sewer workers by the Centre for Education and Communication (CEC), New Delhi, it described the condition inside a manhole which is

> a confined, oxygen-deficient space where the presence of noxious gases can cause syncope-a sudden and transient loss of consciousness owing to brief cessation of cerebral blood flow. The brain cannot tolerate even a brief deprivation of oxygen. The long-term neurological effects of syncope can be debilitating. (Siriyavan, 2007)

In developed countries, manhole workers are provided with proper safety equipment before they descend into the gutter. According to the *Tehelka* report,

> manhole workers there are protected in bunny suits to avoid contact with contaminated water and sport a respiratory apparatus; the sewers are well-lit, mechanically aerated with huge fans and therefore are not so oxygen deficient. In Hong Kong, a sewer worker, after adequate training, needs at least 15 licences and permits to enter a manhole. (Siriyavan, 2007)

In contrast, in India

> the manhole worker wears nothing more than a loincloth or half-pants. In Delhi, since the directives of the National Human Rights Commission in October 2002, the majority of the DJB's permanent workers wear a 'safety belt'. It's a joke. This belt, connecting the worker through thick ropes to men standing outside, offers no protection from the gases and the sharp objects that assault the worker. At best, it helps haul them out when they faint or die. (Siriyavan, 2007)

The report emphasized that it is not the lack of funds or technology which poses a problem. If technology could be used to launch satellites, then why can it not be used for managing garbage and sewage?

> India's urban planners, designers and technologists have never felt the need to conceive a human-friendly system of managing garbage and sewage. Instead, they rely on an unending source of disposable, cheap, Dalit labour. (Siriyavan, 2007)

It would be interesting to look at a report of sub-group on Safai Karmcharies which was submitted to 'The Working Group on the 'Empowerment of Scheduled Castes' for the Eleventh Five Year Plan (2007–2012)' which had suggested that the government forms a study group to understand latest technologies in sanitation systems in vogue in developed countries and emphasised developing technologies that will eliminate the need for workers to enter sewers. The continuing dance of death where sewers are turning into death traps for gullible workers just goes to show that all those recommendations have remained on paper only.

Behavioural Change: People's or Governments'

> The Hindu Social Order is based upon a division of labour which reserves for the Hindus clean and respectable jobs and assigns to the untouchables dirty and mean jobs and thereby clothes the Hindus with dignity and heaps ignominy upon the untouchables.
>
> —Dr Ambedkar (1989)

The *Swacch Bharat Abhiyan* talks about behaviour change of people—which is definitely important—but interestingly maintains silence about government. Perhaps it is time that there is increasing clamour for behaviour change within the government also. And definitely the need for 'behaviour change' vis-a-vis the

government should not begin and end merely at revisiting the sanitation chain.[32]

In a caste-ridden society like India, where one witnesses deep rooted association between caste and cleanliness, which has condemned a section of its own population to the work of cleaning and further stigmatized them, it appears that there is a conscious refusal to look at this linkage on part of the policymakers. This refusal has basically resulted/culminated in providing technical solution to a social problem. It could also be understood this way that all attempts to make India 'Clean' have largely remained focussed on the 'occupational' sphere (of caste) and attempts have been made either to reform the individual or provide some technical device and keep the (caste) structure intact.

And this 'sociological blindness' towards caste is leading to unforeseen circumstances. We are witness to return of caste or its further strengthening with a vengeance.

With the much talked about School Sanitation Campaign there is a strong possibility emerging that the prevalent caste discrimination is being strengthened as in the absence of sweepers in schools students belonging to the scheduled castes are cleaning the toilets.[33] Or with the introduction of pit latrines in a big way the question of emptying of these pits has arrived and which has led to roping in the erstwhile scavenger castes for this profession.

Look at Government Resolution (GR) issued by the social justice department of Government of Maharashtra in November 2015. It stated that successors of employees belonging to scheduled caste communities involved in cleaning roads and lavatories will get similar job. The controversial move which was in complete violation of norms as it had named the particular castes instead of calling them SCs. This decision was based on the recommendations made by a senior bureaucrat V S Page forty years ago.[34] The irony was not lost on people as this particular GR was issued merely three days before the Prime Minister and Chief Minister of Maharashtra dedicated a house in London to the Nation where Dr Ambedkar had stayed during his student days.

Interestingly this move by the Maharashtra government which reserved the jobs of sanitation workers to the Scheduled Castes cannot be considered an exception.

Few months before the 2014 elections to Parliament, Akhilesh Yadav, Chief Minister of Uttar Pradesh, belonging to Samajwadi (Socialist) Party, in a big rally of 'safai mazdoor'—most of them Balmikis—announced that his government would recruit 40,000 sanitation workers and would provide Rs 5 lakh compensation to their family members in case of their death. The rally was seen as an attempt to cut into support base of rival BSP (Bahujan Samaj Party) which has a strong base among the various dalit castes. To put it little bluntly Party Supremo Mulayam Singh Yadav, exhorted the Balmiki community that although it has been associated with cleaning work and was considered at lower level but it was not so now.[35]

The recommendations of a parliamentary committee also show the mindset of the people associated with policy formulations. The Committee dedicated to the welfare of the scheduled castes and scheduled tribes presented its report before the parliament (Dec 1, 2007)—when Congress led UPA government was in power—where it said that cleanliness workers for Central Schools and affiliated houses would be recruited from the scheduled castes only.

Last but not the least, Mr Narendra Modi, as Chief Minister of Gujarat had compared the degrading work of cleanliness—which in the Indian context is mostly done by particular dalit castes—with 'spiritual experience'. It was the year 2007 when collection of Modi's speeches to IAS officials at various points of time were compiled in a book form named 'Karmyog' and were published by the Gujarat government (Shah, 2012). Sample one of his speech, where talking about the Safai Kamdars, Modi exhorts:

> I do not believe that they have been doing this job just to sustain their livelihood. Had this been so, they would not have continued with this type of job generation after generation….At some point of time, somebody must have got the enlightenment that it is their (Valmikis') duty to work for the happiness of the entire society and the Gods; that they have to do this job bestowed upon them by Gods; and that this job of cleaning up should continue as an internal spiritual activity for centuries. This should have continued generation after generation. It is impossible to believe that their ancestors did not have the choice of adopting any other work or business. (Gatade, 2014)

* * *

SBA would be completing two years of its journey on 2nd October 2016.

One learns that the government has already started preparations to reenergize the people and supposedly regain lost momentum. It has directed different government departments to retake the pledge—which was administered to them at the launch of the campaign already. Apart from appointing a specialist who has earlier worked World Bank's Water and Sanitation Concerns to supervise its flagship programme,[36] it has imposed a *Swacch Bharat* cess of 0.5 per cent on all services liable

for service tax, effective from November 15, 2015 supposedly to give a boost to the Clean India initiative. A proposal is also under consideration wherein the private companies and PSUs would be asked to spend around 30 per cent of CSR funds on this initiative.

But whether all the glitter and glow would be able to hide the penetrating questions being raised or the devastating criticism it is being subjected to.

As one writes these lines a historic 125 day rally 'Bhim Yatra: Stop Killing Us' mainly of Safai Karmcharis themselves, which traversed 500 districts and thirty states is reaching the capital on the eve of the 125th birth anniversary of Dr Ambedkar underlining the fact that manual scavengers are still being 'killed' in dry latrines, sewers and septic tanks and for them how fictitious all these promises of 'Clean India' look.[37]

There is deliberate silencing of the woes of the manual scavengers—the Bhim Yatra cited above points out that less than three percent deaths of safai karmcharis have received the mandatory compensation due because of Supreme Courts historic judgement in March 2014. What is more worriesome is that this campaign has been accompanied by silencing of voices of fresh rumblings within the historically despised and stigmatized 'scavenging' communities where there are fresh challenges to the age old 'profession' and a large section of the younger ones of the community are getting ready to come out of broom and human waste.

And if we try to counter pose this voices of resistance within the community to leave the profession and the hype generated around 'Swachha Bharat Abhiyan' one can see that it is an attempt to popularise the broom once again, rather glamourize it, in its 'natural' constituency and thus cleverly bypass the voices of resistance.

Or to put it other way 'The idea of 'clean India' with the contemporary initiatives under the *Swacha Bharat Mission* is a hegemonic discourse and praxis. It not only re-invokes but justifies the caste notions of 'purity and pollution' so that scavengers conform to cleaning toilets and remain contained with wages and the lifestyles by continuing their hereditary occupation' (Bansode).

Notes

1. Swachh Bharat Abhiyan—Clean India Mission—has put before itself broadly the following objectives: 1. Eradicate manual scavenging. 2. Eliminate open defecation by constructing toilets for households, communities. 3. Introduce modern and scientific municipal solid waste management practices. 4. Enable private sector participation in the sanitation sector and 5. Change people's attitudes to sanitation and create awareness.

2. Available at http://www.epw.in/journal/2014/41/web-exclusives/how-clean-my-country.html, accessed on 25th March 2016.

3. The year 2008 was celebrated as International Year of Sanitation at the behest of United Nations. Through resolution 64/292, the United Nations General Assembly recognized (28th July 2010) 'the human right to water and sanitation and acknowledged that clean drinking water and sanitation are essential to the realisation of all human rights'. Universal access to clean water and sanitation is one of the 19 Global Goals that constitute the 2030 Agenda for Sustainable Development Goals. The South Asian Conference on Sanitation [SACOSAN]-a biennial gathering of eight member countries of SAARC-has also given a push to develop a regional agenda and related action plans around Sanitation.

4. Available at http://www.hindustantimes.com/india/swachh-bharat-abhiyan-is-modi-s-scheme-a-success-one-year-later/story-XDjpG9TjuYtkQnFdYKgQyM.html, accessed on 15 March 2016, accessed on 27 May 2016.

5. Available at http://www.sacosanvi.gov.bd/data/frontImages/India_Country_Paper.pdf.

6. Available at http://www.hindustantimes.com/india/swachh-bharat-abhiyan-is-modi-s-scheme-a-success-one-year-later/story-XDjpG9TjuYtkQnFdYKgQyM.html, accessed on 15th March 2016.

7. Available at http://articles.economictimes.indiatimes.com/2015-11-23/news/68510403_1_national-sample-survey-office-swachh-bharat-abhiyan-toilets, accessed on 27 May 2016.

8. There are three main forms of manual scavenging: 1. the manual removal of excreta from dry latrines both public and private, with bare hands and instruments like metal scrapers and brooms, with the help of which the excreta is poured into wicker baskets or buckets, carried on the head or hip for disposal at designated sites like a river or dump; 2. the manual removal of excreta from open drains and public streets because of open defecation and from railway tracks; and 3. the manual removal of excreta from septic tanks as well as cleaning of closed gutters and sewages (Mander, 2015: 35).

9. Available at http://www.thehindu.com/news/national/tamil-nadu/a-modern-airport-with-manual-scavenging/article8246282.ece, accessed on 18 February 2016.

10. Available at http://indiatoday.intoday.in/story/scavenging-horror-new-govt-survey-exposes-massive-use-of-humans-pigs-to-clean-dry-toilets/1/486411.html, accessed on 27 May 2016.

11. Available at http://www.thehindu.com/news/national/manual-scavenging-still-a-reality-socioeconomic-caste-census/article7400578.ece, accessed on 17 March 2016.

12. As an aside it may be added that difference between the official and unofficial figures would see a further quantum

jump if the counting is done by taking into consideration the 2013 act which defines it in much more broader manner and does not limit it merely to removal of excreta from dry latrines.

13. Available at http://www.governancenow.com/views/think-tanks/swachh-bharat-why-manual-scavenging-still-prevalent#sthash.JSaGYJuE.dpuf.

14. Available at http://planningcommission.gov.in/reports/peoreport/peo/rep_tscv1_2205.pdf. p. 120. In spite of its being outlawed and punishable with a prison term, manual scavenging (the removal of human excreta by human beings) continues across the country because of a lack of water-serviced latrines. Our data below supports this dark fact. It can be seen that selected households in Andhra Pradesh, Haryana, Kerala, Tamil Nadu etc. have reported that they take help from manual scavengers to clean up the night soil.

15. Looking back one can even discover that the way some of them viewed the challenge was itself problematic where the victims were themselves blamed for their plight.

For example, Barve Committee even blamed the victims for their plight.

Ancestors of these Bhangis were just field labourers of a low caste, but never did the work of scavenging. Some of these people took to the dirty work of cleansing the latrines for the sake of profit. Slowly this developed into a monopoly. The stage was reached when the Bhangis wanted to exploit this monopoly and a sort of customary right was thus developed. By force of habit the Bhangi lost his self respect to such an extent that he did not consider the dirty work of cleansing latrines as a curse from which he should endeavour to extricate himself.

On 'The Customary Rights of Scavengers' the Malkani Committee (1965) said:

'Scavenging has been a way of life for the family. A fatalistic attitude pervades the whole outlook due to lack of education and absence of other openings for employment.'

Cited in Ramaswamy (2011: 65).

16. Available at http://www.thehindu.com/news/national/supreme-court-orders-states-to-abolish-manual-scavenging/article5840086.ece, accessed on 27 May 2016.

17. Available at http://www.thehindu.com/news/national/supreme-court-orders-states-to-abolish-manual-scavenging/article5840086.ece, accessed on 27 May 2016.

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26. Available at http://timesofindia.indiatimes.com/india/Sanitation-programmes-have-failed-to-achieve-targets-CAG/articleshow/ 50094057.cms, accessed on 27 May 2016.

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16

Gender in Internal and International Labour Migration

Women's Migration, Social Disadvantage, and Social Development

Praveena Kodoth

Labour migration in India has been notoriously difficult to engender not the least because the highly institutionalized relationship between gender and mobility masks women's labour migration and impedes understanding of its nature, patterns, and implications. Gender structures mobility such that labour migration is embedded in family strategies that prioritize male migration or bind women largely to move in association with men. It is relatively rare for women to migrate independently. Nevertheless, village and sector specific studies have shown that women have a considerable presence in temporary, seasonal and circular labour migration, not captured in macro estimates.

Research on labour migration is marked by a rather sharp separation in the understanding of labour mobility within the country and across its borders. At the source both forms of mobility are structured within shared social/cultural institutions hence with the exception of professionals, women are perceived largely as family migrants. India's migration policy restricts less qualified women's mobility to specific countries, prominently the Middle East, a region of high demand for women as paid domestics. This raises the costs of migration and introduces disparity in less skilled women's access to international migration. A systemic production of invisibility of poor working women, who are disproportionately from the historically disadvantaged social groups, underscores the influence of class, caste, and patriarchy in internal and international migration.

As a counterpoint to the under-estimates of women's labour mobility in the macro data, I map its diverse nature and forms within the country and consider their implications for social development. I also probe gender-related assumptions underpinning state policy on women's migration within the country and across its borders. Migration from Kerala has been male dominated but unlike high emigration states like Punjab, Kerala is recognized for migration of women workers particularly as nurses but also as domestics. What conditions enabled nurses and domestics from Kerala to access international mobility and what have been the implications of gender-differentiated mobility for social development?

Seasonal and circular migration, with a marked presence of Scheduled Tribes and Scheduled Castes, is undertaken in conditions that limit workers abilities to improve their labour market prospects and livelihood conditions. Women are particularly affected by migrants' lack of basic health facilities and safe living conditions but also children who accompany migrants lose out on schooling. Not unlike seasonal and circular migration, a large segment of migration from Kerala to the Middle East was in less skilled occupational segments like construction. But spatial mobility from Kerala has been associated with economic and social mobility at least partially through investments in education and health.

Kerala led the way in social indicators since the 1970s, that is, when it was among the poorer states in the country. Extensive labour mobility to the Middle East bolstered disposable incomes of families but dependence on migrant earnings intensified male conjugal authority within households. Malayalee women at different levels of the skill/capabilities ladder migrate independently within and across national borders. Identifiable clusters include fish processing workers who go mostly to coastal states, nurses who have gained global visibility and

domestic workers who go mostly to the Middle East and South-east Asia. But women's labour migration is not in accordance with normative gender in Kerala and at the lower level of the skills hierarchy is increasingly confined to the margins of livelihood strategies of families.

The post-Independence phase of international mobility of women workers from Kerala was coeval roughly with the opening up of demand in the Middle East. Labour mobility during the colonial period was an enabling condition. The early cohort of migrant nurses and domestics was drawn from specific communities, the Syrian Christians and coastal sector Latin Catholics/Muslims respectively. These communities had a presence in Bombay, which was the nodal centre for recruitment to the Middle East. The ability of migrants to nurture capability formation differed according to their initial social profile, support from the community and church and the structuring of migration, which prevented less skilled workers from taking their families with them.

To trace the conditions in which migration took root and the differing implications for social development, I draw on interviews conducted with nurses and domestic workers who migrated between 1950 and 1975 and/or their family members. I also use interviews with emigrant domestics who went later and findings from a primary survey of emigrant domestics from Kerala.[1] The chapter has six sections. The following section examines the gendering of labour migration within the country in terms of scale, nature and meanings of migration and draws out some implications for social development. Section three reviews the experiences with the existing legal frameworks of migration and probes the assumptions that inform state perspectives. Section four focuses on international migration from Kerala and contextualises the migration of nurses and domestics by probing the experiences of the first generation of migrant women. The conclusion draws together some of the implications of internal and international migration for social development and underlines the effects of state perspectives on migration.

Internal Migration

Labour migration is structured by multiple factors (a) macro-economic policy frameworks that structure the demand for and supply of employment (b) strategies of accumulation of capital apparent in how employers recruit and manage labour and (c) cultural norms that shape gendered migration strategies. Macro estimates from the National Sample Surveys and Censuses focussed on long term migration underestimate migration of poor and women workers, which is disproportionately temporary, short term and seasonal. A recent survey by the Centre for Women's Development Studies (CWDS) of village sites in 17 states indicates that women's labour migration is likely to be significantly higher than the NSS estimate (Mazumdar et al., 2013: 61).[2]

Two kinds of contentions have emerged with respect to seasonal migration. One, macro-structural changes and state-induced dispossession have rendered it into a coping strategy for the poor (Breman, 1996, Teerink, 1995, Mazumdar, 2014). Two, seasonal migration is highly differentiated: it is a defensive coping strategy for the poorest families whereas better off migrants' effect improvements to their assets and living conditions (Mosse et al., 2002, Deshingkar and Akter, 2009). Differentiation of migration may be expressed through women. The poorest farmers migrated as families whereas among the less poor, young men migrated, thus women migrants were drawn from the poorest families (Mosse et al., 2002: 69–70). But differentiation could occur between men and women. Survival needs push women in the Santal Parganas to engage in short term seasonal migration four times a year whereas 'men prefer longer term migration linked as it is to higher wages and notions of adventure' (Rao, 2006: 130).

To understand the gendered structuring of labour migration and its implications for women, I first probe the social profile of women labour migrants in association with the gendered meanings of migration and then turn to the nature and implications of women's migration.

i. Who migrates?

Women's labour migration cannot be understood without reference to social structures. There is a marked over-representation of ST and SC women in temporary, seasonal and circular migration. Over half of the ST women and over a third of SC women in the CWDS survey were short term and circular migrants compared to less than one fifth of upper caste women.[3] Women shoulder a disproportionate share of the burden of survival among the poor. Brick kiln, unskilled construction work and agriculture, 'the domain[s] of the poorest workers' had a concentration of SC and ST workers and women (Desingkar and Akter, 2009, Karlekar, 1995: 52–3). Mazumdar et al., (2013: 53, 56–57) find that the major sectors employing women migrants were agriculture (17.5 per cent), paid domestic work (15.9 per cent), brick making (11.8 per cent), and construction (14.3 per cent). Upper caste women had a higher share of professional technical and related workers, call centre, sale workers, nursing and other white collared jobs and moved in

higher proportion to urban destinations even as Other Backward Classes (OBC) women fell in between. Cotton seed production employs children, mostly girls below 14 years, from heavily indebted families of the historically marginalised communities (Venkateswarlu, 2007).

Long term migration for paid domestic work has two distinct categories, day workers and workers who reside with their employers. Migrant domestic work provides greater prospects for employment for lower castes owing to less rigid norms of caste in the destination (Jagori, 2011, Kasturi, 1990). The city of Delhi attracts large numbers of migrant domestics from diverse caste backgrounds. Day workers were mostly SC from adjoining states but with sizeable proportions from the eastern and southern states. ST workers from eastern India were dominant among workers residing with employers where there were comparatively higher proportions of forward and backward castes among day workers.[4]

ii. What are the meanings associated with migration?

Male labour migration builds on long-established connections and is more than a livelihood strategy of the poor. It may be a life cycle event that in the absence of other male members to provide for the family may be subject to restrictions (de Haan, 2006: 119, 115). In contrast, seasonal labour migration undermines normative identities of Santal men, who if they have a choice stay at home and when they don't would rather choose long term migration (Rao, 2006).

Women's labour mobility shades from being proscribed to being normative (or at least not against the norm) along two axes, from high caste to low caste/ tribal and from north to south India. Extensive mobility among SC/ST women, signals a norm that is internalised through socialisation. In a 1978 study, MSA Rao explains how single SC women from Andhra Pradesh (AP) who migrate over long distances to work in tobacco grading sites over two states, are socialised as children into the practice of migrant labour as they accompany their migrant parents (cited in Karlekar, 1995). ST domestic workers from eastern India have been described as flocking to Delhi in response to economic incentives and to 'the charm of the city' (Neetha, 2004: 1684).

The absence of women's labour migration among some tribes need not indicate proscription. Menon (1995) observes that Saora women do not migrate because, unlike the men, their customary economic base has not been fully eroded. In contrast, large scale migration of Soara men as well as Santal and Munda women of the Chottanagpur, who work at an industrial complex in Orissa, corresponded to loss of their traditional economic base (142). In source regions of women migrants, a demonstration effect was visible. Women from Bhumij and artisanal communities, who considered labour migration to paddy cultivation in West Bengal inferior, adopted it in source areas of Santal migration but restrictions on women continued in source areas of migration by non-tribal men (Mazumdar, 2014: 35).

South Indian women have migrated to cities and urban areas seeking employment along with their families but north Indian men go alone (de Haan, 2006). But experience was coded through caste. OBC/higher caste women from South India experienced migrant domestic work in Delhi as shameful even as SC workers felt liberated (Kasturi, 1990). Migrant fish processing workers, mostly unmarried OBC girls from the coastal sector in Kerala and migrant nurses who are mostly Syrian Christians, a forward community, attract stigma at home (Kodoth and Varghese, 2012).

iii. Nature and implications of women's migration

Only a quarter of women workers in the CWDS survey migrated alone as against nearly half of male migrants and nearly half of women migrants who went with family members. The remaining women migrated in assorted groups. Family migration is widespread in brick work, sugarcane cutting and construction and families were recruited predominantly through contractors. Limited upward mobility in low paid occupations was confined to male migrants as women are viewed as helpers even when they perform equally or more demanding tasks than men and are not paid separately when they work with their spouses (Karlekar, 1995; Teerink, 1995, Bhattacharya and Korinek, 2007: 522; Deshingkar and Akter, 2009).

Initial resource conditions, recruitment practices and work organisation in the destination affect the prospects of migrants. Sugar cooperatives in western India are a classic example of implicit collusion among employers that deprives workers of bargaining power.[5] Employers' refusal to hire local labour but rely on contractors to transport tribal families from distant localities even as groups from these localities are channelled to other places (Teerink, 1995). Corresponding to changes in economic policy since the 1990s, employment of migrants from western India has expanded and is increasingly to the urban informal sector but the system of recruitment and work organisation involving sub-contracting and piece rate payments continues to undermine their bargaining power (Breman, 1996).

Mosse et al. (2002: 69) point out that those who migrate independently and seek work on the spot market secure better terms but Bhil migrants choose mostly to be recruited by contractors. There could be a trade-off between competitive strategies and group migration through contractors, which assures relatively secure work at lower wages. Groups linked by spatial and kinship ties provide social and emotional support and some minimal protection against sexual harassment of women (Bhattacharyya and Korinek, 2007: 521; Rao, 2006). Women migrants are burdened with wage work and domestic work but are neither paid separately nor and have control over incomes (Teerink, 1995: 289; Mosse et al., 2002; Bhattacharyya and Korinek, 2007).

In theory, migration of women independent of their families holds greater potential for economic independence. Rogaly et al. (2002: 100) argue that agricultural labour migrants in Barddhaman have achieved some bargaining power because, unlike sugar cultivators in South Gujarat who are mostly Patidars, employers of the former are characterised by competition, which is consistent with greater class differentiation and lack of unity along caste, religion or political party lines. However, Santal women agricultural labour migrants to Barddhaman are unable to sustain the effects of bargaining power because they lack property rights at home (Rao, 2006: 144).

The implications of individual and family migration differ among migrant domestic workers. SC women domestics in Delhi, mostly family migrants, gained some recognition as breadwinners but were subject to patriarchal authority and sometimes even violence. In contrast, ST domestic workers from eastern India who migrated in independent groups or through placement agencies leveraged their families' economic dependence on them into greater voice (Neetha, 2004: 1687).

Migration impacts women when men migrate alone. Case studies document the increase in women's work load in agriculture and housework through male migration among STs (Mosse et al., 2002: 81, Menon, 1995) and from Bihar and UP particularly when remittances were small (Paris et al., 2005; Datta and Mishra, 2011). Macro analysis suggests that household structure defines impact. In small families, the workload of the wives of migrants increases but also their autonomy whereas women in extended families were not affected either way (Desai and Banerji, 2008). Further, social mobility associated with increased incomes leads to withdrawal of women from paid work (Kodoth, 2005).

Despite harsh conditions, women may not perceive seasonal migration as oppressive, for it may allow them to get away, however temporarily from oppressive social relations at home (Menon, 1995; Joseph, 1999; Shah, 2006). At the margins of the social and economic order, women may experience it as a choice. While this does not mitigate or condone the exploitative nature of their work, it directs attention to oppressive social structures. It is not migration *per se* but the position of women in the social structure that disadvantages them whether as migrant workers or as women who stay back while their husbands' migrate (Desai and Banerji, 2008). Because temporary, short-term, and seasonal migration is articulated with the social/cultural and in conditions of extreme deprivation, men do not achieve the social distance necessary to alter inequalities in economic and social power.

iv. Gendered labour migration and social development

Two kinds of comparisons emerge from the foregoing analysis that are pertinent to understanding poorer migrants' prospects for improving social development, one between long term/independent women's migration in low paid occupations and seasonal migrants and two, between women migrants *per se* and women who remain at home when men migrate.

As is well known, the work environment shapes discrimination against women as women and as workers. Women in seasonal migration are the worst affected through the lack of access to public health or other state welfare systems, lack of basic services, harsh working conditions and sexual harassment. Migrants often live in makeshift shelters or out in the open and work in conditions that heighten occupational and reproductive health problems. For instance, migrant women sugarcane harvesters deliver children in highly unsanitary conditions (Teerink, 1995). Employers may expect sexual services from migrant women, increasing the risk to women's health (Rao, 2006).

Seasonal labour migration by women or by families affects children who are withdrawn from/not enrolled in school. The problem of children in migrant labour is complex. Children are considered crucial to the work process in occupations like brick making and extensively used in sugarcane harvesting and cottonseed production. Employers have no incentive to support government schemes for education of migrant children whereas parents value the additional earnings children bring or the child care provided by older children. Hence, NGOs face a big challenge compared to which resources allocated to them are meagre.[6] Thus, women seasonal migrants suffer in terms of their own health and well-being and

rarely achieve the means to invest in their own or their children's health or education.

Comparatively, women's long-term migration even in low paid work improves earnings and has greater potential to contribute to social development. Long-term migration to South Indian cities improved the incomes of all women migrants and asset position of more than half the migrants in the lower income category (Sundari, 2005: 2302). Another group of longer-term migrants, ST domestic workers in Delhi contribute to their siblings' education and have gained the space to decide when and who to marry and to participate in decision making in the family (Neetha, 2004: 1687).

When men migrate alone, women may benefit from improved wealth and social status. In nuclear households, remittances may increase investment in social development (Desai and Banerjee, 2008). Though migration of younger males alone may signal better economic conditions, dependence on remittances in certain circumstances could weaken women's and older male entitlements to household resources with implications for their health and well-being (Mosse et al., 2002: 81).

Education and skills differ according to caste/community and gender and influence migrants' access to remunerative work, therefore people with a better social profile exercise greater choice with respect to migration, are able to improve livelihoods and invest in capability formation. This process reinforces social disadvantage and increases inequality. Social segmentation is marked in migrant labour with relatively large proportions of lower caste women in short term and seasonal labour migration compared to upper caste women.

Gender and Policy Perspectives on Labour Migration

Regulatory frameworks for labour migration are notoriously ineffective. The only law that deals specifically with internal migration, the Inter State Migrant Workmen's Act (ISMWA), 1979, was formulated to protect the rights of migrant workers in the context of an exploitative recruitment system. It mandates registration of contractors, employers and workers, passbooks that record payments maintained in the custody of workers and inspections by state officials. It also has provisions specifically addressing women, 'equal pay for equal work irrespective of sex', maternity benefits and crèche facilities. A recent Parliamentary report lays the responsibility for non-compliance squarely at the doors of the government, commenting that government lacked information about licensed/unlicensed contractors and had made no effort to ensure that workers received benefits under the act (Standing Committee on Labour, 2011). Domestic workers are not recognized fully as workers but activists have obtained some regulations on minimum wages and working hours.

The provisions made to administer the Emigration Act, 1983, rely explicitly on instruments that seek to control the mobility of less skilled women workers to specific destinations like the Middle East, which coincide with areas of high demand for paid domestic workers. Government has tightened barriers against the mobility of less qualified women since 2000 and there has been a ban on the mobility of women below the age of 30 years from India since at least the 1990s. Persons with less than matriculation have Emigration Check Required (ECR) passports and are required to get special clearance from the Protector of Emigrants (POE). Emigration is granted to women on the basis of documents showing age, medical and police verification, visa and a work contract that is attested by the embassy in the destination on payment of a security deposit by the overseas sponsor-employer.

In April 2015, nurses were brought under the ECR category following revelations of large-scale corruption involving recruiting agents and the POE. The new rule is to channel all recruitment exclusively through three public sector agencies. However, less than a year later, the government gave permission to ten private recruiting agencies to recruit nurses. A representative of one of the authorised public sector agencies pointed out that private agencies lobbied successfully with government alleging that the public agencies were unable to cope with recruitment whereas in reality delays were occasioned by the lack of proactive facilitation by government.[7]

Though ISMWA aims to protect migrant workers, state intervention is driven by the perception that migration is a problem. Government effort is directed at reducing labour migration as it puts pressure on civic amenities and on the urban environment (Sundari, 2005). In some contexts, government is reluctant to act on violations such as bonded labour because it would be an admission of its failure to control migration (Deshingkar and Akter, 2009). Often employment programmes in source areas aim to prevent labour migration under the mistaken assumption that populations are sedentary (de Haan and Rogaly, 2002, Mosse, 2002). The official approach deflects attention from the need to strengthen migrants to enhance their bargaining power and well-being.

There is a woeful lack of political commitment to enable workers to access rights under ISMWA and to enable less skilled emigrant women to tap relatively better opportunities on the overseas labour markets through the Emigration Act. Emigration policy is driven by cases of severe abuse of domestics that occasionally make headlines and generate outrage. Women are constructed as symbols of national honour, which transforms their exploitation in overseas employment into an act of emasculation of the nation. This construction is founded on upper caste patriarchy, summed up in the attitude 'it is better to starve than to send women abroad as domestic workers'.

Indian embassies are widely known to be unresponsive to the needs of poorer migrants. 'The embassy is interested in big business. The truth is that poor women are not a concern for them'.[8] The system of sponsorship and recruitment in the Middle East invests employers with inordinate powers over their workers. The lack of full coverage under the labour laws in the Middle East and the isolated nature of their work sites increase the vulnerability of domestic workers. In this context, the Philippines experience shows that augmenting skills and establishing a reputation enables workers to secure better opportunities on the labour market and reinforces their security in relative terms (Kodoth, 2016).

Experiences of emigrant less skilled workers in the Middle East are highly varied. Success depends on women's access to supportive social networks in the destination in the absence of which women are forced to rely on risky informal recruiting networks. Women aspirants are aware of the risk but believe that they can sever their dependence on recruiting agents once they build personal connections with employers. Those who depend on informal recruiters repeatedly for jobs are relatively worse off because they incur higher costs repeatedly and are prey to the expectations of agents' that they will tolerate abuse.

Officials shift the blame on to Arab employers portraying them as predatory.[9] Migrants resist these stereotypes and underscore other aspects of their experience, the respect and affection they received from their Arab and other foreign employers in comparison with Indian ones and their everyday subtle negotiations of exploitative working conditions. When asked specifically about abuse in the Middle East, they frequently point out that employers in India are no less abusive but also pay less.

There is no average employer of emigrant domestics in the Middle East. Emigrant domestics face structural violence but social networks enable them to negotiate with individual employers and to take advantage of a thriving informal market (Kodoth, 2016). In comparison with the practices of recruiting agents and employers of internal migrants—whether in construction, brick kiln labour or sugar cane harvesting—a sizeable section of Middle Eastern employers of domestics would appear as benign. Thus, policy restrictions against their mobility are motivated by considerations extraneous to labour rights. The use of gender in the interests of an upper caste-nationalist patriarchy explains the apathy towards exploitation of migrant women workers in the country and expressions simultaneously of outrage about abuse of domestics in the Middle East.

International Migration: The Case of Kerala

Large scale international migration following the Gulf boom in the early 1970s transformed the social and economic landscape in Kerala, reducing poverty and inequality and altering social relations. Recent analysis suggests that migration gave impetus to economic growth led by the service sector (GoK, 2006). Remittances were spent on houses and consumer goods, invested in small businesses and in status-ascribing practices such as weddings but also in health and education. Migration picked up when demographic transition was well underway and the foundations for providing basic education and health to the people of the state had been laid. But social development including gender parity in basic health indicators and school education was built upon the re-negotiation of normative gender, which migration enabled and advanced. In the British era, migration to South East Asia, Ceylon, and to Presidency towns provided men with independent earnings and allowed them to claim conjugal authority over their wives in social contexts that sanctioned polyandry/serial monogamy and age-based authority in extended families.[10]

i. Gender and male migration

Anthropologists argue that migration has reconfigured identities and paved the way for new gender practices. Among poorer migrants, new ideals of masculinity converged around lavish spending and status-ascribing practices (Osella and Osella, 2000; Kurien, 2002) often expressed through women. Across the major religious groups, remittances were spent on expanded marriage customs, included gift giving, and inflated dowries. Migration transformed labouring patterns in the state, fostering withdrawal of women from wage work into unpaid housework.[11] A recent survey by the Centre for

Development Studies (CDS) showed that in 2011, wives of migrant men had a lower average age at marriage than all women in Kerala, 25 per cent of them married before 18 years and the age gap between spouses were bigger than the average. A smaller proportion of them were employed compared to all women in Kerala (Zachariah and Rajan, 2012).[12]

The gender impact of migration varies. Like in the case of internal migration, wives of migrant men had greater autonomy with respect to decision making and mobility when they lived independently or with their natal families rather than with their parents-in-law (Gulati, 1993). A study of three villages with dominantly Muslim, Christian and Hindu migrants respectively shows differences in the use of remittances (Kurien, 2002: 96, 130). Muslim migrants from north Kerala did not use remittances for education but there was redistribution through charity. Ezhava (OBC) migrants in a south Kerala village and Christian migrants in central Kerala spent remittances on education which they valued greatly but among the former there were barriers to the employment of educated girls. Christians fostered white collar employment by women but nurses and low paid workers were subject to stigma. Muslims girls in north Kerala married at a lower age than Christian and Hindu girls in south Kerala and the absence of their husbands' generated anxiety regarding women's sexuality and there was surveillance of wives of migrant men. Thus migration mostly of poorly educated young men intensified women's dependence on remittances and helped institutionalise the male provider family even as a new emphasis on patriarchal authority of younger men impeded age based authority in extended families.

ii. Migration of women workers

Only 15 per cent of emigrants were women and only a quarter of women emigrants were employed overseas compared to 70 per cent of male emigrants, according to the CDS survey. But women's share was 51 per cent of illiterate emigrants, 32 per cent of emigrants with less than primary education and 29 per cent of emigrants with degrees (Zachariah and Rajan, 2012). These concentrations correspond to two distinct segments of women migrants, poorly educated workers, mostly domestics and professional migrants, mostly nurses. Because the dominant gender/sexual norms imbue women's migration as nurses and domestics with derogatory meanings, it bears asking how women claimed mobility and prized open new avenues of employment.

International mobility of nurses and domestics from Kerala goes back to the 1940s.[13] At present, Malayalee women from a wide social base dominate migrant nursing and destinations span the Middle East, Africa and the OECD (Kodoth and Jacob, 2013). Domestics, mostly from the South Indian states go to fewer destinations.[14] The first generation of emigrant nurses were overwhelmingly Syrian Christians, a socially privileged group, whereas less skilled emigrants were mostly from the Latin Catholics on the southern coast and Muslims from Malabar, both designated as OBC.

The Syrian Christians received early access to formal education in their home state of Travancore. In search of urban employment, they were drawn to Bombay—the nodal centre for recruitment to the Middle East since the 1930s when the Bahrain Petroleum Company first recruited middle-level Indian workers. The Latin Catholics were among the least advanced social groups, an outlier in terms of social indicators even in the 1990s (Kurien, 1999). But their migratory history in the colonial era engendered connections in Bombay and had a demonstration effect. Emigration of domestics was partly an offshoot of demand from more affluent Malayalee migrants in the Middle East.[15]

iii. Nurses

Scholars ascribe the dominance of nursing by Christians to caste prejudice which relegated it to a low status profession among Hindus and its association with a Christian care ethic. Counter-intuitively, the first nurses in the state of Travancore were drawn from the upper caste Hindus (Aravamudan, 1978). Further, Christian nurses were subject to stigma. Thus, girls from respectable families were not readily permitted to study nursing (George, 2005).[16] For Thresiamma, who migrated to Kuwait in 1967, stigma on nurses was inextricably linked to migrant employment which aroused the suspicion of sexual transgression. 'You are behind a veil. The community cannot see you. How do they know what you are doing?' In 1969, she married a Syrian Christian employed in Kuwait and insisted on a wedding in Kerala. 'I went from Delhi directly to Kuwait. People would have said I ran away with him and came back with two children.'[17]

A combination of material conditions distinct to the community enabled the migration of Syrian Christian women in the mid-twentieth century. The Syrian Christians acquired a strong migratory disposition in the early twentieth century as the first major social group in Kerala to experience demographic transition.[18]

Population expansion and consequent pressure on land led to the search for alternate employment taking them to urban centres across the country as well as to destinations in South-east Asia.

Kuwait had only begun to set up its health infrastructure in 1950 as part of the modernisation program initiated by the Sheikh. In the early years of oil explorations, nurses in Kuwait were mostly Arab, British, and Egyptian (Monroe, 1954). Mr Kuruvilla's sister who migrated to Kuwait in 1951 must have been among the earliest Indian nurses in Kuwait. She was recruited directly by the royal family from Bombay to provide nursing care for the Sheikh's children. Her elder sister built a career in Bombay where she migrated in the 1940s as a nursing student. Mr Kuruvilla, who took an engineering diploma from Bombay before joining the Kuwaiti army in 1969, is married to a nurse.

The Syrian Christians faced with a population boom, scarcity of land and fears of unemployment received active support of the Church in producing legitimacy for migration (Varghese, 2007). Missionary involvement in training nurses may have reassured Christian parents who sent their daughters to study in far off places.[19] According to Mr Samuel, who migrated to Kuwait in 1959, Malayalees were more ready to go than people from other regions of the country when overseas placement agencies recruited in Bombay. Mr Samuel was one of 14 children, eight boys and six girls. With a matriculate qualification, he worked for a few years in Madras and Bombay before following his six older brothers to Kuwait. Four brothers with similar qualifications as Mr Samuel were recruited by British Petroleum for the Kuwait Oil Company (KOC). Mr Samuel's wife studied nursing in Bombay and followed him to Kuwait in 1961. Her older sister, who studied nursing in Bombay, preceded her to Kuwait.

The Catholic Church was directly involved in recruitment which boosted the legitimacy of the process. It mobilized nursing students to go to Germany in response to a request from the German church.[20] Missionary networks took Malayalee nurses to Austria even as aspiring women moved independently to Italy, which as a dominantly Roman-Catholic country was perceived to be safe by their families. The church was not directly involved in recruitment to the Middle East and North America but in these destinations Syrian Christians could rely on social networks (Kodoth and Jacob, 2013).

These conditions generated space for women to claim nursing education and to compete for employment. Demographic change meant increased family size, more daughters to be married and rising pressure to mobilize dowries. There were incentives in the form of free education and stipends offered by nursing schools and though some students were required to sign bonds, women responded to recruitment drives by nursing schools that sought to overcome shortage of students (George, 2005: 41).

Women from agricultural families with many children and dowries to be paid were on particularly strong ground to claim nursing careers. Thresiamma explained that agricultural land provided subsistence for families like hers which however lacked cash that was necessary to pay dowries and to support education expenses.[21] She responded directly to advertisements from nursing schools and secured admission in Bihar and Punjab. She joined the Salvation Army Missionary hospital in a remote rural area in Punjab, where her cousin was a student in 1958 and later took up an appointment at the prestigious AIIMS in New Delhi.

One of ten children, Thresiamma has vivid memories of the pain of downward mobility and disparaging behaviour by better off relatives. Her family sold land and mortgaged the house to finance the marriages of her two older sisters. Determined to save the house, she resigned her job at AIIMS in anticipation of a job in Bahrain, where she had relatives. But before this job could materialize she was selected by the Kuwait health ministry through an interview in Delhi. Her starting salary in Kuwait at 62 KD (Rs 2000) was eight times what she received last received at AIIMS in 1965.

Older nurses motivated young girls. Mariamma was impressed as a child by her much older nurse cousins, who used to visit from Bombay. 'They looked so smart. I thought I will become a nurse'. Malayalee women were well placed to attend interviews conducted in the big cities. In 1963, Mariamma was selected for a Kuwait health ministry job through an interview in Bombay along with 17 nurses, 16 of them Malayalees. Back home in Kerala, there was no dearth of Catholic girls who had completed school and were ready to study nursing. Rosie, who left for Germany by ship from Kochi in 1962, to study nursing had approached the parish priest for a teaching post. Philomina was selected from several hundred applicants for six student positions and would later secure jobs in Germany for her two sisters and several other nurses from Kerala.

Migration acquired dynamism in the early years. Philomina, who returned from Germany as her husband refused to migrate, later moved to Switzerland. Nurses

moved from destinations associated with comparatively lower prospects for inter-generational mobility such as East Africa and the Middle East to Europe and North America, where migrants could settle down and give their children better opportunities.

iv. Domestics

Mercy was a housewife in Kuwait in the 1970s, a domestic worker in Qatar in the 1980s and operated a small informal crèche in Kuwait in early 2000. In January 2016, her extended family had come home to celebrate her younger sister's son's wedding. The bridegroom is a household care worker in Italy, like Mercy's two younger brothers and their wives. Her daughter's husband works in a glass factory in South Korea. The family called him back from his previous job in Kuwait to send him to the US but the day before the interview he had an accident. Mercy's son works in Qatar. Her elder sister's son-in-law works in a restaurant in Australia and was previously in Israel. Overseas migration goes back at least three generations in this family. Mercy's father worked in Singapore in the first half of the twentieth century.

Mercy's mother-in-law, Louise Fernandez, migrated to Kuwait in 1955 as a domestic worker to care for a child of the local Parish priest's sister's family. I was unable to ascertain Louise's employer's occupation but early nurse migrants took domestics with them for child care. The family got Louise a job in a government run school once the child started school. Louise obtained visas for her son John and her sister Brigit in the 1960s. It was through John that many of their relatives obtained visas. Louise was from Puthiyathope, a fishing village in Trivandrum known as 'small Kuwait' and has a concentration of migrant domestic workers.

In the early years, women sourced visas through individual suppliers in Trivandrum on a limited scale.[22] Veronica got a visa through an intermediary but in Kuwait she developed connections with recruiting agents and facilitated jobs for her sons and many women aspirants from Puthiyathope. Her family was relatively well to do in the fisher community: she had never worked outside the home and her husband, who owned a small fishing boat, was opposed to her migration. Veronica was motivated by her paternal uncles who gained affluence in Singapore in the early twentieth century. One of them moved to London. Compared to these two families, her family was poor.

The Latin Catholics on the southern coast had connections in Bombay that channelled information about jobs in the Middle East and provided support to aspirants when they travelled to the city for emigration clearance. Personal connections were emphasised by relatively poor women like Beatrice, who went to Kuwait in the late 1960s. Beatrice was familiar with migrant work. When inter-state movement of rice was barred because of scarcity, she sourced small quantities of red rice from mills in Travancore for sale to Malayalee families in Bombay, where her sister made a living brewing illicit liquor.

Even in the early twentieth century, there was considerable mobility from the coastal sector as men and women went to Singapore, Ceylon, and later the Middle East. Women's labour migration was rarely reported but Beatrice's maternal aunts had migrated to Ceylon as wage labourers. By the mid twentieth century, economic differentiation in families owing to previous migration fuelled aspirations among women. Connections in Bombay enabled them to access information and prepare for the journey even as previous migration of middle-level professionals to the Middle East created demand for domestics.

In the early decades, derogatory meanings associated with emigrant domestic work were subdued. Migration was embedded in family networks or connections that were respected. Louise's husband was the care taker of the parish church and had strong ties with the priest. As the sister of the parish priest, Louise's employer carried trust with the family. However, Mercy did not take up paid work on her first visit to Kuwait soon after her marriage to John, who was earning well in a company job. After separating from John, she took up domestic work in Qatar.

Women who migrated in the early 1970s were forthright about their aspirations for upward mobility. The preferred strategy was to take their school-educated sons to Kuwait and less frequently their husbands to harness higher male wage rates and maximise savings by living in shared rentals. Beatrice needed to mobilize dowries for her four daughters with no sons to help her. She took her older daughter to Kuwait before the latter was married, which was frowned upon. Brigit's five daughters have all worked in Kuwait and two of them still work there—as a domestic and as a clerk in a business—but they went after marriage.

The 1980s was a turning point in the migration of domestics, which gained momentum in association with informal recruiting even as the Indian state instituted barriers within the purview of the Emigration Act, 1983. Informal recruiting practices helped circumvent state barriers but raised the costs of migration and fuelled a

perception that emigrant domestics engaged in sex work and/or were subject to sexual exploitation. Stigma has made recent emigrants circumspect in speaking about their experience and to legitimacy for mobility on socially acceptable grounds, underlining the breakdown of marital provisioning (Kodoth, 2014).[23]

Overseas migration is part of the common sense of families in the coastal stretch in Trivandrum. Access to visas to Israel, Italy, London, and Australia, the relatively new destinations, is limited by steep costs. But with the exception of Israel, younger women go to the new destinations mostly with their spouses. Men and women take calculated risks, going through illegal routes, aware of the chance however slim, to acquire regular status in Italy and Australia and hoping to accumulate considerable savings during a temporary stay in Israel or London. Domestic work jobs in the Middle East remain attractive to relatively poor families as they are cheaper and easily accessible.

v. Social networks

Social networks relay information about jobs and impart a sense of security to emigrants, their parents or spouses. But they make it difficult for families and communities that do not possess them to access migration. The effects of networks are evident in the clustering of Catholic nurses in Germany and Mar Thoma nurses in Kuwait, reported by my respondents (see also Kurien, 2002). Indian women were among the first emigrant domestic workers to be employed in the Middle East from outside the Arab region. The nature of outflows mostly from Goa, Kerala and Andhra Pradesh, depended on connections previously forged in the destinations and en route in Bombay. Thus, the first Latin Catholic domestics from Trivandrum were channelled to Kuwait and the single largest destination of Muslim women from Malappuram was the UAE.[24]

There were important distinctions between the two occupational segments. Syrian Christians benefitted from rapid expansion of social networks in Bombay, the Middle East, Europe, and North America. The direct involvement of the Catholic Church enabled outreach to a wide cross section of the community. The large numbers of trained nurses in Bombay and Delhi in the 1960s were within reach of overseas placement interviews, serving to widen the base of social networks. In contrast, emigrant domestics were drawn from a relatively narrow base largely the kin clusters of the first emigrants. The lack of anchorage in the Latin Catholic Church impeded flow of information and social legitimacy for migration. Thus, emigrants were forced to rely on informal recruiters who reached out to the villages for aspirants in the 1980s.

vi. Social development

The feedback effects of migration of nurses and domestics on social development differed in terms of inter-generational mobility by families and communities. Mobility prospects varied according to initial endowments as well as the conditions that structured migration. Demographic change and the pressure to mobilise dowries in association with the social legitimacy lent by the church made way for the first generation of employed Syrian Christian women.[25] Feedback effects were pronounced. Migration generated aspirations among young women and incentives to pursue higher education. Relatively poor Syrian Christian families were willing to mobilise resources if need be to educate their daughters. Even today, nurses from poor backgrounds are obsessively concerned with their children's education (Osella and Osella, 2008) as they seek to lay the foundations for professional employment for their children or to enable marriage matches of daughters with men in professional jobs.[26]

At the time of migration, many of the early nurses were single. Their major employers in Kuwait were the KOC, the Anglo-American Mission and the Health Ministry. Mariamma's cousin was recruited by the KOC, which at the time employed only single women. Upon marriage she resigned and shifted to a job in the health ministry.[27] Nurses found it difficult to shrug off the expectation of support for siblings' education and marriage expenses, thus it was not unusual for nurses to work for a few years before getting married in order to support their natal families.[28] Thus nurses were likely to be at least in the mid-twenties at marriage. Thresiamma paid for the marriages of her two younger sisters and saved her own dowry before getting married at 28 years. Nurses like her married men of their own choice insisting that it was a matter of convenience rather than 'love'.

Nurses who were older daughters in large families could remain unmarried, contributing to younger siblings' education and the family's financial stability.[29] Marriage could be delayed owing to difficulties in finding an appropriate match for migrant nurses.[30] Mariamma, the youngest daughter of the family was not weighed down by responsibilities yet she was 28 years old when her family arranged her marriage to a lab attendant of the same age working with the American Mission in Kuwait. This was a big leap. A generation ago, child marriage was the norm and the Syrian Christians had the lowest age

of marriage for women among the major social groups (Zachariah, 2006; Lindberg, 2014).

The less advanced socio-demographic profile of the coastal Latin Catholics and the difficulties of supporting their families in the destination combined to restrict gains in social development. Early emigrant domestics had little formal education, were married early and had large families. They were sceptical of the returns to education. When her husband objected to her taking her youngest son, who had completed intermediate education, to Kuwait, Veronica said she told him: 'Even if they study here they will get nothing. So I am taking them there.' Women expressed the fear that their sons would fall into 'bad company' if they remained in the village as male sociality was associated with heavy drinking in the fisher community. A few daughters joined the migrant work force as domestics or in clerical jobs in offices; most were married after matriculation or intermediate education to men employed in the Gulf. Pauli who had five daughters and three sons asked: 'How could I educate her [her youngest daughter]? All responsibility was on me. I needed money to pay dowries and for visas [for her sons]'.

Only in the third and fourth generation, children of migrant families pursue higher education and professional employment. There are thirteen adults and five school-going children in the fourth generation of Louise's family. Of three adult women, one works in Kuwait and two are unemployed graduates. Of the ten adult males, two are pursuing higher education in the US, five are employed in Kuwait and three are engineers in Bangalore, Kuwait and the US respectively. Among Veronica's granddaughters' is an engineer in Canada, a housewife and several who are still studying. In Beatrice's family, the third generation had an emigrant domestic but the remaining grandchildren were teachers, housewives and informal sector workers with intermediate education. As migration did not generate a generalised feedback effect on education, it is likely to have sharpened economic differentiation in the community. Thus the younger generation in the coastal villages aspire widely to less skilled jobs in the OECD or the Middle East based on matriculate or intermediate education.

* * *

Indian policy perspectives are marked by the refusal to support migration and thus fail to enable migrants to shore up their bargaining power and to break the stranglehold of recruiters. Regulatory failure accompanied by institutionalisation of largely unauthorised informal recruitment has made way for rampant infringement of rights of migrant workers including large numbers of women from disadvantaged social groups. Seasonal and short term women migrants within the country are the worst affected as they also lack recognition as workers.

The embedding of international labour mobility in social networks localises it largely to specific regions of the country. In the sending regions of Kerala, social mobility is strongly associated with migrant employment. Aspirations are met by diversified strategies including irregular migration of both men and women in less skilled jobs to OECD countries. Emigration of nurses and domestics breached social norms but material conditions in Kerala in the mid-twentieth century and connections in Bombay and the Middle East facilitated access to overseas employment. Inter-generational mobility depended upon the position of a group in the social order, which determined initial endowments, and support from the community. Migration of nurses had a strong impact on education in the community and bolstered inter-generational mobility whereas emigrant domestics were not motivated to invest in education until two generations later. The importance of personal connections restricted migration to kin clusters and made way for economic differentiation. However, in comparison with less qualified/skilled women migrants within the country, emigrant domestics from Kerala make substantial gains, subject to their ability to foster support networks in the destination.

The lack of implementation of labour law pertaining to migrant workers within the country, stark exploitation of women workers and their extreme vulnerability to abuse belies the view that restrictions on overseas migration of less skilled women serves to protect women. Official perspectives on migration within the country and across it borders are held together by caste, class, and patriarchal interests. As they are not responsive to workers perspectives and to destination-specific issues, they serve to reinforce social disadvantage and impede social development.

Notes

1. This fieldwork was conducted in 2013 as part of an ICSSR project and spanned regions of emigration in Kerala and AP.

2. An expanded estimate of 15 per cent included short-term migrants and marriage migrants who reported paid employment in the destination but their primary survey estimate was 39 per cent which they caution may be on the higher side owing to selection of village sites (Mazumdar et al., 2013). Short term migrants comprised 10 million people according to the NSSO as against 100 million (Deshingkar and Akter, 2009). Micro

and village level studies show that women are close to half of migrant labour in several contexts (Breman, 1989; Karlekar, 1995; Mosse et al., 2002).

3. STs were over 26 per cent of the migrant women workers in rural destinations and 21% in urban, which is close to three times their share of the general female population in rural areas and close to ten times in urban areas (Mazumdar, 2014: 17).

4. Forward castes comprised 31 per cent (Jagori, 2011) and OBC were 15 per cent (Neetha, 2004).

5. The sugar industry employs approximately 9 lakh migrant workers (Jadhav, 2016).

6. A widely accepted estimate is that 6 million children are out of school owing to labour migration. Severe lack of political commitment to education of migrant children owes to the nexus between contractors, politicians and bureaucrats (Deshingkar and Akter, 2009).

7. Interview, Official public sector agency, April 26, 2016.

8. Interview, Official public sector recruiting agency 18 October, 2014.

9. Interviews, government officials concerned with recruiting and emigration.

10. The Malayali presence in Malaya and Singapore, which grew in the first half of the twentieth century, included a cross section of OBC and more privileged social groups (Sandhu, 2010, Rai, 2014).

11. Rural women's work participation rates have declined steadily in Kerala since the 1980s. Studies have documented the withdrawal of women from paid work in response to Gulf migration (Kodoth, 2005).

12. Survey by the same authors in 2014 estimated 2.5 million overseas migrants from the state.

13. Interviews were conducted with first generation emigrant nurses and domestics and/or their family members (1950–75). Respondent nurses worked in Kuwait (2), Germany (2), USA (1) and Canada (1). I also spoke to the husband and brother respectively of two nurses (Kuwait) and the daughter of a nurse whose journeys spanned East Africa, Kuwait and UAE. A documentary film on the experience of Malayalee nurses in Germany and my interview with Shiny Jacob Benjamin, the Director of the film are also used here. Barring the respondent who migrated to the US in the early 1970s, all my respondents were Syrian Christians. Interviews were done with 11 emigrant domestics from the early cohort and I spoke to daughters of six of the early cohort of migrants. Information about Louise, the earliest emigrant domestic in the sample and her sister Brigit was sourced from their daughters.

14. Fieldwork in AP and Kerala indicated that the Middle East was the largest destination for domestic workers but women from the Godavari region and Southern Kerala go to Israel. Destinations were most diverse in Trivandrum, also including Singapore, Malaysia, Italy, London, and Australia.

15. The Malabar Muslims were reported to have a foot hold in the informal recruiting business in Bombay and domestics from the region were among the early migrants to Dubai.

16. Two categories of women, nurses and stage artistes, suffered the worst kind of stigma (Kerala Legislative Assembly Proceeding, 1963 cited in Abraham, 2004: 19).

17. For implication of sexual morality in stigma on nurses, see Walton-Roberts (2012).

18. With a higher fertility rate than other groups, the Syrian Christians share of the population of the state increased from about 10.5 per cent to 13 per cent between 1901 and 1941 (Zachariah, 2006: 10–16).

19. In 1946, 80 per cent of Indian nurses were trained under missionary programmes (Healey, 2013: 57–59).

20. It is estimated that 6000 odd Syrian Catholic girls went to study nursing in Germany in the 1960s and 1970s (Gottschlich, 2012: 2).

21. This view found strong echo among emigrant nurses in Germany (Jacob Benjamin, 2013).

22. Women from East Godavari went to Kuwait in the early 1970s through recruiting agencies in Bombay. In Malappuram preliminary inquiries suggest strong links between recruiters in Bombay with ties in the Middle East and individual recruiters in the towns.

23. The National Domestic Workers Movement and Self Employed Women's Association representatives in Trivandrum as well as respondents in villages with sizeable numbers of emigrants spoke about the secrecy aspirants maintained about their intentions, which made it difficult to identify them prior to migration and orient them about risks.

24. The single largest destination of domestics from Trivandrum was Kuwait (35 per cent of journeys) and from Malappuram, it was the UAE (40 per cent of journeys) (Primary Survey, 2013).

25. The previous generation of women in these families did not work outside the home (George, 2005).

26. Except, two of Rosie's daughters who were housewives and two who were teachers, children of nurse respondents were in professional employment. Kurien (2002) observed that the emphasis was not on professional employment for daughters but marriage to professionally-employed men.

27. British Petroleum lifted the restriction on employment of married women in 1955 (Johnson, nd).

28. Nurses in Germany spoke of how their families did not understand that they took loans to support the marriages of the sisters or education of their brothers at home (Jacob Benjamin, 2013).

29. Interview with Mr Kuruvilla, whose eldest sister, a nurse in Bombay remained unmarried and contributed to her parent's income along with the sister who migrated to Kuwait in 1951. Baby who migrated to Canada in 1968 was the youngest of five sisters. Her eldest sister worked as a nursing tutor in Kolar and supported the family.

30. Nurses in Germany found spouses among unemployed men from their community and some married Germans (Interview with Jacob Benjamin).

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17

In Pursuit of an Inclusive Financescape in India

Changing Course, Shifting Goals

Tara Nair

The recent development theories put access to financial services at the core of the development process and consider imperfections in financial markets as major factor that influences human development and labour market outcomes. It is argued that the ability of poor households to invest in human capital augmenting activities like schooling of children or making medical treatment available to earning members depends on their ability to mobilize financial resources timely and at affordable costs. Galor and Zeira (1993) were among the first to link credit market imperfections with human capital achievement and macro economic growth. They argued that as credit markets are imperfect (with borrowing costs higher than lending costs), and human capital investment is indivisible, the size distribution of absolute wealth affects economic activity. 'If borrowing is difficult and costly, those who inherit a large initial wealth and do not need to borrow have better access to investment in human capital' (p. 36).

Studies by Banerjee and Newman (1993) and Aghion and Bolton (1997) pointed to the exclusionary impact of credit constraints in the presence of informational asymmetries. In information constrained situations credit constraints become particularly binding on the poor, who lack the necessary endowments—equity, collateral, or social capital—to set up their own projects by accessing bank credit. Development of the financial system is, thus, important both not only from the point of view of achieving efficiency in economy-wide resource allocation, and from the angle of ensuring comparative economic opportunities for individuals (World Bank, 2008). It is argued that credit market constraints not only are exclusionary in an ethical sense, but they arrest the course of economic growth 'by keeping capital from flowing to its highest value use, a poorly functioning financial system will also produce higher income inequality by disproportionately keeping capital from flowing to "wealth-deficient" entrepreneurs' (Levine, 2005: 887). Haber et al. (2003) and Rajan and Zingales (2003) have, among others, established that well functioning financial systems can be inclusive in that they broad-base access to financial services rather than patronising 'entrenched incumbents'. The crux of the process lies in ameliorating information and transactions costs.

This indeed is a departure from the earlier perspective that some degree of inequality is inevitable for growth and a trade off between growth and social justice, especially, in the initial stages of development is almost inevitable (Kuznets, 1955). Governments, hence, have the responsibility to design appropriate redistributive public policies to counter the negative effects of wealth concentration. In the new prescription, financial system development and deepening of financial markets could take care of the inequities by offering savings, payments, and risk-management products to a variety of households and enterprises, including that of the poor. It is founded on the view that what individuals lack is opportunities and not abilities. Good opportunities are available always and everywhere. Financial resources help everyone seek out these opportunities that 'lie hidden' at every stratum of the economic pyramid.

Experience the world over, however, shows that financial market development more often than not benefits major economic actors, mostly large firms, wealthy households, and the state apparatus. The disadvantaged segments including poor households, micro enterprises, and socially marginalized communities tend to be bypassed by the developments in the financial markets because

of cultural factors, information deficit, and inadequate capacity on the part of financial institutions to deliver products and services appropriate to these segments. In other words, financial sector development to be inclusive it is important that special strategies are designed to address the question of access to financial services for the poor and low-income population.

Financial Inclusion–Meanings

In one of the earliest attempts to describe financial exclusion Leyshon and Thrist (1995: 312) defined it as 'those processes that prevent poor and disadvantaged social groups from gaining access to financial system. It has important implications for uneven development because it amplifies geographical differences in levels of income and economic development'. According to the European Commission (2008: 9), financial exclusion refers to 'a process whereby people encounter difficulties accessing and/or using financial services and products in the mainstream market that are appropriate to their needs and enable them to lead a normal social life in the society in which they belong'. The Reserve Bank of India (RBI) has defined financial inclusion as the 'Process of ensuring access to appropriate financial products and services needed by all sections of the society in general and vulnerable groups such as weaker sections and low income groups in particular, at an affordable cost in a fair and transparent manner by regulated, mainstream institutional players'.[1] This definition emphasizes that only the mainstream, regulated financial players are capable of bringing about meaningful financial inclusion as they have the ability to make the necessary investment in the build-up phase, to cross-subsidize the services in the initial stages till they become self-sustaining, and to offer the entire suite of products to facilitate meaningful financial inclusion.

India's Approach to Financial Inclusion: Historical Overview

A substantial part of the modern Indian banking history has been marked by a biased approach wherein financing large urban industries and trade has been privileged over rural economic activities. The exclusion of the 'rural' and the 'small' by the banking system persisted through the early decades of post-Independence and led finally to the state opting to take administrative and regulatory control of the major banks in its hands through their nationalization. The Banking Companies Acquisition and Transfer of Undertakings Act 1969 justified the nationalization move by highlighting the 'social purpose' of banks and their moral liability to subserve the development priorities and objectives of the nation (BSIR, 1987).

It was during the 'difficult years'[2] spanning the decade of the 1960s, characterized by shortfalls in agricultural output and slow down of industrial production, that the accent on infusing the banking system with a sense of social control and usefulness became an important aspect of the central bank's credit policy. The apex bank had by then taken note of the disproportionately smaller inflows of credit into small industries and cooperative institutions and reduction in lending to the agricultural sector. By social control of banks, it was envisaged that the available lendable resources would be purposively distributed in accordance with basic economic and social objectives and effective savings mobilization achieved.[3] The idea and prescriptions relating to priority sector also took shape during this decade. The general consensus then was that only a government owned banking system could direct distribution of credit to sectors that support the economic activities of rural and small producers and weaker sections. The credit policy statement 1967–68 prescribed that the commercial banks should urgently increase their involvement in the financing of key sectors such as agriculture, small-scale industries, and exports. It may be noted that credit to small farmers was a critical ingredient of the green revolution package (Johnson et al., 2003). The scope of the priority sector got redefined many times, but agriculture, small-scale industries, and exports have continued to figure among sectors that require focussed attention.[4]

Alongside the efforts to focus attention on the sectoral disparity in banking, there was increasing concern regarding the regional discrepancies too. The study group headed by D. R. Gadgil (constituted to suggest the Organisational Framework for the Implementation of the Social Objectives, 1969), recommended that rural banking must be based on 'Area Approach'. The RBI Committee of Bankers on Branch Expansion Programme of Public Sector Banks (1969; Chairman: K. F. Nariman) endorsed this idea while recommending that every district should have a 'Lead Bank'. As per the Lead Bank Scheme that was introduced subsequently, designated banks were entrusted with coordination of district level banking activities along with those of developmental agencies towards promoting overall rural development.

The Banking Commission set up around the time of nationalization (Chairman: A.M. Khusro), and submitted its report only in 1972, however, expressed reservations about the ability of both the commercial banks and the

cooperatives 'to fill the regional and functional gap in the rural credit system',[5] and recommended setting up of a chain of special 'rural banks' to co-exist along with the rural branches of commercial banks. These banks could come into existence in three ways: by converting primary credit cooperatives into full service banks; as subsidiaries of commercial banks; and as special banks sponsored by commercial banks and supported by local participation (Datta, 1978). Importantly, the Commission recognized the complexities inherent in a country of India's size and regional diversity and endorsed a multi-pronged approach to banking development.

The idea of setting up niche rural banks was revived in 1975, immediately after the country was placed under Emergency by the then government. At the heart of the state agenda during this phase, encapsulated in the omnibus Twenty Point Programme, was freeing of small farmers, artisans and rural and landless labourers of the burden of indebtedness, along with providing land, housing etc. to landless households (Chandra et al., 2008; Rangnekar, 2012). As exemplified by the Working Group (Chairman: M. Narasimham; 1975), rural banks were to be designed in such a way that they blend the virtues of 'localness' as in cooperatives and the business acumen of commercial banks. This led to the enactment of the Regional Rural Bank Act in 1976. The RRBs were envisioned as financial intermediaries that would help the state further the mandate of development of rural productive sectors by providing credit and other financial services to small and marginal farmers, agricultural labourers, artisans and small entrepreneurs.[6]

Thanks to the various initiatives that promoted the idea and practice of socially useful banking, a fairly elaborate architecture was created in India between 1969 and 1990 to extend banking services to the excluded sections in the financescape–more precisely the 'bankingscape'—of the country. Such architecture has come to be comprised of rural branches of commercial banks (guided by an area approach),[7] cooperatives, RRBs, and specialized apex agencies like the National Bank for Agriculture and Rural Development (NABARD, 1982), and Small Industries Development Bank of India (SIDBI, 1990). These institutions and their mandates/approaches have collectively articulated a distinct notion of financial inclusion, a notion amply informed by the political vision of welfarism under the mixed economy model. State-owned banks, and expansion of bank branches to rural areas formed the core of the strategy advocated during this phase to broad-base supply of credit, while directed credit to certain population segments/priority sectors and subsidized interest rates were the major instruments to motivate credit demand.

The official data pertaining to this period did reveal expansion of bank branch network in rural areas and significant improvement of the share of institutional sources in cash borrowings of households, especially rural households since 1970s through the 1980s (Ramachandran and Swaminathan, 2001; RBI, 1977; 1987). Evaluation studies that systematically examined the outcomes of these initiatives have also found noticeable traces of 'inclusion gains' like increased access by marginalised sections to credit, especially directed credit, since the late 1960s. Bank nationalization in the 1960s and 1980s helped broadbase the banking network in the country, especially, among the rural populations. The share of rural bank offices increased from 17 per cent to 57 per cent between 1969 and 1991. The volume of rural deposits grew phenomenally during this period from the Rs. 1450 million to Rs. 310,098 million (from 3 per cent to 15.5 per cent of total deposits). Rural credit volumes too rose significantly from Rs. 543 million to Rs. 185,990 million (from 1.5 per cent of all credit to 15 per cent).[8] The increase in the share of advances under priority sector in gross non-food credit too was substantial—from 15 per cent in 1969 to around 43 per cent in the late 1980s. Importantly, during this phase a sizeable, hitherto non-bankable population was exposed to the workings of the organised formal banking system. In that sense, the social banking phase that spanned the late 1960s through the 1980s marked the first attempt at making the financescape inclusive.

As mentioned above, directed credit support to identified target segments was one of the major anchors of social banking. This approach came in for serious criticism from many quarters since the mid-1980s. Large scale interventions like the Integrated Rural Development programme (IRDP) were critiqued for their design and delivery failings, inadequate focus on the business and financial management skills on the part of beneficiaries, and banks' apathy to develop appropriate low cost appraisal mechanisms. Through its two reports (1992 and 1998) on reforming the financial sector of India, the Narasimham Committee had developed a taut critique of the philosophy of social banking and attributed the overall erosion of economic stability of the banking system observed in the 1990s largely to the patronage and politics that underlay directed banking and behest lending. Such a diagnosis led the committee to recommend complete elimination of interest subsidy element in priority sector loans and deregulation of

Table 17.1 Growth in Rural Banking in India

	No. of rural bank offices	Rural deposits (Rs. Million)	Rural credit (Rs. Million)	% in total		
				Rural offices	Rural deposits	Rural credit
1995	33,017	5,181,962	2,517,431	51.7	13.7	11.9
2000	32,443	15,942,346	6,668,190	47.8	14.2	10.2
2005	31,967	21,310,411	10,997,562	45.7	12.2	9.5
2010	32,320	42,033,772	24,927,696	37.2	9.2	7.5
2011	33,367	49,326,552	29,581,454	36.2	9.2	7.3
2012	35,936	57,318,585	38,051,765	35.6	9.4	7.9
2013	39,233	66,988,868	45,619,081	35.9	9.6	8.3
2014	44,653	78,715,111	52,461,338	36.9	9.9	8.4
2015	48,536	91,567,646	59,834,599	37.2	10.3	8.7

Source: https://rbidocs.rbi.org.in/rdocs/Publications/PDFs/bs72-95-1.pdf; RBI, *Basic Statistical Returns* (various years).

interest rates for loans extended by scheduled commercial banks up to Rs. 20,0,000.

Towards Reforming Social Banking

The reports of the Narasimham Committee can be considered as forming the basic manifesto of financial sector reforms that have come to constitute an integral element of the economic reform process initiated in the country in 1991. They marked a drastic reversal of banking policy focus from nurturing a banking sector subservient to the political notions of development to developing a pro-market and private sector-led financial system, which is seen as embodying the virtues of liberalism, efficiency and discipline. The banking reform measures introduced from around the early 1990s somewhat arrested the pace of expansion of bank branches in rural centres. The share of rural bank offices, which registered an increase from 22 per cent in 1969 to 58.5 per cent in 1991, came down to 52 per cent in 1995.[9] In the subsequent years the share of rural banking has suffered some setback (Table 17.1). However, there seems to be a reversal of that trend from 2013 onwards. We will discuss this in detail subsequently.

Innovation in Pro-Poor Banking—1990s and After

A distinct phase of financial inclusion was ushered around the early 1990s in the midst of such significant changes in the policy outlook regarding banking. The subsequent decade and half have witnessed the emergence of several innovative institutional arrangements in the financial services sphere, especially, in rural areas, guided by the imperatives of economic liberalization (Nair, 2015). These innovations mainly aimed at externalizing the economic burden of extending outreach that the banks have been made to internalize during the previous decade. The major approach to achieving this has included linking banks up with informal institutions such as self help groups (SHGs) and microfinance institutions (MFIs), who mobilise poor households, aggregate small demands and manage timely repayment.

The documentation done by NABARD in the late 1980s of groups that work on the principle of self help summarized their key attributes of success as homogeneity of members in terms of caste and economic activity, trust-based lending, informality in working, democratic decision making based on deliberation and collective consensus, creation of common funds out of savings, internal lending, small loan size, provision of loans in successive dozes and small amounts, exclusive women membership and involvement in development agencies in formation and promotion of groups (NABARD, 2009). The SHG bank linkage programme (SBLP) anchored by NABARD generated considerable momentum since the mid-1990s as a hybrid credit delivery strategy to serve the needs of the rural poor, which combines 'the flexibility, sensitivity and responsiveness of the informal credit system with the strength of technical and administrative capabilities and financial resources of the formal credit institutions'.[10] The objective of the programme as envisaged in the guidelines is to help the poor to collectively build their savings, which could then be leveraged for bank credit. The pace of SBLP particularly accelerated in the late 1990s. The number of bank linked SHGs increased from 81,780 in 1999–2000 to 620,109

in 2005–06, while the amount of bank loan sanctioned to these groups went up from Rs. 114,775 to Rs. 2,238,565.

The progress of SBLP has remained significantly skewed towards the southern states, which are better-off in terms of banking resources endowment and income per capita. States that have higher proportion of poor population have made slow progress in bank linkage of SHGs. It may be noted that spread of banking has historically been lopsided with the states in southern, northern and western regions accounting for most of the bank branches as compared to those in the north-eastern, central and eastern regions. This disparity had worsened since the mid-1990s (Kumar and Golait, 2009).

SBLP being a group-based approach to bank linkage, individual banking engagement was not considered a priority within the programme. Even as the programme expanded its reach to several regions, only a minuscule proportion of ordinary women members got the opportunity to directly deal with commercial banks or learn about commercial banking. This has eventually led to a situation where thousands of women SHG members have been counted out of the financial inclusion calculus as they do not own individual bank accounts. This is despite the fact that the small thrifts of these women have made their way to the banks in the form of collective savings of SHGs. For most of the bankers, poor women's savings kept with them come handy when a group defaults on loan repayment. In other words, for them these savings function as security deposits that reduce lending risk.

Parallel to the SBLP, the microfinance institutions model or MFI model has also been in operation since the early 1990s. The early stage MFIs were all non-profits. Starting from early 2000s, most of them have transformed into for-profit non-banking finance companies (NBFC) mainly to diversity and expand capital base to achieve faster growth. These MFIs did grow at dramatic rates through the first half of 2000s expanding their client base across several states, though southern India remained their major bastion. Despite a slew of crises mainly in the state of Andhra Pradesh that nearly damaged their pro-poor image, MFIs could continue their growth story, thanks to the collective efforts of sector networks and continued bureaucratic patronage. The RBI recognized NBFC-MFIs as a special class of non-banking companies in 2011 and granted banking license to one of the largest MFIs—Bandhan—in 2014. In 2015 the apex bank extended in-principle license to eight more MFIs to transform to small finance banks, the niche bank category introduced in 2014. Thus unlike the SBLP, through definite measures, commercial microfinance model has been co-opted into the larger institutional canvas of financial inclusion.

Bank-led Financial Inclusion Mission

It was around the mid-2000s that financial inclusion became a focused and structured project led by banks and actively supported by the state. The Rangarajan committee has prescribed a basic individual bank account as the central instrument that can coordinate multiple fund flows—savings, small credit, overdraft, payments, money transfer etc.—from and into excluded households. The committee has recommended leveraging of business facilitator/business correspondent (BF/BC) models riding on appropriate technology to achieve expansion of banking outreach. In terms of design and approach this phase of the financial inclusion drive has been significantly different from the earlier initiatives. The pace of efforts to further financial inclusion has accelerated since the beginning of the current decade, thanks to a few important policy directives from the RBI and the increased accent by the then union government on extending banking coverage to spatially reach out to un-banked and under-banked sections of population.[11]

The *Swabhiman* scheme launched in 2011 shifted the focus to households and individuals and promised to create a branchless system of financial services provision in villages with population in excess of 2000 by March 2012 with the help of BCs and technology. It also promised to spare the villagers from exploitative middlemen by directly crediting benefits, payments and subsidies to their bank accounts and to show a way to the large population of migrant workers and their dependents back home to send and receive money safely and quickly. For the innovative and entrepreneurial minds the new drive is supposed to proffer the best opportunity to innovate around viable business models that combine the interests of technology and society.

After analysing the learnings from the *Swabhiman* programme the Department of Financial Services prepared a Comprehensive Financial Inclusion Plan or *Sampoorn Vitteaya Samaveshan* (SVS) in June 2014 wherein the building blocks for future efforts were spelt out. The major drawbacks of *Swabhiman* were identified as non-coverage of all villages, poor remuneration to BCs, lack of trust among people in mobile BCs, technology bottlenecks (lack of connectivity, for instance), widespread financial illiteracy and the resultant poor operation of accounts. The SVS mission was expected to address these gaps in two phases, i.e., 2014–15 and

2015–18, by which time almost every habitation and all the households in the country would have access to small credit protected by the credit guarantee, micro insurance and micro pension.

Interestingly, the term Sampoorn Vitteaya Samaveshan abruptly disappeared from usage with the launching of *Jan Dhan Yojana* (JDY) by the Prime Minister on 15 August 2014, though the focus and main features of JDY are similar to the SVS. The scheme is projected as 'the big push' strategy of the newly elected government to accelerate the pace of financial inclusion. It must, however, be acknowledged that the scheme is a continuation of what the earlier regime had launched around 2011. The numerous features added in the new dispensation (extending to urban areas, interoperability to RuPay cards and AEPS, simplified or e-KYC, emphasis on financial literacy, etc.) apparently have evolved from the learnings of the earlier phase. Also the main components of JDY are similar to SVS, but for the extension of targets to households (instead of villages) and expansion of area to urban along with rural. The scheme aims to ensure two Aadhar-linked bank accounts per every household, each account having an overdraft facility, RuPay debit card and accident insurance cover of Rs 1 lakh. It also offers additional life cover of Rs. 30000 to one person per household in the age group of 18–60, who is not an income tax payer and is not covered under any other state sponsored insurance schemes. JDY promises to impact households in three ways: (1) securing transactions (digital banking with no leakage), (2) securing household economy (bank accounts to channelise credit and subsidies to support economic activity and livelihoods); and (3) social security (insurance, pensions).

On a closer look it becomes clear that like in the case of its predecessor, JDY too attempts to marry two fiscal objectives—(1) to bring in the unbanked population sections within the fold of the formal banking system; and (2) to improve the efficiency of delivery of government transfers and targeted subsidies. The first objective is derived largely from the financial deepening agenda that got strengthened in the aftermath of the financial crisis of the 2000s, while the second one is driven by the reform agenda of increasing the efficiency of government provisioning through direct cash transfers.

It needs to be acknowledged that the sheer pace of account opening under JDY has been unparalleled. According to the latest data published by the Department of Financial Services the number of accounts opened under the scheme as on end March 2016 is Rs. 214.3 million. Of these 61 per cent accounts have been opened in rural areas[12] (http://www.pmjdy.gov.in/account). A little above one-fourth of these accounts are 'zero balance' accounts. RuPay cards have been issued to 177.5 million accounts. The outstanding balance in all the accounts is reported to be Rs. 3,56,720 million.

The agenda of direct transfer of subsidies to beneficiaries of government schemes has become the mainstay of bank-led financial inclusion. It may be noted that since 2008 the central government, followed by several state governments, has been experimenting with linking of social safety net programmes (wages under the National Rural Employment Guarantee Scheme or NREGS, scholarships, pensions, health benefits and other types of income support) to banks in an effort to ensure that benefits and payments flow transparently to the right targets without wastage, duplication and leakages.[13] The identification infrastructure of Aadhar and the electronic fund transfer technology together were to form the backbone of the basic architecture of the DBT system (*Economic Survey*, 2011–12). The Task Force for Direct Transfer of Subsidies (June 2011; Chairman: N. Nilekeni) proposed a general solution framework for the direct transfer of subsidies to beneficiaries, and made specific recommendations for kerosene, LPG and fertilizers. 'Just as a real-time transfer of funds takes place when people top up their mobile talk time, the Government, through the CSMS will transfer the cash component of subsidies directly and in real-time to the bank accounts of beneficiaries. Beneficiaries may then access these funds through various banking channels such as bank branches, ATMs, business correspondents, internet, and mobile banking. Achieving full financial inclusion is crucial for direct transfer of subsidies'.[14]

The current government's approach to financial inclusion has come to rest almost singularly on the platform of 'JAM number trinity'—Jan Dhan, Aadhaar, Mobile, which it considers would offer 'exciting possibilities to effectively target public resources…allow prices to be liberated to perform their role of efficiently allocating resources and boosting long-run growth' (*Economic Survey*, 2015: 21). The philosophy of growth that underlies this conviction is all too evident. As the Economic Survey of 2015 (22) puts it, 'Economic growth is good for the poor, both directly because it raises incomes and because it generates resources to invest in the public services and social safety nets that the poor need. Growth – and the prospects and opportunities that it brings–also encourages individuals to invest in their own human capital…However, growth must be complemented with effective state-delivered programs that raise the

living standards of the most vulnerable in society. To be successful, anti-poverty programs must recognize that policies shape the incentives of individuals and firms, and also acknowledge the limited implementation capacity of the state to target and deliver public services to the poor'.

The 2016 Economic Survey has simplified the problem of financial exclusion by deconstructing it into three straightforward challenges: the challenge of identification, transfer and access. The solutions too are framed within a simplistic scheme—use technology to replace human discretion, open bank account for every individual beneficiary and deepen mobile penetration and agent network along with creation of new banking entities. As per the Survey the spread of JAM is limited only by problems in establishing bank-beneficiary connections. With the focus of inclusion discourse squarely placed on the rather mundane details of technical and managerial solutions, the politically informed debates around the deep-rooted structural bottlenecks perpetuating marginalization and exclusion of regions and populations in social and economic spheres seem to have lost their salience.

As per the data presented in 2016 Economic Survey, a fifth of the country's population received some cash transfer into their bank accounts in 2014–15. A total of Rs. 4,40, 350 million has thus been transferred to 296 million individual accounts. NREGS constituted 41 per cent of these transfers, followed by LPG subsidy (37 per cent) and National Social Assistance Programme (14 per cent). The 29 scholarship programmes formed 7 per cent of the cash transfer. Bank linked benefit transfers, to a large extent, have helped the state address problems of leakage and corruption rampant at the level of delivery and access.

An overall review of the progress of bank-led financial inclusion reveals that the parameters of spread in banking have indeed changed over 2010–15 due to the concerted efforts of the state and the banking sector. The progress made in spreading banking infrastructure has been highly impressive relative to the status in 2010 (Table 17.2).

Table 17.2 Change in Financial Inclusion Parameters: 2010–15

Particulars	2010	2013	2014	2015	Increment in 2015 over 2013
Banking Outlets in Villages—Branches	33,378	40,837	46,126	49,571	16,193
Banking Outlets in Villages—Branchless mode	34,316	227,617	337,678	504,142	469,826
Banking Outlets in Villages—Total	67,694	268,454	383,804	553,713	486,019
Urban Locations covered through BCs	447	27,143	60,730	96,847	96,400
BSBDA through branches (No. in million)	60.2	100.8	126	210.3	150
BSBDA through branches (Amt. in Rs. billion)	44.3	164.7	273.3	365	321
BSBDA through BCs (No. in million)	13.3	81.3	116.9	187.8	175
BSBDA through BCs (Amt. in Rs. billion)	10.7	18.2	39	74.6	64
BSBDAs (No. in million)	73.5	182.1	243	398.1	325
BSBDAs (Amt. in Rs. billion)	55	182.9	312.3	439.5	385
OD facility availed in BSBDAs (No. in million)	0.2	4	5.9	7.6	7
OD facility availed in BSBDAs (Amt. in Rs. billion)	0.1	1.6	16	19.9	20
KCCs (No. in million)	24.3	33.8	39.9	42.5	18
KCCs (Amt. in Rs. billion)	1,240.10	2,623	3,684.50	4,382.30	3,142
GCC (No. in million)	1.4	2.6	7.4	9.2	8
GCC (Amt. in Rs. billion)	35.1	76.3	1,096.90	1,301.60	1,267
ICT A/Cs BC Transaction (No. in million)	26.5	250.5	328.6	477	451
ICT A/Cs BC Transactions (Amt. in Rs. billion)	6.9	233.9	524.4	859.8	853

Source: RBI (2014, 2015).
Note: KCC – Kisan Credit Card; GCC – General Credit Card.

Table 17.3 Banking Access by Households: 2001 and 2011

	Census 2001			Census 2011		
	Total no. of households	Number of households availing banking service	%	Total no. of households	Number of households availing banking service	%
Rural	138,271,559	41,639,949	30.1	167,826,730	91,369,805	54.4
Urban	53,692,376	26,590,693	49.5	78,865,937	53,444,983	67.8
Total	191,963,935	68,230,642	35.5	246,692,667	144,814,788	58.7

Source: Government of India. 2013. *An Overview on Financial Inclusion,* Department of Financial Services, New Delhi. http://financialservices.gov.in/Banking/Overviewofefforts.pdf

The expansion in rural coverage has largely been through branchless mode. The total number of outlets including ATMs and kiosks rose by about 4,70,000 over 2010–15. About 325 million Basic Savings Bank Deposit Accounts (BSBDA) were added over this period, 54 per cent of them through business correspondents. The matter of concern, however, is the apparent low utilization of these facilities. This is reflected in the low volumes of actual transactions in the accounts created (Box 17.1).

Measuring Financial Inclusion

Several estimates have shown that the access to banking by adult population in the country is far from satisfactory. The Census of India provides a rather vague idea about the percentage of households that avail banking service. A comparison of 2001 and 2011 data suggests that the share of banked households increased from 36 per cent to 59 per cent over the decade (Table 17.3). The increase in the share was more in the case of rural households—from 30 per cent to 54 per cent—as compared to urban households (from 49 per cent to 68 per cent).

Measures of financial inclusion (FI) based on households obviously hide some important dimensions of exclusion of banking resources like gender inequality in access to bank services. Moreover, as mentioned earlier, the commonly understood definition of financial inclusion focuses on formal bank accounts held by individuals. The Global Findex (2014) survey of the World Bank reported that 53 per cent of adults in the country have a formal account (as against 35 per cent in 2011), whereas only 15 per cent use an account to make or receive payment, which is the lowest among BRICS countries (Demirguc-Kunt et al., 2015). With high dormancy rate of 43 per cent, the country is home to about 42 per cent of all dormant accounts in the world. The gender gap in account holding is also significant; only 43 per cent of the women have bank accounts as against 63 per cent men.

The CRISIL Inclusix has emerged as the most publicized index of financial inclusion at the regional level in India since 2010. Defining financial inclusion as 'the extent of access by all sections of society to formal financial services, such as credit, deposit, insurance and pension services, CRISIL has developed a relative index of FI that combines three parameters relating to basic financial services—branch penetration (BP), deposit penetration (DP), and credit penetration (CP)–for national/regional/state/district levels. The latest CRISIL Inclusix 2014 (status as on upto 31 March 2013)

Box 17.1 Dormancy of Accounts: Paradox of Inclusion

The debates on financial inclusion emphasises that dormancy of accounts or non transactional accounts go against the very logic and mission of the inclusion project. A study conducted among 1339 households in 6 districts of Maharashtra in 2014 found that only 37 per cent of the account holders had carried out some transaction in their bank accounts in the month that preceded the survey date. About 8 per cent were found not to have made any transactions since the time the account was opened. About a fourth of them have made some transaction six months ago or beyond and another 25 per cent used the bank account over the previous one to six months. Such low transactional status indicates that effective financial inclusion is still not achieved in the villages that the study covered (Nair, 2015). Research done by MicroSave in Tamil Nadu in 2010 had showed similar results – 12 per cent of the respondents had made transations within three months of the study, six per cent within three to six months and the rest beyond that period.

Source: MicroSave (2010)

Table 17.4 Regional Variation in Access to Banks and Bank Accounts

Region	Bank penetration		Credit penetration		Deposit penetration		Inclusix	
	2013	2012	2013	2012	2013	2012	2013	2012
Southern Region	69.7	57.1	88.7	80.8	83.1	71.8	76.0	66.1
Western Region	54.1	45.4	37.3	30.6	60.5	52.5	48.2	40.9
Northern Region	49.0	42.4	32.8	29.2	59.1	53.2	44.0	39.5
Eastern Region	43.1	31.0	35.1	24.3	44.8	39.5	40.2	30.8
North-eastern Region	41.2	30.9	35.8	24.1	45.9	41.0	39.7	30.9
India	52.4	42.7	45.7	38.7	60.3	53.2	50.1	42.8

Source: CRISIL (2015).

combines RBI data relating to banks as also data on MFIs furnished by MFIN. It assesses the degree of financial inclusion at the national, regional, state, and district levels and covers 652 districts in 35 states and union territories.

The CRISIL estimate for 2013 shows that the value of the index has steadily increased from 37.6 in 2010 to 42.8 in 2012. In 2013, CRISIL has included MFIs along with banks and found the index to have improved to 50.1. The study by CRISIL has reaffirmed the significant inter- and intra-state variations in access to financial services (Table 17.4). The southern region, historically the leading territory in banking finance business, tops the financial inclusion landscape, followed by the western region.

The phenomenon of skewed distribution of banking resources among population segments and geographic locations has been a subject of discussion in academic and policy circles for decades in India. The early measures to capture FI made use of independent indicators like number of bank branches on the supply side and number of loan and deposit accounts, on the demand side. At an aggregate level such indicators at best reflect a partial picture of inclusiveness of the financial system and at worst, completely misrepresent the ground realities. And they are hardly useful in comparative analyses. Such limitations have been partially overcome with the help of multi-dimensional indices like the CRISIL Inclusix that combine various dimensions of varying significance to produce a singular estimate.

The most conspicuous absentee in all the available estimates of financial inclusion is the cooperative sector. This is partly due to the official strategy of strategizing financial inclusion as 'bank-led', and partly due to difficulty in accessing timely data on financial transactions of cooperatives. Similarly, the SHG sector has not been able to find a berth in FI index making exercises, though groups provide the most organic platforms for millions of households to engage with banks. One effort has recently been made by Ambarkhane et al. (2014) to incorporate SHGs along with other financial services providers as supply side parameters in index estimation.

It may be noted that the strategy of financial inclusion has evolved through the years since the launch of the FI mission by the state in the mid-2000s and alongside the efforts to reform and deepen the financial sector. The definitional scope of FI has also been enlarged to include the whole gamut of financial services and range of institutional options. Thus by the time the Committee on Medium-term Path on Financial Inclusion submitted its report in December 2015, the vision of FI has become much wider. The Committee has put forward a fairly complex definition—'"convenient" access to a set a basic formal financial products and services that should include savings, remittance, credit, government-supported insurance and pension products to small and marginal farmers and low-income households at reasonable cost with adequate protection progressively supplemented by social cash transfer besides increasing the access for micro and small enterprises to formal finance with greater reliance on technology to cut costs and improve service delivery'.

Rural Indebtedness and the Dominance of Informal Sources: The Illusion of Inclusion?

Usurious moneylending has long since been recognized as an integral institutional feature of the agrarian structure of India. The official reports from the pre-independence years had taken note of the various moneylending practices followed across provinces and their consequences for the debt burden of small peasants.

Shah et al. (2007) quote from the Madras Provincial Banking Enquiry Committee (MPBEC) report of 1930 to illustrate the complex cumulative working of debt: 'Frequently the debt is not repaid in full and a part of the loan persists and becomes a pro-note debt. In the course of time, it…be paid off or… become a mortgage debt. By the existence of this heavy persisting debt, the creditor takes the bulk of the produce and leaves the ryot unable to repay short-term loans…The ryot cannot clear his short-term debt because of the mortgage creditor and he cannot cultivate without borrowing because his crop goes largely to the long-term creditor. If he pays his long-term creditor his current debts swell and overwhelm him'. As per this Report the predominant reason for borrowing in 1929 was repayment of prior debts and a major source of loans were rich landowners. They used the debt and mortgage mechanism to secure ownership over land.[15]

Around the late 1960s, debates around debt and usury gained further salience mainly as part of the larger debate on the mode of production in Indian agriculture. Some scholars have considered usurious moneylending as an institution that acts as an obstacle to the emergence of capitalist agriculture. As Rudra (1977) explains, this is because of the two roles played by money lending in the rural production system: (1) usury diverts capital away from productive channels as usury is more lucrative than making productivity enhancing investments in land; and (2) it helps the local power structure reinforce its control over the rural poor. The theories of agrarian distress and stagnation in post colonial India have explicitly addressed the interlinked nature of transactions among land, labour, and credit markets as a major factor that discouraged capital formation, and in turn perpetuated backwardness of Indian agriculture and immiserisation of wage workers and peasants (Thorner, 1956; Bardhan, 1980). In an interlinked transaction 'the parties trade in at least two markets on the condition that the terms of all trades between them are jointly determined' (Bell and Srinivasan, 1989). Daniel Thorner[16] described the extreme form of the phenomenon of interlocking that he came across in Mysore thus:'…the principal landowners are at one and the same time the largest employers of agricultural labourers, the chief traders, the main moneylenders, the shop keepers and the village officials… In parts of the Punjab, Western Uttar Pradesh, in Gujarat and in Andhra…(large) peasants may at the same time be obtaining part (perhaps even the major part) of their income from renting out land, lending money or grain, or trading in agricultural commodities'.

In the late 1970s the enquiries into the persistent backwardness of Indian agriculture focused sharply on the features of usury and what determines usurious interest rates in backward agriculture. An interesting debate around these issues unfolded over 1975–77. One line of argument (Bottomley, 1975) emphasized that the cost of administering private loans and the premium for risk (which arises from non-repayment, delayed repayment or partial repayment of loans) were the major determinants of monopolistic interest rates in the unorganised rural markets. Countering this, Bhaduri (1977) developed a model to show that usurious interest rates in agrarian credit markets stem from two distinct characteristics: its isolation and highly personalised nature. According the model developed by Bhaduri (1986), in the isolated agrarian credit market the lender evaluates an asset by comparing the personal value he attaches to it *vis a vis* the value in the organized market. For the borrower, with no or restricted access to the organized market, the choice is limited to compare the personal value of the asset to him with its undervalued price in the unorganized market. In other word, lender's risk becomes irrelevant in the determination of interest rate in markets where he enjoys the double advantage of having access to the organized markets and the monopoly power to undervalue asset prices. Usurious extraction becomes the basis on which interest rates are determined in these markets. In a later work Bhaduri (1986) tried to demonstrate how indebtedness leads to contractually interlocked agrarian markets and, in turn, gives rise to 'a contrived system of forced commerce'. He concurred with the position that such commercial mode of exploitation not only demonstrates unequal relations of economic power, but also acts as a mechanism for maintaining such unequal power structure, often at the cost of retarding agrarian growth.

The above set of writings that appeared over the late 1960s and 1970s have built up a commendable theoretical apparatus to look at the issues relating to rural and agricultural credit markets as also rural indebtedness. Informed by the rich theoretical work of these decades, several scholars started taking serious interest in critically examining the role of institutional credit agencies like commercial banks and cooperatives in rural credit markets. These studies took note of the significant increase in the flow of institutional credit to rural areas through branch expansion between the mid-1960s and the mid-1990s (coinciding with the green revolution and bank nationalization) (Nair, 2000) and presented robust evidence that broadbasing of rural branches in unbanked

locations was associated with reduction in rural poverty (Burgess and Pande, 2005). This phase of development of banking in India—the social banking phase—could well be seen as a period when rural credit transcended the image of mere commodity 'that needed to reach the poor to free them from usurious moneylenders'. There was increasing appreciation that rural credit 'could also be seen as a public good critical to the development of a backward agrarian economy like India…' (Shah et al., 2007: 1353). The results of the All India Debt and Investment Survey 1991corroboated this by reporting considerable improvement in the share of institutional sources, mainly commercial banks, in the cash debt outstanding of rural households.

The pattern of distribution of institutional credit across rural and urban/metro populations was closely analysed by researchers in 1990s and 2000s as banking reform agenda gathered momentum following the reports of the Banking Sector Reforms Committee (1997–8) that recommended greater market orientation of banks and urged them to enhance their competitive efficiency, productivity and quality and range of services. These enquiries brought to the fore some critical problems with organised banking such as their diminishing rural orientation and increasing neglect of weaker sections (Chavan, 2007; Ramachandran and Swaminathan, 2004). The 59th Round survey of the NSSO pertaining to the 2002 disturbingly indicated that the hold of moneylenders got strengthened since the early 1990s. This survey also brought to the notice of researchers inter-state variation in the prevalence of informal credit (Basole and Basu, 2009). States with developed commercial agriculture such as Punjab, Tamil Nadu and Andhra Pradesh were found to have higher prevalence of informal credit. West Bengal, which had implemented land reform, though to a limited degree, also showed a high percentage of non-institutional rural credit. The new class of money lenders include a variety of agencies—input suppliers, commission agents, buyers of produce, the non-banking finance company, and the traditional moneylender.

The perpetual prevalence of money lenders is often made possible by the lack of or callous implementation of institutional reforms in other markets. For example, in Punjab, as per the APMC Act, the commission agent (called Arhtiya) is the sole mediator in the sale of food grains to food procurement agencies. The Arhtiya receives the sale proceeds in his bank account and passes it on to farmer later. The farmer often raises loans from these agents as advance against multiple future crops to fulfill his credit needs. This arrangement ensures that the commission agents have perennial presence in the rural production system in the state and the farmer's indebtedness to him continues through cycles of loans and repayments (Verma, 2015).

Changes in Rural Indebtedness over 2002–12: Insights from Debt and Investment Surveys

As per the NSSO's 70th round survey relating to debt and investment in India, 31.4 per cent of all rural households in the country had an outstanding debt as on end June 2012 as against 26.5 per cent in 2002 (NSSO 59th Round Survey, 2005). The corresponding estimate for urban households is 22.4 per cent. The percentage of indebted cultivator households (households with land holding of 0.002 ha or more) was estimated to be much higher—45.6 per cent—than the non-cultivator households (28.8 per cent). The estimates for 2002 were 29.7 per cent and 21.8 per cent respectively. It may be mentioned that the estimates made in the NSSO Report on the Situation of Agricultural Households in India (2013) show that 51.9 per cent of the agricultural households[17] in India are indebted or having an outstanding loan as on April 2013.

Importantly the estimates from the survey show that non-institutional agencies played a larger role in advancing credit to rural households and their relative significance as sources of credit increased over the period 2002–12. They had advanced loans to 19 per cent of the rural households in 2012 (as against 15.5 per cent in 2002) and formed 44 per cent of all cash loans outstanding. The share of institutional sources too increased from 13.4 per cent to 17 per cent over the same decade. Their share in cash loan outstanding among rural households, however, declined marginally from 57 per cent to 56 per cent. What is striking is the significant rise in the share of institutional sources in cash debt outstanding of urban households from 75 per cent to 85 per cent during 2002–12. The percentage of urban households indebted to informal sources is just 10 per cent.

The dependence on non-institutional sources is observed across asset size classes, while the dependence on institutional sources is observed to improve steadily as the size of household asset holding increases.

The IOI estimates shown in Table 17.5, suggest that there has been an overall expansion of rural credit market with both institutional and non-institutional agencies improving their physical outreach to rural households over 2002–12. However, the rural households as a whole experienced a marginal decline in loan exposure to

Table 17.5 Incidence of Indebtedness and Percentage in Cash Loan outstanding of Rural Households

	IOI		Share in cash loan outstanding	
	2002	2012	2002	2012
Institutional sources	13.4	17.2	57.1	56.0
Non Institutional sources	26.5	31.4	42.9	44.0

Source: NSSO (December 2005); NSSO (December 2014).

institutional sources and a corresponding rise in exposure to non institutional sources.

Within group comparison shows that both incidence of indebtedness and share in cash loan outstanding improved in favour of institutional sources for both cultivators and non-cultivators. However, the share of non-institutional sources in cash loan outstanding remains much higher in the case of non-cultivator households (Figures 17.1 and 17.2).

Among non-institutional sources, professional money lenders remain the most critical players in 2012 too. These are pure money lenders who extend small loans on verbal promise and large loans against promissory notes. The loans are granted on personal security or mortgage against land, house and ornaments, in case the loan is of larger size. They usually charge compound interest rate. The agriculturist money lender usually is a landlord or a rich peasant with surplus made from agriculture to invest in money lending. The NSSO data indicates that their presence has dwindled in the countryside over the years with only 2 per cent households reporting outstanding loans amounting to just 5 per cent of all outstanding loans. The share of loan outstanding due to professional moneylenders, on the other hand, is estimated to be the highest (28 per cent); even higher than both cooperative financial agencies and commercial banks. Importantly, they account for about a third of all the loans outstanding by non-cultivator households in country.

When it comes to the cost of funds, 14.9 out of the 31.4 per cent indebted rural households had borrowed at rates exceeding 15 per cent per annum as on April 2013. Half of these loans carried annual interest rates in excess of 30 per cent. Lower interest rates—ranging from 6 to 12 per cent—were reported 8 per cent households, while only 3 per cent could avail credit at rates below 6 per cent. Another 6 per cent reportedly availed loans at no cost. It is important to note that the interest rates

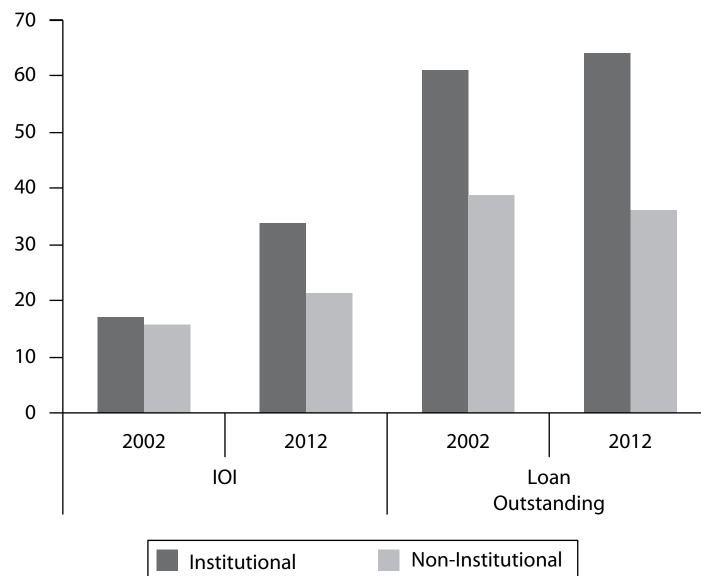

Figure 17.1 Share in Cash Debt Outstanding by Type of Credit Agency: Cultivator Households

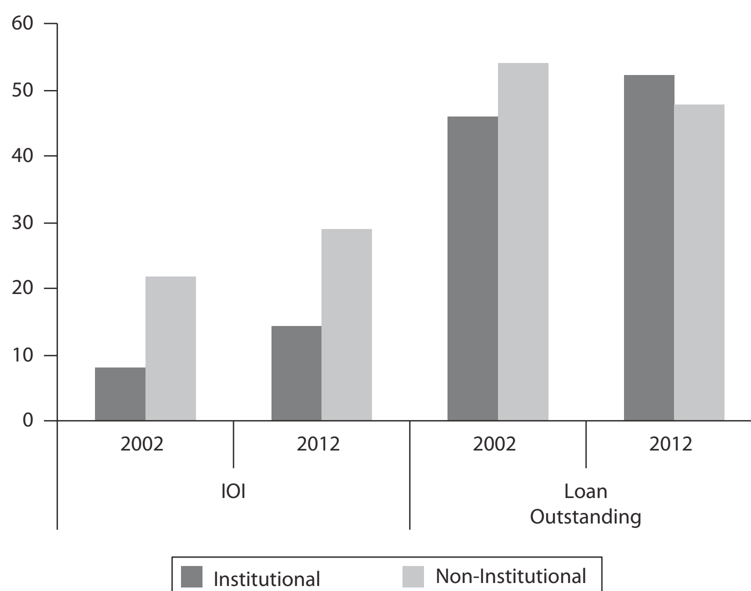

Figure 17.2 Share in Cash Debt Outstanding by Type of Credit Agency: Non-cultivator Households
Source: NSSO (December 2005); NSSO (December 2014).

captured by the NSSO Survey through the self reports of rural households are most likely to be underestimates. The actual costs tend to be hidden in various forms of repayment (Kurup, 1976; Bhaduri, 1977).

Even with a grossly underreported data base, one could find that the source of debt and interest rates are closely associated (Table 17.6). More than 80 per cent of the households that reported outstanding loans from institutional sources in the 70th Round survey were reportedly paying annual interest rates in the range of 6–15 per cent. A fourth out of these reported interest rates varying between 6 per cent and 10 per cent. In contrast,

Table 17.6 Percentage Distribution of Outstanding Cash Debt by Nature of Credit Agency: 2002 and 2012

Interest rate	% distribution of outstanding cash debt			
	Institutional		Non-institutional	
	2002	2012	2002	2012
Nil	1	1	18	18
< 6	2	7	2	2
6 to 10	4	26	1	0
10 to 12	9	13	1	1
12 to 15	48	43	1	4
15 to 20	34	7	3	6
20 to 25	1	2	33	34
25 to 30	0	0	0	1
≥ 30	0	1	40	34

Source: NSSO (December 2005); NSSO (December 2014).

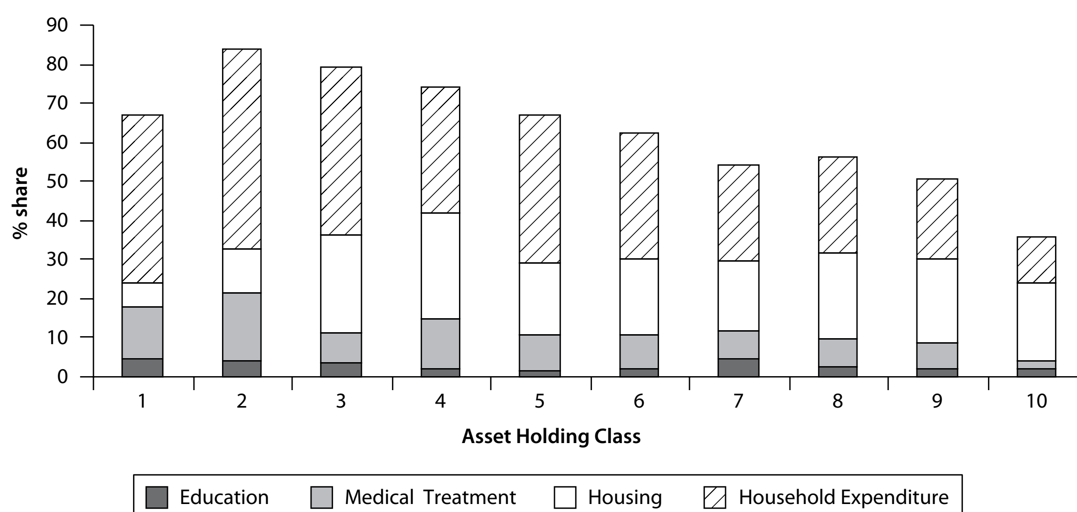

Figure 17.3 Percentage Distribution of Cash Loan Outstanding by Major Non-business Purpose–2012
Source: NSSO (2013).

69 per cent of households indebted to non-institutional sources were reportedly paying annual interest rates about 20 per cent, with 34 per cent of them paying 30 per cent or more as interest. A comparative examination of 2002 and 2012 rates suggests setting in of overall moderation in institutional rates. Some rub-off effect is visible in the case of non-institutional rates, though majority of the loans they had extended over 2012–13 carried very high costs. It is worth exploring whether thanks to the institutional innovations introduced in the rural economy to broadbase credit reach have started impacting the unorganized rural credit market in terms of reducing the degree of its isolation. In other words, it is important to understand whether the organised and unorgansied credit markets have begun to show signs of better integration in recent years.

Overall 60 per cent of the loans outstanding was deployed in non-business activities and 40 per cent in business activities, including 29 per cent in farm and 11 per cent in non-farm activities. The non-business over 80 per cent of the households in the bottom 40 per cent of the asset classes had reportedly borrowed for purposes other than business. Households in the upper size classes had used relatively larger part of the borrowed funds to meet expenses related to business, mainly farm business. Only the top 10 per cent of the households reported any significant use of loans for non-farm business. Among the non-business purposes where loans had been deployed, routine household expenditure figures as the most dominant purpose in the case of households in the bottom 20 per cent in terms of asset holding, followed by medical treatment. As the asset holding increases housing emerges as a major purpose of loan use (Figure 17.3).

The other critical aspect of rural indebtedness is the very high debt-asset ratio (DAR) among the lowest asset holding class (39 per cent). The ratio monotonously declines as asset value of the households increases.

Table 17.7 presents the comparative picture of some of the more populous states in India with respect to percentage of indebtedness among cultivator and non cultivator households in 2002 and 2012. In all the states, excepting West Bengal and Jammu and Kashmir, percentage of non-cultivator households with cash loan outstanding is much less than the cultivator households (Figures 17.4 and 17.5). The data appears to reiterate the oft repeated argument about the lack of access to finance faced by the non-farm sector. The various measures adopted over the years to deepen the reach of the financial system seems to have benefited the cultivator households mainly in the southern states along with Maharashtra. The southern states had also reported a rise in the incidence of indebtedness of non-cultivator households between 2002 and 2012. Such households in Maharashtra still account for only about a fifth.

Conceptualizing Inclusion

The concept of 'inclusion' as different from the concepts of integration or mainstreaming acknowledges and accepts diversity. It conveys the ability of the system to change in order to meet the needs of all citizens, especially the vulnerable and the excluded, and forging

Table 17.7 Incidence of Indebtedness among Cultivator and Non-cultivator Households

State	Incidence of indebtedness			
	Cultivators		Non-cultivators	
	2002	2012	2002	2012
Andhra Pradesh	54.00	69.99	33.50	50.02
Kerala	42.90	68.07	35.90	49.10
Maharashtra	37.80	55.80	14.90	21.94
Karnataka	39.10	55.74	20.70	43.65
Tamil Nadu	40.30	54.70	26.60	38.62
Rajasthan	36.70	46.33	25.40	33.07
Himachal Pradesh	17.90	43.17	7.20	24.82
Gujarat	33.90	42.60	20.70	20.88
Bihar	22.50	40.99	20.80	28.56
Madhya Pradesh	31.70	40.89	15.00	17.31
Punjab	28.50	40.19	22.50	31.72
Odisha	31.30	39.60	17.50	24.64
Uttar Pradesh	24.10	38.47	21.40	28.44
Uttarakhand	3.90	38.27	10.00	25.14
Haryana	31.70	32.92	21.10	20.66
Jharkhand	12.90	24.01	9.20	18.15
Chhattisgarh	23.00	21.76	9.80	10.61
West Bengal	24.70	17.56	18.00	23.72
Assam	6.70	14.12	8.90	9.35
Jammu and Kashmir	3.80	10.91	2.20	12.80
Telengana		73.85		53.99
India	29.70	45.94	21.80	28.85

new relationships. This is fundamentally different from the process of integration. While integration demands the excluded to adapt themselves to fit in with the dominant system, inclusion recognizes the rights of all and makes changes to the system to accommodate diversity. While integration refers to plugging the gaps in the existing social contract, inclusion refers to changing the system per se for the benefit of all.

The critical question, hence, is whether the financial institutions are able to deal with all individuals irrespective of the size of their credit or saving needs with equal respect and dignity. This would mean that all individuals irrespective of the nature and magnitude of transactions are able to meaningfully interact in the normal environs of banking institutions and to access necessary support for such interactions. They will then be able to see themselves as belonging to the system. Inclusion is thus about transformation.

The debate on financial inclusion cannot be delinked from the larger discourse on social inclusion. It cannot be limited to achieving targets of account opening during the shortest possible time. Inclusion is about addressing squarely the basic structures of inequity in society and shaping appropriate institutional arrangements, including laws and policies, and allowing them time and space to evolve and mature.

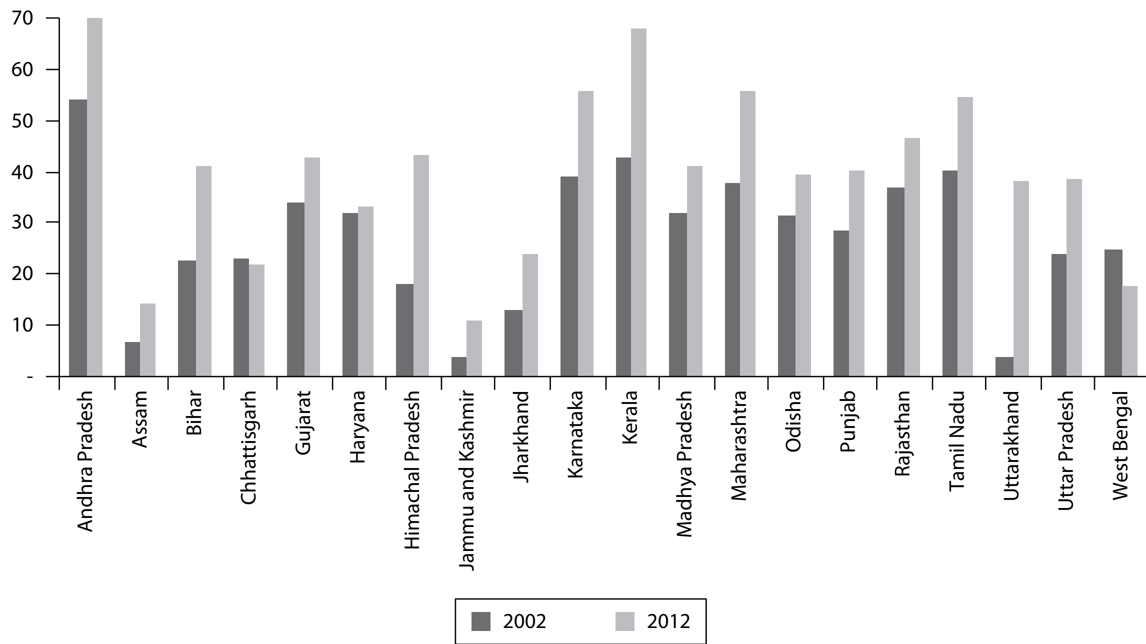

Figure 17.4 Incidence of Indebtedness among Cultivator Households: 2002 and 2012
Source: NSSO (December 2005); NSSO (December 2014).

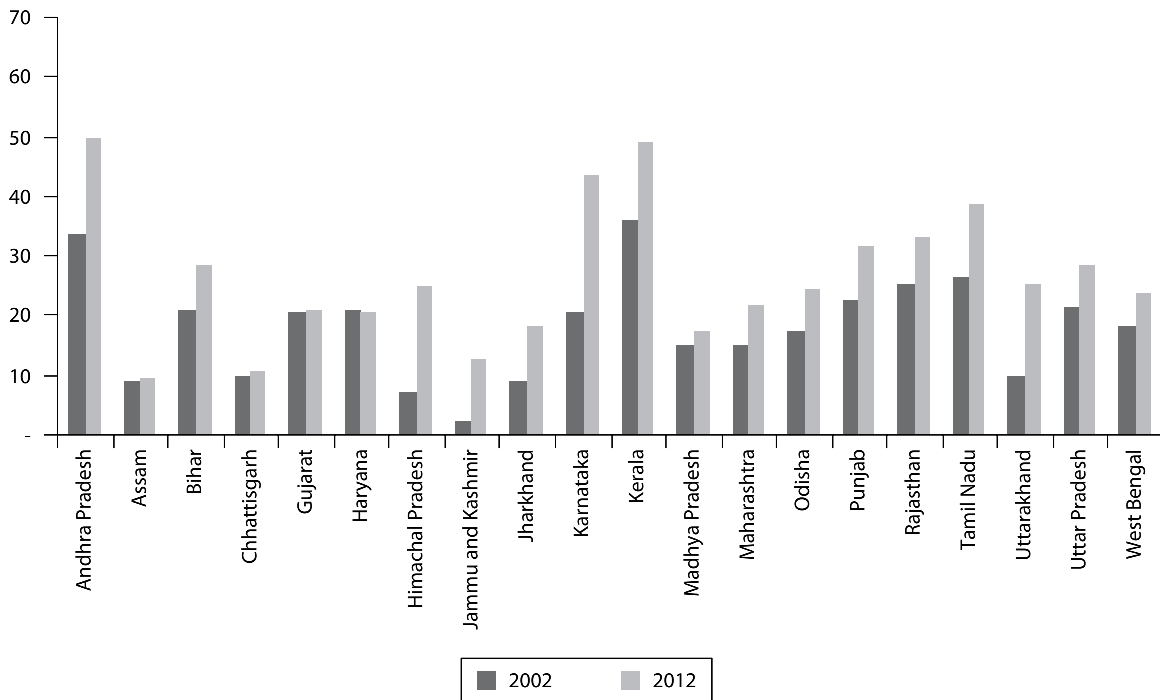

Figure 17.5 Incidence of Indebtedness among Non-cultivator Households: 2002 and 2012

Notes

1. K.C. Chakrabarty, 'Financial Inclusion in India: Journey So Far and Way Forward', http://rbidocs.rbi.org.in/rdocs/Speeches/PDFs/CN18060913FS.pdf, accessed 13 June 2014.

2. Balachandran (1998).

3. RBI (2009).

4. The need of commercial banks to increase their involvement in the financing of priority sectors, viz., agriculture and small scale industries was emphasized at a meeting of the National Credit Council held in July 1968. The description of the priority sectors was later formalised in 1972 on the basis of the report submitted by the Informal Study Group on Statistics relating to advances to the Priority Sectors constituted by the Reserve Bank in May 1971. Targets and sub-targets of priority sector lending have come into force since 1974. RBI, Master Circular – Lending to Priority Sector, RBI/2014–15/82, RPCD.CO.RRB.BC.No.5/03.05.33/2014–15, July 1, 2014. https://rbidocs.rbi.org.in/rdocs/notification/PDFs/82MCLPS010714.pdf.

5. Quoted in Naqui Uddin (2003).

6. Sukanya Bose, 'Regional Rural Banks: The Past and the Present Debate', Available at http://www.macroscan.org/fet/jul05/pdf/RRB_Debate.pdf.

7. Apart from the Lead Bank Scheme, the Service Area Approach (SSA) was introduced in 1989, wherein each bank branch in rural and semi-urban area is to designated to serve a select area of a cluster of villages in terms of meeting the bank credit needs.

8. Available at https://rbidocs.rbi.org.in/rdocs/Publications/PDFs/bs72-95-1.pdf.

9. Available at https://rbidocs.rbi.org.in/rdocs/Publications/PDFs/bs72-95-1.pdf.

10. NABARD, 'Guidelines for the Pilot Project for Linking Banks with Self Help Groups', Ref. No. NB.DPD.FS.4631/92-A/91-92 Circular No. DPD/104, 26 February 1992.

11. For a detailed discussion of the financial inclusion plans, see, Nair and Tankha (2015).

12. Available at http://www.pmjdy.gov.in/account.

13. In his budget speech of 2011, the then Finance Minister referred explicitly to the intention of the government to 'move towards direct transfer of cash subsidy to people living below poverty line in a phased manner'.

14. CSMS refers to Core Subsidy Management System.

15. For a crisp narration of how usurious moneylending was dealt with by the colonial administration during the early 20th century, see, Shah et al. (2007).

16. As quoted in Rudra (1978).

17. It may be mentioned that the estimates made in the NSSO Report on the Situation of Agricultural Households in India (2013) show that 51.9 per cent of the agricultural households in India are indebted or having an outstanding loan as on April 2013.

These are households that receive value of produce from agricultural activities greater than Rs.3000, excluding agricultural labour households, over the last 365 days.

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Part III

Social Development Index

18

Social Development Index 2016

Surajit Deb

Given the complex nature of the process of social development, it has become common to apply broad-based indicators from both the material and non-material dimensions to capture development. The Indian development report card, viz., the Economic Survey 2015–16 (GoI 2016) has argued that development indicators for India must go beyond increases in gross domestic product or per capita incomes and encompass enhancement of opportunities in social infrastructures such as education, health, employability, poverty, housing, and basic amenities. It can further be observed that the multi-dimensional indices have not only remained popular but also became very successful as indicators of societal change in recent years. Thus, while individual indicators such as mortality rates, school enrolment and literacy ratios, access to safe drinking water and toilets can be used to focus on specific aspects, composite developmental indices, such as the social development index is frequently computed to monitor the country's aggregate levels of living. Therefore, composite indicators of development encompassing several dimensions of human social well-being are considered better indicators of social progress. The Human Development Index (HDI), Social Development Index (SDI) and the Multi-Dimensional Poverty Index (MPI) are all multi-dimensional indicators as opposed to the measures of per capita income or poverty levels, which are one-dimensional.

A composite index of social development can be used to simplify the complexities of social development across Indian states and assess their progress along several dimensions and then convincingly condense the complexities down to single numbers. The composite index is a function of indicators and weights that express the attainments of a particular state in different development dimensions into a single score that can be ranked along with the corresponding score of other states. However, much of the quality and reliability of such comprehensive indices are known to depend on the choice of components included and the method of aggregation. For instance, the HDI methodology that conceives the index as a simple average of three separate indicators remained open to criticism in the academic literature (Srinivasan, 1994; Noorbakhsh, 1998; Booysen, 2002; Chowdhury and Squire, 2006; Foster et al., 2012; Decanq and Lugo, 2013). There have also been some recent concerns that composite indices spanning different development dimensions need to be supported by theoretical perspectives as well as statistical systems and not an index based on averages (Alkire, 2008, 2016; Ravallion, 2012).

The HDI measure covers only those dimensions that are essential for the quality of human life and therefore perceive human development as progress made in education, health and living standards. The societal progress necessitates abolition of social deprivation and working of social institutions, since socio-economic marginalization of certain groups may act as a major barrier to social cohesion in a country. The two government departments in India, viz., Department of Social Justice and Empowerment and Department of Empowerment of Persons with Disabilities (Divyangjan) working under the Ministry of Social Justice and Empowerment (GOI) are entrusted with the empowerment of the disadvantaged and marginal sections of the society. Hence, while the former emphasizes on the need for development of specific sections, viz., scheduled castes, other backward class, senior citizens, victims of substance abuse, de-notified, nomadic and semi-nomadic tribes, beggars and transgender persons, the latter is directed towards facilitating empowerment of the persons with disabilities. Thus, the

assessment of social dimensions of development would logically demand that aspects of social discrimination are added in the analysis. The notion of SDI therefore remains broader than the HDI in the sense that elements such as social exclusion, gender discrimination, access to basic amenities and other social issues such as child labour or slum population, which generally act as possible deterrent to social inclusion, are also incorporated in the composite index. In the present case, SDI is a multi-dimensional index taking into account six important dimensions of social development, viz., demographic parameters, health indicators, educational attainment, basic amenities, economic and social parameters (refer Table 18.1).

The social development index like any other development indices should have the following features: (i) the methodology is transparent and based on statistical foundation, (ii) the database is consistent and recent, and finally, (iii) the derived indices are suitable to perform comparison of the index over time. The first in the series of SDI for Indian states, viz., SDI-2006 or the subsequent SDI-2008 was developed based on equal weights in aggregating different dimensions into a composite indicator. The SDI-2010 revised the methodology and used principal component analysis to estimate the composite indices of SDI for the Indian states. The principal components analysis (PCA) is primarily employed to aggregate individual dimensions of social development that are correlated to form a composite indicator by capturing most of the variations in the original multivariate data. The SDI-2012 and SDI-2014 were subsequently developed following the same PCA methodology to determine the set of weights to be used for aggregation on the basis of their statistical importance (refer Hasan and Hasan, 2013; Qadeer, 2015). The use of PCA in our methodology is considered necessary, since the use of equal weights among indicators—as is done in the case of HDI—could encounter potential methodological problems, in case two or more indicators in our analysis are inter-linked and correlated. The use of PCA is not only considered appropriate when there is a high degree of correlation present in the multiple attributes, but is also argued to be better suited in establishing the optimal weights of variables in relation to the method of equal weights.

While the methodology of SDI-2016, developed in this chapter, remains the same as in SDI-2014, the present exercise uses recent data information as much as possible. For instance, we have made use of data from NSS 71st round (2014) for male and female literacy rates, Labour Bureau's latest series on male and female wage rates as well as the most recent Sample Registration Schemes and School Education Survey data. It may be mentioned that we have replaced some of the data series from National Family Health Survey (NFHS-3) 2005–06, by District Level Household Survey (DLHS-4) 2012–13 on indicators like contraceptive prevalence and institutional deliveries. It may be noted that the Ministry of Health and Family Welfare (GOI) designated the International Institute for Population Sciences, Mumbai as the nodal agency to conduct the NFHS in providing essential data on health and family welfare and emerging issues. The fourth series, viz., NFHS-4 would provide state-level information on many relevant aspects of our health and nutrition indicators for the year 2015–16. However, we could not utilize this useful source in this version since summary data and indicators only for 15 out of 29 states were made available at the time of our index construction.

Social inequality and exclusion can take several forms, but in India they mainly operate along the lines of caste, tribe, gender, or religious bias. It is also maintained that the previous development policies followed in the last decades were responsible for generating inequality between the rural and urban areas of living. We have therefore provided separate SDIs for rural and urban areas of each state in addition to the aggregate index. We also construct separate SDIs, which are disaggregated over social groups, viz., scheduled caste (SC), scheduled tribe (ST) and non-SC-ST groups of population, as well as gender classes, viz., male and female for each state. In total eight different SDI series, viz., Aggregate SDI, Rural SDI, Urban SDI, Social SDI for SC, ST and Non-SC-ST, and Gender SDI for Male and Female have been provided to examine the disparity across states. The rest of the chapter is structured as follows. The next section elaborates the methodology on how uncorrelated principal components are extracted through linear transformations of the original variables by retaining most of the variations in the original data set. In the third section, we discuss in detail the definition and data-source of each of the indicators that are used in the analysis. The analyses of our results are included in section 4. The final section highlights the results and discusses the policy implications.

Methodology

A major methodological caveat in respect of aggregative indices occurs in view of choice of variables and selection of appropriate weights. A number of methods can be

Table 18.1 Database for the Dimensions/Indicators of SDI 2016

Dimension/indicator	Data base
Dimension 1: Demographic	
1.1 Contraceptive prevalence rate	District Level Household and Facility Survey (DLHS-4, 2012–13), GOI [2015a].
1.2 Total fertility rate	Sample Registration System (SRS), 2013, Registrar General of India (RGI) 2014.
1.3 Infant mortality rate	SRS, 2013, RGI [2014]
Dimension 2: Health	
2.1 % of institutional delivery	DLHS-4, 2012–13, GOI [2015a]
2.2 % of undernourished children	National Family Health Survey (NFHS-3, 2005–06, International Institute of Population Science (IIPS [2007]
Dimension 3: Education	
3.1 Literacy rate	National Sample Survey (NSS 71st Round, 2014), GOI [2015b)
3.2 Pupil-teacher ratio	8th All India School Education Survey, 2009, GOI [2014a]
3.3 School attendance rate (age 5–14)	NSS, 66th Round (2009–10), GOI [2012a]
Dimension 4: Basic Amenities	
4.1 % of households. living in concrete house	Census Housing Tables, GOI [2012b]
4.2 % of households having access to drinking water	Census Housing Tables, GOI [2012b]
4.3 % of households having access to toilet facility	Census Housing Tables, GOI [2012b]
4.4 % of households having electricity connection	Census Housing Tables, GOI [2012b]
Dimension 5: Economic	
5.1 Percentage of pop. living below poverty line	Press Note on Poverty Estimates, 2011–12, GOI [2013b]
5.2 Unemployment Rate (current daily status, age 15–59)	NSS, 68th Round (2011–12), GOI [2013c]
5.3 Monthly per capita expenditure	NSS, 68th Round (2011–12), GOI [2013d]
Dimension 6: Social	
6.1 Disparity between SC & general population in literacy	NSS, 66th Round (2009–10), GOI [2012a]
6.2 Disparity between ST & general population in literacy	NSS, 66th Round (2009–10), GOI [2012a]
6.3 Disparity between female & male population in literacy	Census 2011, RG&CS
6.4 Disparity between female to total unemployment rate	NSS, 68th Round (2011–12), GOI [2013d]
6.5 Disparity between muslim & total population in literacy	NSS, 66th Round (2009–10), GOI [2013e]
6.6 Child sex ratio	Census 2011, RG&CS

found in the literature that were applied to determine the dimensional weights e.g., method of equal weights, data-driven weighting schemes, statistical weights (principal components, cluster analysis, factor analysis), regression based weights, or normative weights. The Human Development Index (HDI) has restricted itself in using equal weights among the three basic dimensions, viz., health, knowledge, and income. It may be noted that although the original HDI methodology was revised in 2010, the new HDI continues to assign equal weight to all three dimensional indices on the assumption that that the three dimensions are equally

important. Under the previous HDI formula, health was measured by life expectancy at birth; education or knowledge by a combination of the adult literacy rate, primary school enrolment, secondary school enrolment, and university enrolment; and income or standard of living by GDP per capita adjusted for purchasing-power parity (PPP USD). While health is still measured by life expectancy at birth, the HDI-2010 differed in measuring achievements in knowledge by combining the expected years of schooling for a school-age child in a country entering school today with the mean years of prior schooling for adults aged 25 years and older. Similarly, the income measurement was changed from purchasing-power-adjusted per-capita GDP to purchasing-power-adjusted per-capita GNI. In the previous HDI, each of the dimensions carried equal weight, i.e., one-third in producing the final HDI score, while indicators within the dimension of education accounted for one-twelfth. The new HDI continues to assign equal weight to all the three dimensions, while the two education sub-indices are weighted equally. However, the new HDI is based on the geometric mean so that poor performance by a country in any dimension is now directly reflected in the new HDI (UNDP, 2015a).

A variety of other statistical techniques can be distinguished in the literature that deals with the determination of suitable weighting scheme in specific cases. For instance, the International Institute of Social Studies (ISS, The Hague, Netherlands) is bringing out the *'Index of Social Development'* at the international level by synthesizing about two hundred indicators spread over six dimensions, viz., civic activism, clubs and associations, inter-group cohesion, inter-personal safety, trust and gender equality and inclusion of minorities (ISS, 2014). The aggregation process chosen to combine different indicators into this final index is a variant of the matching percentiles methodology (Foa and Tanner, 2012). The *"Ease of Doing Business Index"* published by the World Bank provided alternative results based on principal component analysis (PCA) in formulating the composite index that covers ten indicators (World Bank, 2013). The *'Quality of Life Index'*, brought out by the Economic Intelligence Unit (EIU) of the Economist Group uses nine dimensions to determine a nation's score, which are: health, family life, community life, material well-being, political stability and security, climate and geography, job security, political freedom and gender equality. The weights in this index are determined through regression analysis on the assumption that a highly valid and reliable measure of the latent variable exists (EIU, 2005).

In the Indian context, Planning Commission initiated the first National Human Development Report for India (GOI, 2002), and the second one that remains the most recent in this series was brought out by the Institute of Applied Manpower Research (GOI, 2011b). It may be noted that the Indian HDI (IHDI) is also conceived as simple average of the three dimensions, viz., health, education and income, and using life expectancy at birth, literacy rate, adjusted mean years of schooling and inequality adjusted per capita real consumption expenditure as indicators. The different HDI series prepared by the Ministry of Development of North Eastern States (MDONER) for the eight north-eastern states (GOI, 2011a) as well as the ones by different state governments at further disaggregated levels broadly follow similar methodology.[1] The Ministry of Finance published 'Report of the Committee for Evolving a Composite Development Index of States' (commonly known as the Raghuram Rajan Committee Report) containing *"Multi-Dimensional Index"* (MDI) to identify the backwardness of states and use it in recommending the devolution of center-state funds in India (GOI, 2013 a). The MDI index is built covering ten dimensions including: (1) monthly per capita consumption expenditure, (2) education, (3) health (4) household amenities, (5) poverty rate, (6) female literacy, (7) per cent of scheduled caste and scheduled tribe population, (8) urbanization rate, (9) financial inclusion, and (10) connectivity. This study used weights determined on the basis of principal component analysis within the dimensions, but employed equal weights of 0.1 for each of the ten dimensions.

The derivation of single composite index of social progress out of numerous indicators bears a key concern that some of the development (or deprivation) indicators may be interlinked, and thereby display a high statistical correlation. For instance, studies on malnutrition in India reiterated that the children of illiterate mothers are also more malnourished, which would point towards a correlation between the education and health indicators. In case, two or more indicators are correlated, the use of equal weights among indicators could encounter potential problems for the robustness of the composite index. The PCA involves a multivariate statistical technique that helps transform a number of possibly correlated variables into a smaller number of uncorrelated ones, which we call principal components. Thus, a principal component technique is employed to derive the composite index of social development by aggregating over several indicators according to their respective statistical importance. The PCA-determined weights of the indicators are designed

in such a way that the resultant composite index accounts for a maximum variance in the data set. The method of developing multi-dimensional indices by employing the PCA based weights is considered superior in relation to the method of equal weights, specifically in cases where values in different dimensions are correlated.

The construction of the multi-dimensional social development index by using the PCA determined weights requires the application of a series of sequential steps. As our first step, we convert some of the negative indicators in Table 18.1 into positive indicators. Since the SDI is a linked to development, the negative (or deprivation) indicators such as, total fertility rate, infant mortality rate, percentage of under-nourished children, pupil–teacher ratio, school drop-out rate, percentage of population below poverty line, unemployment rate and ratio of female to total unemployment rates are made positive by taking the inverse of the respective values. Second, it is important that before we perform the PCA each of the individual indicators must have been normalized and made scale-free. The normalization of data is important given that the indicators are measured in different units and also display widely different means as well as relatively large standard deviations. It is therefore necessary to convert them in some standard comparable units such that the initial scale chosen for measuring them do not bias the results. Thus, each of these raw indicators is mapped onto a unit-free scale by subtracting the lowest value of the particular indicator among states from each of the state's value under that indicator, and then dividing by the indicator-range among states, viz., $(x_{\mathrm{np}}-x_{\mathrm{npmin}}) \div (x_{\mathrm{npmax}}-x_{\mathrm{npmin}})$. In the present exercise, we have employed a method of normal or single stage principal component analysis, which requires that all the respective indicators under each development dimensions have to be combined. Therefore, for our second step, we add-up the scale-free values of the indicators within each dimension to arrive at the representative development dimensions for each state. These normalized values are finally subjected to PCA for the determination of statistical weights, as discussed below.

Our data set can now be considered as a $(n \times p)$ data matrix $(X_{n,p})$, where n is the number of Indian states plus all India ($n = 30$) and p is the number of social development dimensions ($p = 6$). The elements of this matrix are $x_{i,j}$, where $x_{i,j}$ is the value of the j-th indicator for the i-th state. The application of PCA needs a significant correlation among individual dimensions, because the weights are set in accordance to the correlation among dimensions. The correlation matrices involving relevant dimensions used for working out each of the eight SDIs are provided in Appendix Tables 18A.1 through 18A.8. We can identify some clear relationships among various dimensions of social development in these tables. For instance, high and positive correlation can be observed in the case aggregate SDI between demographic and health indicators ($r = 0.83$) or between demographic and educational indicators ($r = 0.68$) or between demographic and basic amenities indicators ($r = 0.72$) or between health and basic amenities indicators ($r = 0.80$), and so on (Table 18A.3).

The principle of PCA lies in finding weights to be given to each of the concerned dimensions, where weights maximize the sum of the squares of correlation of the dimension with the composite index. Suppose that y_1 is a principal component of $x_1, x_2, x_3, \ldots, x_p$, such that: $y_1 = a_{11}x_1 + a_{12}x_2 + \ldots + a_{1\mathrm{p}}x_{\mathrm{p}}$. Then the variance of y_1 is maximized given the constraint that the sum of the squared weights of $x_1, x_2, x_3, \ldots x_p$ is equal to one. The PCA determines the weight vector $(a_{11}, a_{12}, \ldots a_{1p})$ by selecting higher weights for those series that vary a lot so that they influence the composite index relatively more. Once the weights are chosen, the first principle component would indicate the dominant pattern of variance in the indicators. The second principal component (y_2) similarly finds out a second a weight vector $(a_{21}, a_{22}, \ldots a_{2p})$ such that the variance is maximized subject to the constraints that it is uncorrelated with the first principal component. This signifies that y_2 has the next largest sum of squared correlations with the original variables, and the variances of the subsequent principal components would be smaller. The analysis also produces an estimate of how much variance in the x's is explained by each principal components.

One problem of using PCA in indexing is to decide on how many components to retain. It can be noticed in the applied literature that using the first principal component has remained the standard practice. To capture the total system variability of the original variables, we could use all the components, but if the first components accounts for a large proportion of the variability (around 70–80 per cent), it implies that there is one dominant component in the underlying variables. In the present analysis we use the first principal component since it explains about 84% of the variance in the data in most cases. In PCA, each of the principal components is described by the pair of *eigen-value* and *eigen-vector*, where each *eigen-value* describe the amount of variance explained by each principal component and the factor-loadings

are the coordinates of the *eigen-vector*. The factor-loadings measure the importance of each dimension in accounting for the variability in the particular principal component. The *eigen-vectors* provide the weights to compute the uncorrelated principal components, and the principal component scores are then worked out as linear combinations of normalized original variables with the factor-loadings as weights.

In order to construct our composite indices of aggregate SDI, rural SDI, urban SDI, social SDI and gender SDI for the Indian states, we have consistently used the PCA scores based on the first principal component. The SDI-Aggregate, SDI-Rural and SDI-Urban are determined by the first principal component of the combination of six development dimensions covering twenty-one indicators. The SDI-Social is constructed for different social classes using the first principal component of the five development dimensions involving thirteen indicators. Finally, the SDI-Gender is computed for male and females by the first principal component of three development dimensions comprising six indicators. The method of using the first principal component, which is the linear combination of the initial indicators and has the largest variance, appears to be a better estimate than the simple average of original variables bearing high-degrees of correlation.

Data Source

The details on various indicators employed under each dimension that are finally used in the construction of respective SDIs along with the account of their data base are discussed below. The different groups of SDIs are subsequently constructed by using the most recent available data on each indicator. The constructed set of indices would not only allow us in ranking the states of India according to the social progress, but also help us to examine the equivalence between the states' performances in social development and their economic growth achievements.

SDI: Rural, Urban, and Aggregate

In these indices, six dimensions, viz., demographic, health, educational, basic amenities, economic standards and social deprivation have been used, separately for the rural, urban, and total areas of each state.

I. Demographic Indicators

(1) Contraceptive Prevalence Rate: It refers to the proportion of currently married women using any form of contraceptive for family planning purposes. The data has been collected from the state-wise fact sheets of District Level Household Survey (DLHS-4) 2012–13, as reported in Health and Family Welfare Statistics in India (GOI, 2015a).

(2) Total Fertility Rate: This is defined as the number of children that would be born to each woman if she were to live to the end of her child bearing years (15–49 years) and if the likelihood of her giving birth to children at each age was the currently prevailing age-specific fertility rates.This data is compiled from the Sample Registration System (SRS), 2014, Registrar General of India (RGI), referring to the year 2013.

(3) Infant Mortality Rate: This refers to the number of infants dying under one year of age in a year per 1000 live births of the same year. This data is made available from the SRS 2014, RGI, referring to the year 2013.

II. Health Indicators

(1) Percentage of Institutional Delivery: It includes the percentage of delivery in an institution of both public and private sectors in the state. The data have been compiled from the state-wise fact sheets of DLHS-4, 2012–13, as reported in Health and Family Welfare Statistics in India (GOI, 2015a).

(2) Percentage of Undernourished Children: The nutritional status of children is calculated according to anthropometric measure (weight-for-age) from NFHS-3 in IIPS [2007].

III. Educational Attainment Indicators

(1) Literacy Rate: This data have been compiled from the Key Indicators of Social Consumption in India: Education, National Sample Survey, 71st Round, 2014 (GOI 2015 b).

(2) Pupil–Teacher Ratio: This is the ratio of number of students to a teacher in primary schools in different states of India and the data have been compiled from the 'Eighth All India School Education Survey, 2009', available in GOI [2014a].

(3) School Attendance Rate: The data on percentage of population currently attending school have been gathered from NSS 66th Round Survey, 2009–10 provided in GOI [2012a], which captures the current attendance rate in educational institutions per 1,000 persons for the 5–14 years age group of population.

IV. Basic Amenities Indicators

We have employed four variables to measure access to basic amenities, viz., percentage of households which live in concrete house (roof and wall); have access to safe drinking water; have access to toilet facility; and have electricity connection. The Registrar General and Census Commissioner's Housing Tables data from GOI [2012 b] have been used as the source.

V. Economic Indicators

We have used three indicators in this dimension, viz., head-count ratio of poverty, unemployment rate (according to current daily status) and the monthly per capita expenditure (rural plus urban) for different states. The data on percentage of population living below poverty line (Tendulkar methodology) in 2011–12 has been taken from GOI [2013 b]. The unemployment rate as defined by the number of person (age 15–59) unemployed according to current daily status per thousand persons in the labour force, which has been compiled from NSS 68th Round Survey, 2011–12, Key Indicators, GOI [2013 c]. Finally, the data on monthly per capita expenditure according to modified mixed reference period) are compiled from the NSS 68th Round Survey, 2011–12, Key Indicators, GOI [2013d].

VI. Social Indicators

We have used six indicators in this dimension, which are: disparity ratio between the scheduled castes (SCs) and general population in literacy rate, disparity ratio between the scheduled tribes (STs) and general population in literacy rate, disparity ratio between female and male literacy rates, ratio between female unemployment rate to total unemployment rate, disparity ratio between Muslim and total population in literacy rates, and the child (or juvenile) sex ratio. While the first three indicators as well as the fourth indicator are intended to capture the educational deprivation of SCs, STs, Muslims and women, the remaining two would assess the female deprivation of employment and the survival of girl child. The data on SC, ST and general literacy rates are taken from NSS 66th Round Survey, 2009–10, GOI [2012 a]. The female and male literacy data have been compiled from the Census 2011 information. The female and male unemployment rates are gathered from the NSS 68th Round Survey, 2011–12, Key Indicators, GOI [2013 d]. The data on literacy rates of Muslim and total population are taken from the NSS 66th Round Survey, 2009–10, GOI [2013 e]. Finally, the child-sex ratio referring between 0–6 years were taken from the recent Census 2011 data.

The twenty-nine states and union territories covered for this part of our analysis are: Andhra Pradesh (undivided), Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Goa, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand and West Bengal. Table 18.1 lists all the twenty one indicators under six dimensions along with their years of reference for each data indicator series.

SDI-SOCIAL

We have used five dimensions, viz., demographic, health, educational, basic amenities and economic to construct these indices, separately for the scheduled caste (SC), scheduled tribe (ST) and non-SC-ST groups of population for each state.

Demographic Indicators: We have used three indicators in this dimension as before, viz., contraceptive prevalence rate, total fertility rate and the infant mortality rate on each social group. The data for all the three series have been collected from the state-wise fact sheets of NFHS-3 in IIPS (2007).
Health Indicators: We have utilized two indicators under the health dimension, viz., percentage of institutional deliveries and percentage of undernourished children, and the data have been compiled from the state-wise fact sheets of NFHS-3, 2005–06, IIPS [2007].
Educational Attainment Indicators: The literacy rate and drop-out rates have been used as two indicators in this dimension. For literacy rates, we have used the data on SC, ST and general literacy rate from NSS 66th Round Survey, 2009–10, GOI [2013 f]. The data on drop-out rates are gathered from 'Statistics on School Education', 2011–12, GOI [2014].

VII. Basic Amenities Indicators

The same four indicators, viz., percentage of households which live in concrete house (roof and wall); have access to safe drinking water; have access to toilet facility; and have electricity connection, but disaggregated over SC, ST and

general class have been used with Census data from GOI [2012 b].

Economic Indicators: As before, we have used the percentage of population living below poverty line (head count ratio) and unemployment rate (current daily status) in this dimension. The unemployment rate as defined by the number of person unemployed per thousand persons in the labour force of that particular social group has been compiled from NSS 66th Round Survey, 2009–10, GOI [2012 a]. The head count poverty ratio data for the SC, ST and Non-SC-ST has been sourced from "IDFC India Rural Development Report, 2009–10", GOI [2012c].

We initiated this part of our analysis with the same twenty nine states but had to exclude some due to data limitations. Thus, Mizoram had to be dropped altogether from our analysis since its social class-wise breakups on many indicators are unavailable. There also remain additional data limitations for a particular social class in specific states, e.g., data on scheduled caste population for Nagaland or the data on scheduled tribe population for Delhi, Haryana and Punjab continues to be incomplete. Given these data gaps, the development index is constructed for twenty seven states referring to SC population, twenty five states referring to ST population and twenty nine states pertaining to non-SC-ST population. Table 18.2 below lists all the thirteen indicators under five dimensions along with their years of reference for each data indicator series.

SDI-MALE AND SDI-FEMALE

We have used three dimensions, viz., health, educational and economic to construct the Gender-SDI indices, separately for the male and female population in each state.

Health Indicators: The two indicators used in this dimension are infant mortality rate and percentage of undernourished children on each gender class. The data for both the series are taken from the state-wise fact sheets of NFHS-3, IIPS [2007].

Table 18.2 Database for the Dimensions/Indicators of SDI-Social, 2016

Dimension/indicator	Data base
Dimension 1: Demographic	
1.1Contraceptive prevalence rate	National Family Health Survey (NFHS -3, 2005–06), International Institute of Population Science (IIPS 2007)
1.2 Total fertility rate	NFHS-3, 2005–06, IIPS [2007]
1.3 Infant mortality rate	NFHS-3, 2005–06, IIPS [2007]
Dimension 2: Health	
2.1 % of institutional delivery	NFHS-3, 2005–06, IIPS [2007]
2.2 % of undernourished children	NFHS-3, 2005–06, IIPS [2007]
Dimension 3: Education	
3.1 Literacy rate	NSS, 66th Round (2009–10), GOI [2013f]
3.2 Drop-out rate (high school)	Statistics of School Education, 2011–12, GOI [2014]
Dimension 4: Basic Amenities	
4.1 % of households. living in concrete house	Census Housing Tables, [2012b]
4.2 % of households having access to drinking water	Census Housing Tables, [2012b]
4.3 % of households having access to toilet facility	Census Housing Tables, [2012b]
4.4 % of households having electricity connection	Census Housing Tables, [2012b]
Dimension 5: Economic	
5.1 Percentage of Pop. living below poverty line	IDFC India Rural Development Report 2009–10, GOI [2012c]
5.2 Unemployment rate (current daily status)	NSS, 66th Round (2009–10), GOI [2012a]

Table 18.3 Database for the Dimensions/Indicators of SDI-Male and SDI-Female, 2016

Dimension/indicator	Data base
Dimension 1: Health	
1.1 Infant mortality rate	National Family Health Survey (NFHS-3, 2005–06), International Institute of Population Science (IIPS 2007)
1.2 % of undernourished children	NFHS-3, 2005–06, IIPS [2007]
Dimension 2: Education	
2.1 Literacy rate	NSS 71st Round, 2014, GOI [2015b]
2.2 High school completion rate	GOI [2012d]
Dimension 3: Economic	
3.1 Unemployment rate (current daily status)	NSS, 68th Round (2011–12), GOI [2013c]
3.2 Wage rate	Labor Bureau, 2009–10, GOI [2014]

Education Indicators: The two indicators included under this dimension are literacy rate and higher secondary completion rate. The male and female literacy rates have been taken from the Key Indicators of Social Consumption in India: Education, National Sample Survey, 71st Round, 2014 (GOI 2015 b). The high school completion rates of boy and girl students are compiled from 'Results of High School and Higher Secondary Examinations 2010', GOI [2012d].

Economic Indicators: We have considered unemployment rate and wage rate, classified by male and female, under this dimension. The data on male and female unemployment rate has been compiled from NSS 68th Round Survey, 2011–12, GOI [2013 c]. For the wage data, we have used the data series on average daily wage rate by directly employed workers in states during 2009–10 provided in 'Statistical Profile on Women Labour', brought out by GOI [2014 c]. This part of the analysis covers the same twenty nine states included in the previous analysis. Table 18.3 below lists all the six indicators under three dimensions along with their years of reference for each data indicator series.

Results

SDI: Rural, Urban, and Aggregate

The individual states are ranked in Figure 18.1 on the basis of their aggregate SDI scores build over six dimensions covering twenty one indicators. The states of Goa, Kerala, Sikkim, Mizoram and Delhi belonged to the top five

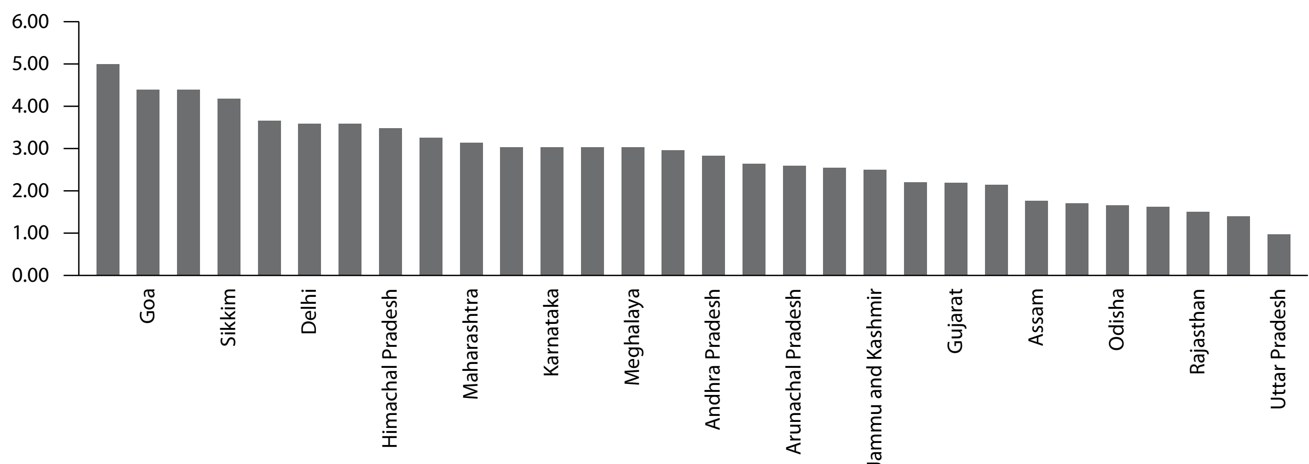

Figure 18.1 Aggregate SDI Scores

ranks, while Bihar, Uttar Pradesh, Jharkhand, Madhya Pradesh, and Odisha occupied the lowest five ranks. It can be seen that a large number of states have done better than the all-India in social development, which remained at twenty second out of twenty-nine states in our sample. However, with twenty one states remaining above the all-India level and yet a low score for all-India SDI would signify that social development lagged behind for a large section of Indian population mainly concentrated in the seven highly populated states of Chhattisgarh, Rajasthan Odisha, Madhya Pradesh, Jharkhand, Uttar Pradesh, and Bihar. It may be noted that these seven states also occupied the lowest ranks in the previous edition of aggregate SDI for the year 2014. On the contrary, the two relatively smaller states from the north-eastern region, viz., Sikkim and Mizoram have entered to secure places in the first five ranks ahead of Delhi.

In Figure 18.2, we look into individual state's rankings in all the six constituent dimensions so as to understand the configuration of the aggregate SDI scores. It is apparent that Goa achieved high in the aggregate SDI ranking due to good performances in demographic, basic amenities and economic dimensions despite falling short on the social dimension. On the other hand, Kerala—considered the pioneer of social development features among Indian states—excelled in demographic, health and social dimensions, but did not perform satisfactorily in the direction of basic amenities. The functioning of social development in the north-eastern state of Mizoram remained substantial in the dimensions of health, education and basic amenities but not on the demographic and economic dimensions. Another noteworthy state from the north-eastern origin, viz., Sikkim stood out in several dimensions including surpassing all the states in the health and education, but lagged behind in demographic and economic indicators. On the contrary, Delhi's ranking remained high only due to better performances in two aspects, viz., basic amenities and economic dimensions, despite encountering setbacks in all the four remaining dimensions. Table 18A.9 provides the insight on the state's ranking for all the six individual dimensions of social development. One can observe that there are instances where states have failed to secure any top ranks in the aggregate SDI but revealed considerable progresses in specific dimension(s) of social development. For instance, one can perceive some notable performances for the state of Andhra Pradesh in the demographic dimension. Similarly, the achievements of Assam (in social dimension), Himachal Pradesh (in economic

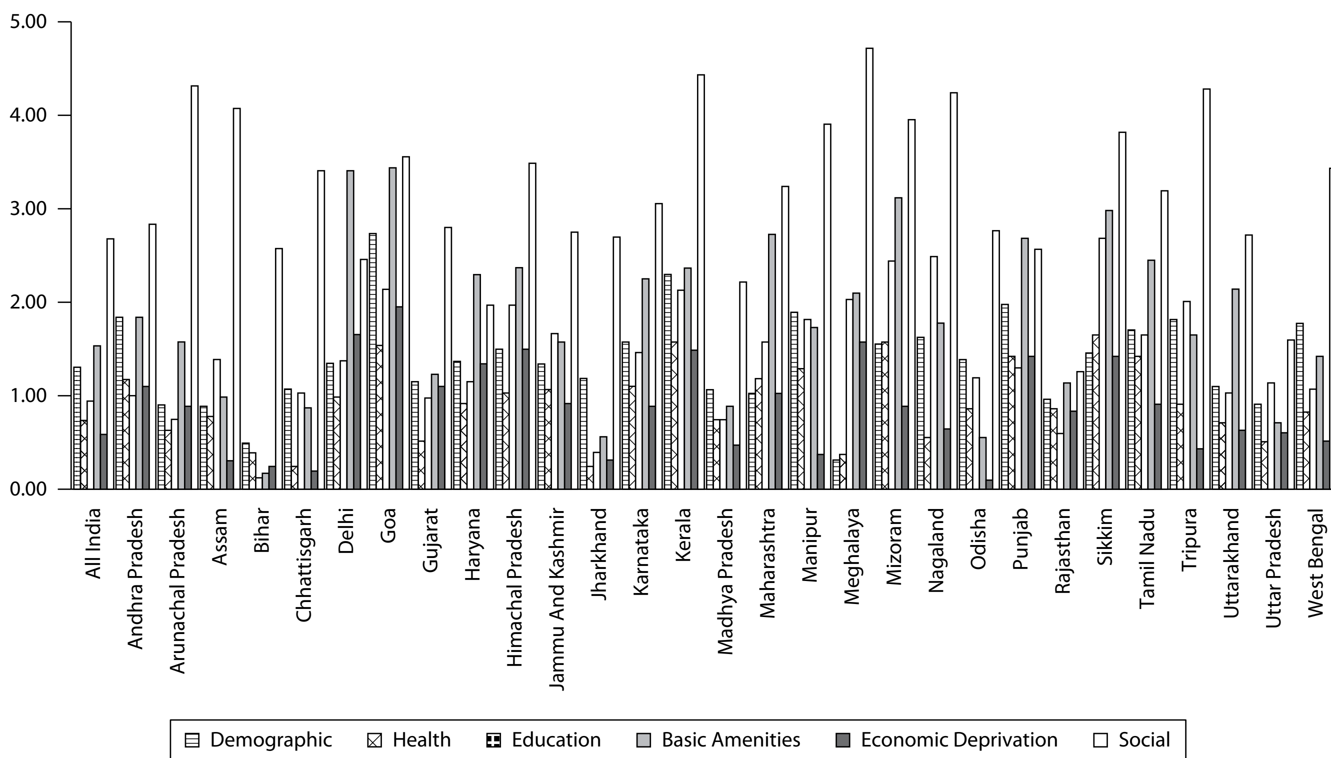

Figure 18.2 Aggregate SDI in Individual Dimensions

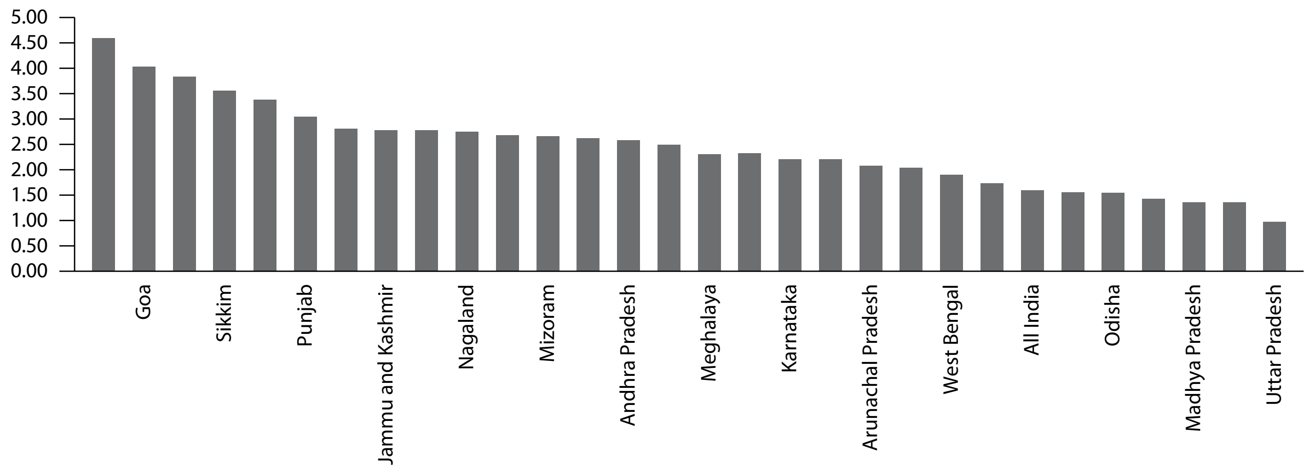

Figure 18.3 Rural SDI Scores

dimension), Maharashtra (in basic amenities), Meghalaya and Nagaland (in educational dimension), Punjab (in demographic and basic amenities), Tamil Nadu (in health and basic amenities), Tripura (in demographic and social dimension), and West Bengal (in demographic dimension) remained noteworthy.

It is sometimes argued that the reason for widening economic divide in the country is due to the growth strategy that favoured the urban India in relation to rural India. The widening gap between the per capita expenditure levels of rural and urban areas as evident in the NSS data is often linked to the growing income inequality between the rural and urban India. In this background, it becomes relevant to study as to how the social development moved across rural and urban areas of India. The individual state's Rural SDI scores are provided in Figure 18.3, where it is found that the states, which belonged to the top five ranks in aggregate SDI does not occupy the top ranks as par the Rural-SDI ranking (Figure 18.3). The top two positions are occupied by Goa and Kerala, followed by the states of Sikkim, Himachal Pradesh and Punjab that constitute the top five ranks of Rural-SDI. It can be discerned that Himachal Pradesh and Punjab have now entered the top five ranks by replacing the states of Mizoram and Delhi.

We use Figure 18.4, containing information on individual dimensional ranking of states in Rural-SDI, to understand the development experiences for rural areas in Himachal Pradesh and Punjab as well as in Mizoram and Delhi. The representation of state's ranking

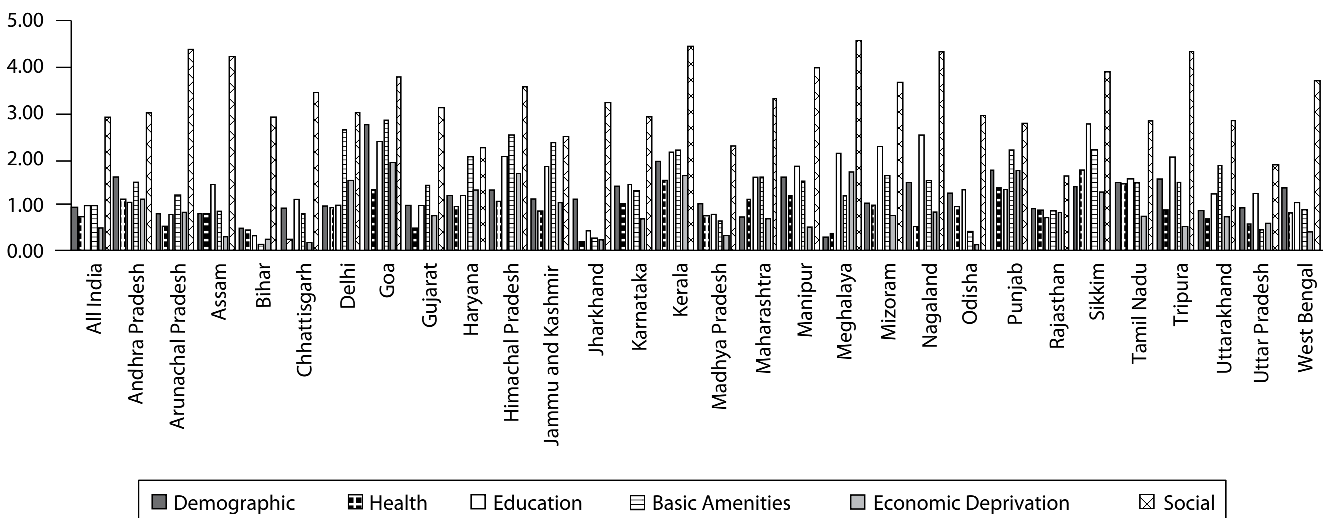

Figure 18.4 Rural SDI in Individual Dimensions

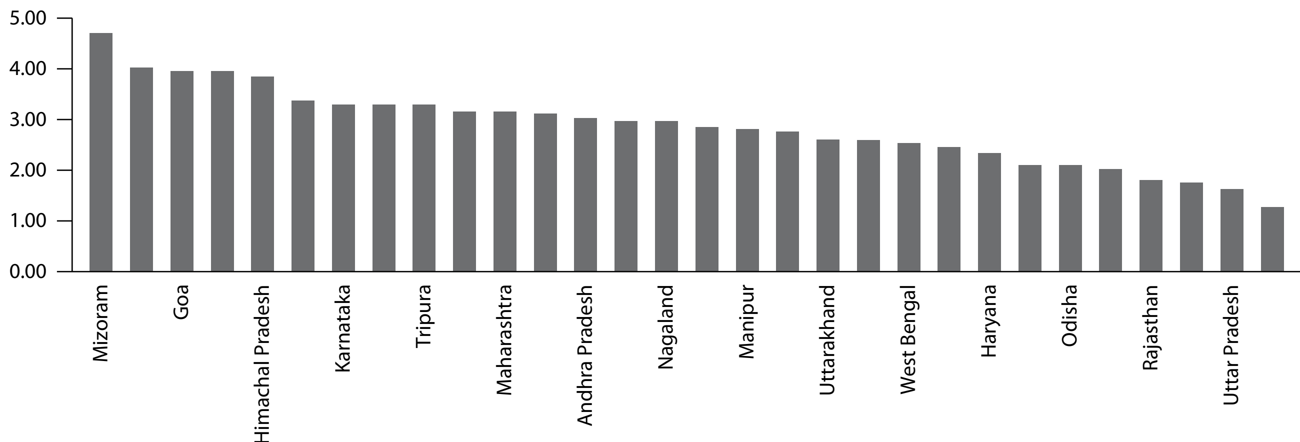

Figure 18.5 Urban SDI Scores

in six individual dimensions of Rural SDI is included in Table 18A.10. One can notice that the rural areas in Himachal Pradesh revealed progress in the education, basic amenities and economic dimensions. Similarly, the rural areas of Punjab have performed well in all the four dimensions, leaving aside the dimensions of education and social. On the other hand, the social development experiences of Mizoram revealed that the performances of rural areas lagged behind that of urban areas in all the six dimensions. In the same way, the state of Delhi went down in Rural SDI ranking due to inadequate attainments in demographic, educational and social dimensions.

The ranking of states changes yet again when we examine the social development experience according to the Urban-SDI classification. Thus the topmost position is now occupied by Mizoram followed by the states of Kerala, Goa, Sikkim, and Himachal Pradesh, which constitute the top five ranks (Figure 18.5). It is recognized that Himachal Pradesh is again placed within the top five ranks by replacing Delhi. One can additionally use Figure 18.6, which includes information on the ranking of states in individual dimensions of Urban-SDI, to comprehend the urban experience of social progress. A close examination of state's ranking of six individual dimensions of Urban SDI included in Table 18A.11 reveals that there is not much rural-urban divide in the social developments of Himachal Pradesh. However, the table also brings to light that the rural areas have performed better in education and basic amenities

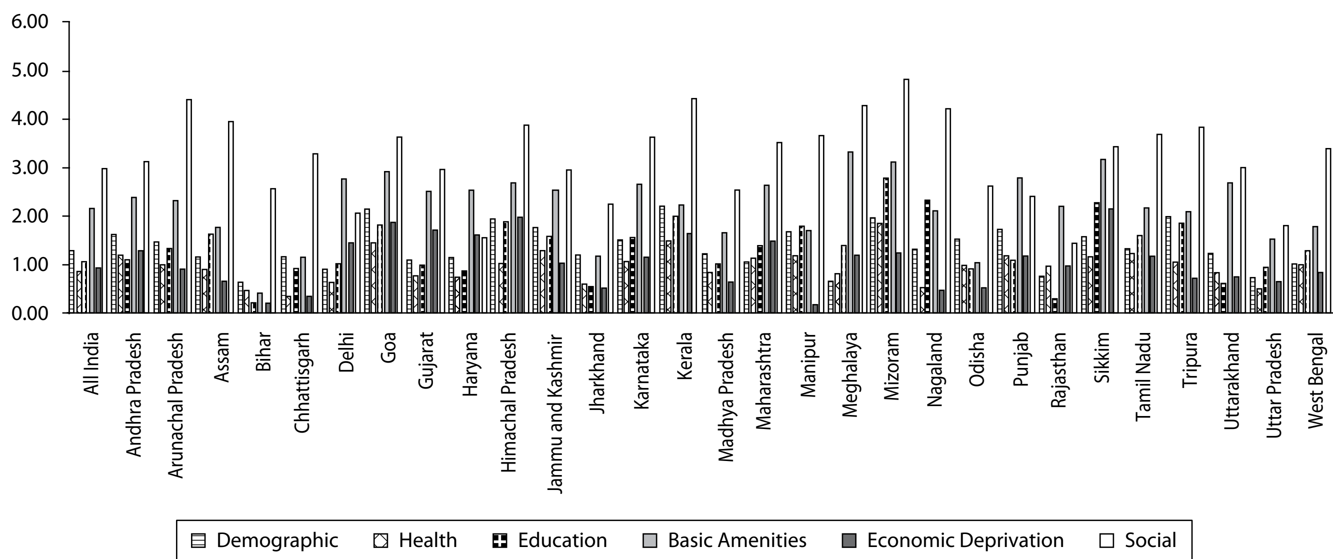

Figure 18.6 Urban SDI in Individual Dimensions

dimensions, whereas the urban areas excelled in the demographic, health, economic and social dimensions in the state.

Table 18.A12 provides a comparison of the PCA scores and ranks of Rural-SDI, Urban-SDI and Aggregate SDI of individual states. This information helps us in distinguishing any inconsistency between the rankings of SDI-Rural and SDI-Urban for any particular state. It can be perceived that the Urban-SDI registered progress ahead of Rural-SDI in 26 out of 29 states and also at the all-India level, with the highest disparity recoded for Mizoram, Meghalaya, Karnataka, Gujarat, Assam, and Arunachal Pradesh. In fact, it is only in three states of Delhi, Goa and Punjab that the Rural-SDI moved ahead of Urban-SDI. With the rural classification being somewhat artificial for the state of Delhi, it will just be the two states of Goa and Punjab, where Rural-SDI scores settled relatively higher than the Urban-SDI scores. On the contrary, the north-eastern state of Mizoram recorded scores in Urban SDI ahead of Rural-SDI or Aggregate-SDI scores. Last but not the least important is the fact about the social deprivation of states that scored the lowest rankings in the Rural SDI, Urban SDI as well as the Aggregate SDI. It is incontestably noted that seven states, largely from the *Hindi-Belt*, viz., Chhattisgarh, Rajasthan Odisha, Madhya Pradesh, Jharkhand, Uttar Pradesh and Bihar are placed in the lowest ranks of aggregate SDI ranking as well as in the rural or urban classification due to their worst demonstration in majority of the development dimensions.

SOCIAL SDI: SC, STs, AND NON-SC-ST

The backward classes, viz., scheduled castes (SCs) and scheduled tribes (STs) continue to suffer social and economic exclusion in India and thereby get in the way of country's inclusive development (GOI, 2016). We therefore work out the SDI for social groups, viz., SC, ST, and Non-SC-ST to assess progresses made by these marginalized sections of the society vis-à-vis the general population, as discussed in Table 18.2. The ranking of SDI-Social for SC is provided in Figure 18.7, where it is observed that Kerala, Goa, Delhi, Sikkim and Himachal Pradesh occupy the top five ranks, while Bihar, Arunachal Pradesh, Uttar Pradesh, Jharkhand, and Odisha fill the lowest five ranks. The ranking of SDI-Social for ST provided in Figure 18.9 reveal that Sikkim, Himachal Pradesh, Kerala, Goa and Tamil Nadu fit in the first five ranks, while Jharkhand, Bihar, Odisha, Rajasthan, and Uttar Pradesh obtain the last five ranks.

The states of Goa, Kerala and Sikkim, which had previously occupied top positions in aggregate SDI, performed equally well in the SDI scores of both SC and ST class of population. To pinpoint the area(s) of social deprivation for backward class, we use Figures 18.8 and 18.10 that furnishes information on the individual dimensional ranking of states in Social-SDI for SC and ST population, respectively. One can observe that Goa performed competently in four out of five dimensions of development for both the SC and ST class of population. That is, the SC class lagged in education and the ST class in economic dimension in the state. On the same account, the achievements in the educational and economic dimension for both the SC and ST class remained low in the state of Kerala. In the state of Sikkim, the SC (ST) class is found to underperform in the economic (education and economic) aspects. The SC population of Delhi has apparently done well in all dimensions except for the demographic and educational segments,

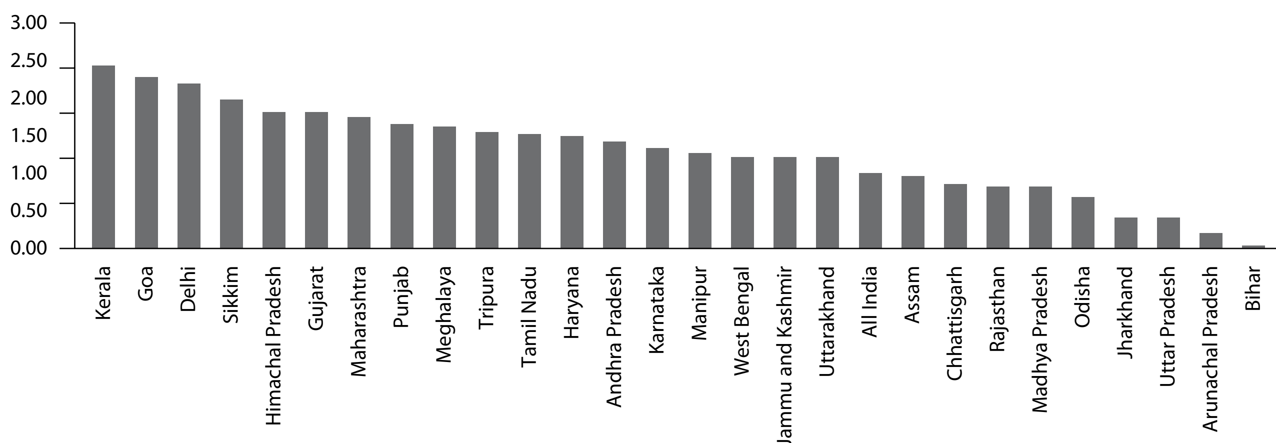

Figure 18.7 Social SDI Scores: Scheduled Castes

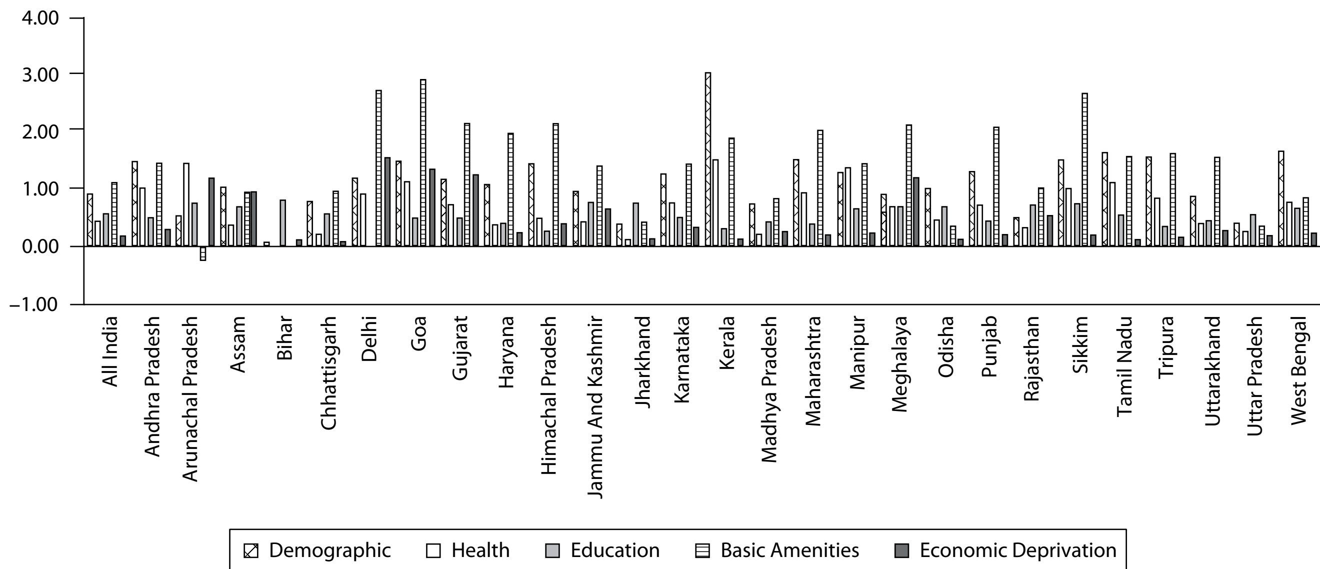

Figure 18.8 Social SDI in Individual Dimensions: Scheduled Castes

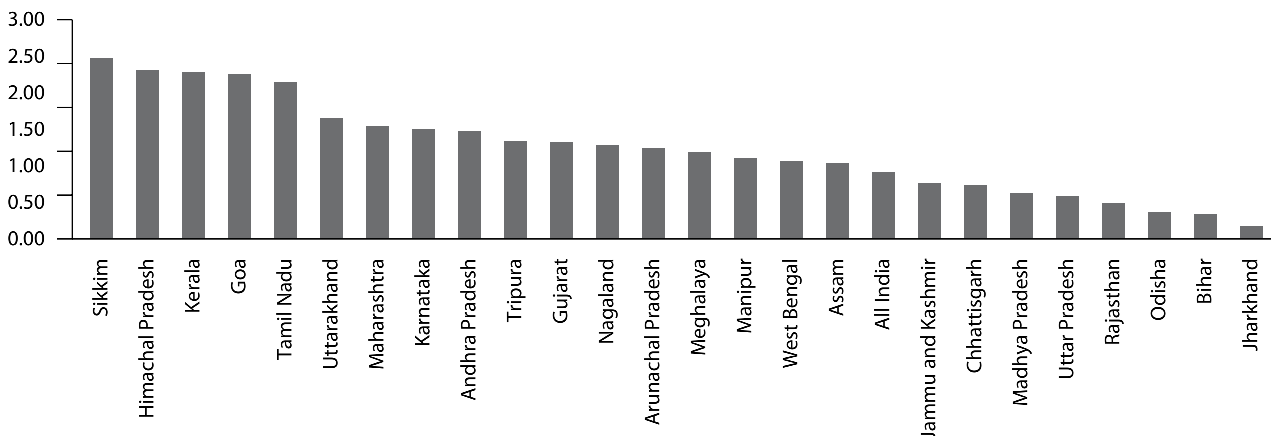

Figure 18.9 Social SDI Scores: Scheduled Tribes

whereas the ST population of Himachal Pradesh lagged behind in economic dimension. The ST population of Tamil Nadu has done well in all dimensions except for the educational component, while the SC population of Gujarat lagged behind in dimensions of demography, health and education in spite of doing well in the basic amenities and economic aspects.

The states of Bihar, Jharkhand, Uttar Pradesh, Odisha, Madhya Pradesh, and Rajasthan continue to record social deprivation for both the SCs and STs, and therefore remained at the bottom of the Social SDI rankings. In this regard, a mention can be made of Assam for recording greater social deprivation for the non-SC-ST class of population in the state (Figure 18.11). In fact, an analysis of information on the ranking of states in individual dimensions of Social-SDI for non-SC-ST population reveal that the non-SC-ST population lagged behind the SC or ST class of population in all excepting for the educational dimensions (Figure 18.12). Tables 18A.13, 18A.14, and 18A.15 include the state's rankings in all the five individual dimensions for social groups SC, ST and Non-SC-ST class of population, respectively.

The comparison of PCA scores and rankings of SDI-SC, SDI-ST and SDI-Non-SC-ST of individual states are provided in Table 18.A16, and it can be seen that the all-India recorded a position of nineteenth in the SDI-SC ranking and eighteenth in both the SDI-ST

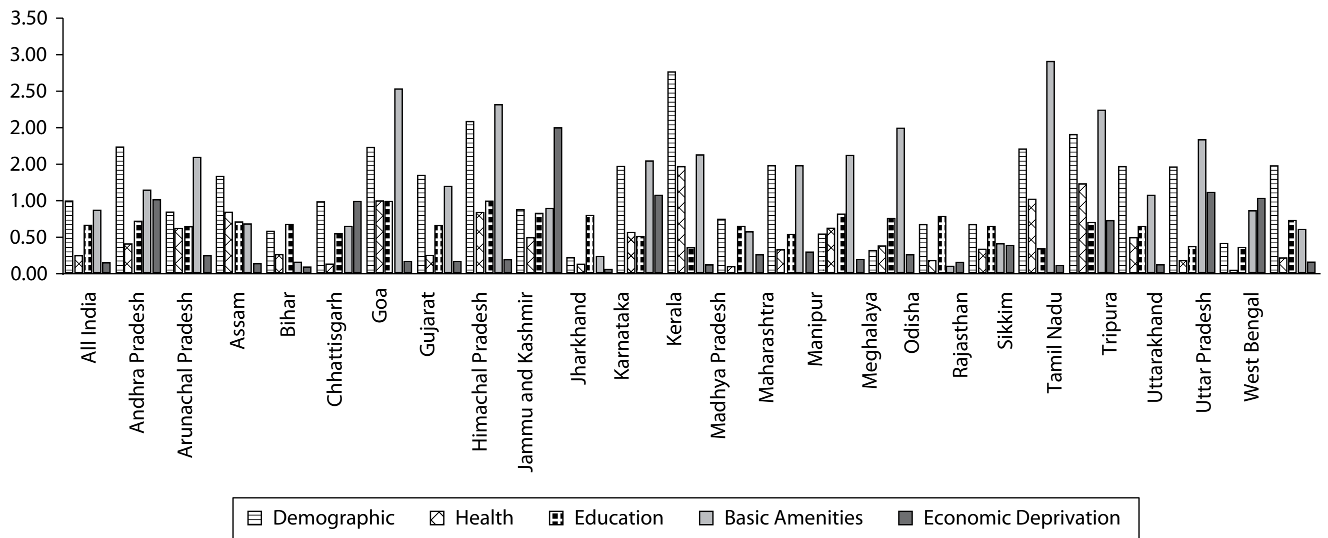

Figure 18.10 Social SDI Scores in Individual Dimensions: Scheduled Tribes

and SDI-Non-SC-ST rankings. Information from this table can be meaningfully used for examining the equivalence among rankings of SDI-SC, SDI-ST and SDI-Non-SC-ST for a particular state. For instance, a wide variations between the rankings of SDI-SC or SDI-ST vis-à-vis SDI-Non-SC-ST would indicate that the backward class population are lagging behind (or drawing level) with the non-backward class of population. It can be recognized that the SDI for SC moved behind SDI for Non-SC-ST–indicating lesser social development for SC population–in twenty one out of twenty seven states as well as in all-India. It is only the six states, viz., Assam, Gujarat, Kerala, Meghalaya, Sikkim and Tripura that demonstrate the opposite attribute of SC population moving ahead of Non-SC-ST population in social development. While the differences between the SDI rankings of SC and Non-SC-ST remains nominal for certain states, the states of Arunachal Pradesh, Punjab and Himachal Pradesh exhibited the highest degrees of disparity between the two.

Correspondingly, we observe that SDI for ST moved behind SDI for Non-SC-ST—indicating slower social development for ST population—in seventeen out of twenty five states as well as in all-India. There are eight states, viz., Arunachal Pradesh, Assam, Bihar, Kerala, Nagaland, Sikkim, Tamil Nadu, and Uttar Pradesh reveal the converse feature by which the ST population progressed ahead of Non-SC-ST population in social development. It may be noted that only Jammu and

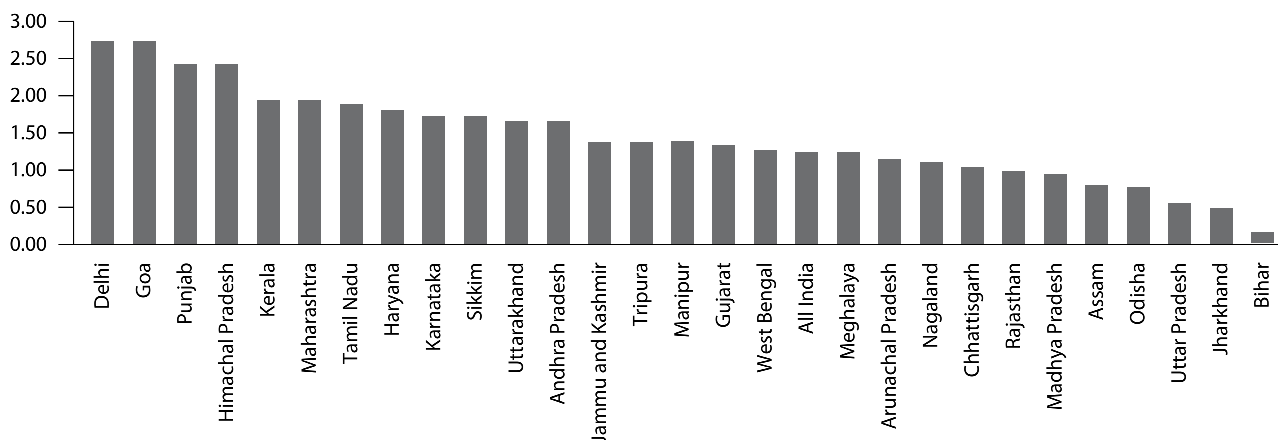

Figure 18.11 Social SDI Scores: Non-SC-ST

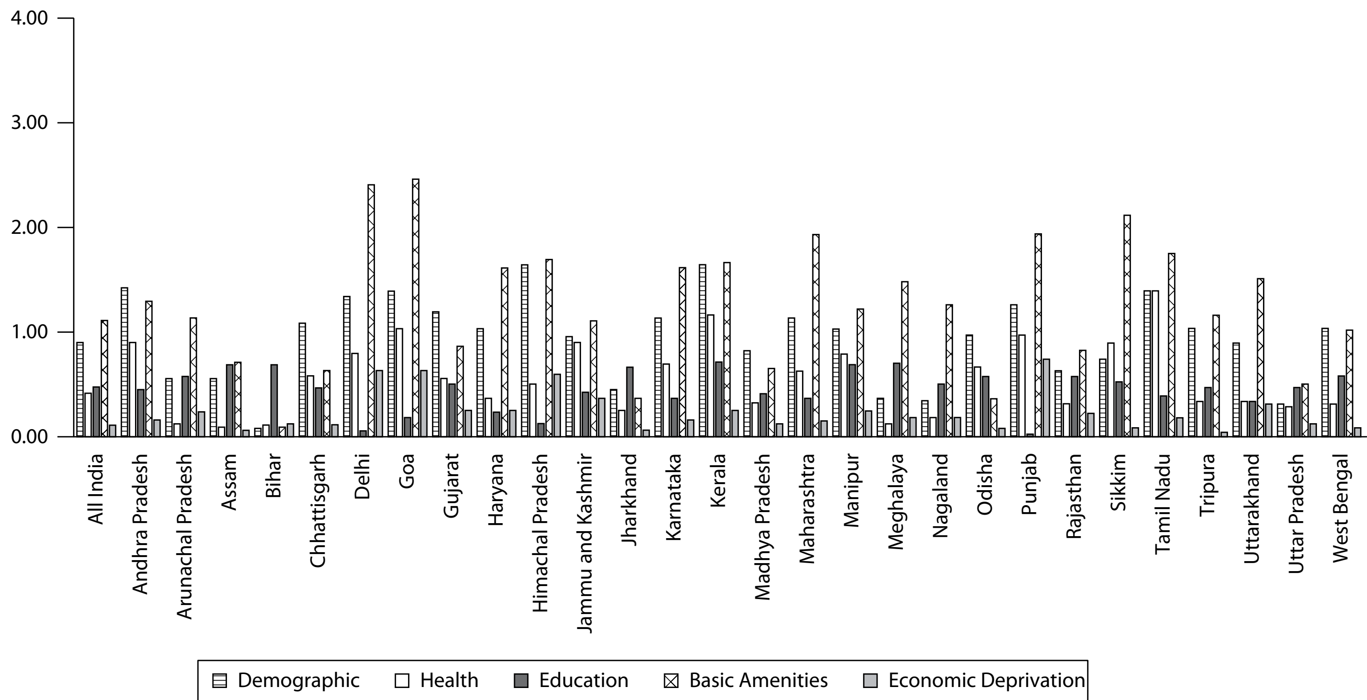

Figure 18.12 Social SDI in Individual Dimensions: Non-SC-ST

Kashmir and Goa demonstrated the highest degrees of disparity in this regard. As a final point, we provide a comparison of rankings between SDI-SC and SDI-ST in a particular state. It can be revealed that the SDI for SC moved ahead of the SDI for ST—indicating greater social deprivation for the ST population—in seventeen out of twenty-four states as well as in all-India. The degree of disparity is registered highest in the states of Gujarat, Jammu and Kashmir, and Rajasthan. It may be noted that there are only seven states, where the ST population progressed ahead of SC population in social development, which are Arunachal Pradesh, Assam, Bihar, Karnataka, Sikkim, Tamil Nadu, and Uttar Pradesh.

SDI MALE AND SDI FEMALE

It is common to find that gender discrimination in India that starts from the sex determination test and abortion of the female fetuses, and continues to discriminations in girl's nutrition and schooling through the gender discriminations in wage and employment or unequal inheritance. While there has been a marginal increase in the country's sex ratio from 933 in 2001 to 940 in 2011, significant variations exist between Kerala recording a sex ratio in favour of women vis-à-vis Delhi, Chandigarh, or Haryana that have an adverse sex ratio. Some of the states display sharp gender inequality in health and education, so that it is common to find girls recording higher infant mortality or school drop-out rates. A high unemployment rate for female is evident in other states, along with the concentration of women workers in casual, unskilled and low paid jobs. To capture the male-female disparity in social development, the SDI across gender is built on the basis of three dimensions of health, education and economic and covering six indicators as given in Table 18.3. The rankings of SDI-Gender are provided individually for male in Figure 18.13 and for female in Figure 18.15, respectively. It is found that Kerala, Sikkim, Manipur, Mizoram and Goa represented the top five ranks in SDI-Male. The ranking in the case of SDI-Female changed to Kerala, Mizoram Sikkim, Goa and Manipur. On the other hand, states like Madhya Pradesh, Jharkhand, Bihar, Chhattisgarh, Uttar Pradesh, and Odisha remained at the bottom of the rankings in both SDI-Male and SDI-Female sequences. Interestingly, twenty two states have performed better than the all-India level in SDI-Female as compared to seventeen states achieving better than the all-India in SDI-Male in the sample of twenty-nine states.

The information on individual state's rankings in all the three constituent dimensions is also provided individually for male in Figure 18.14 and for female in Figure 18.16,

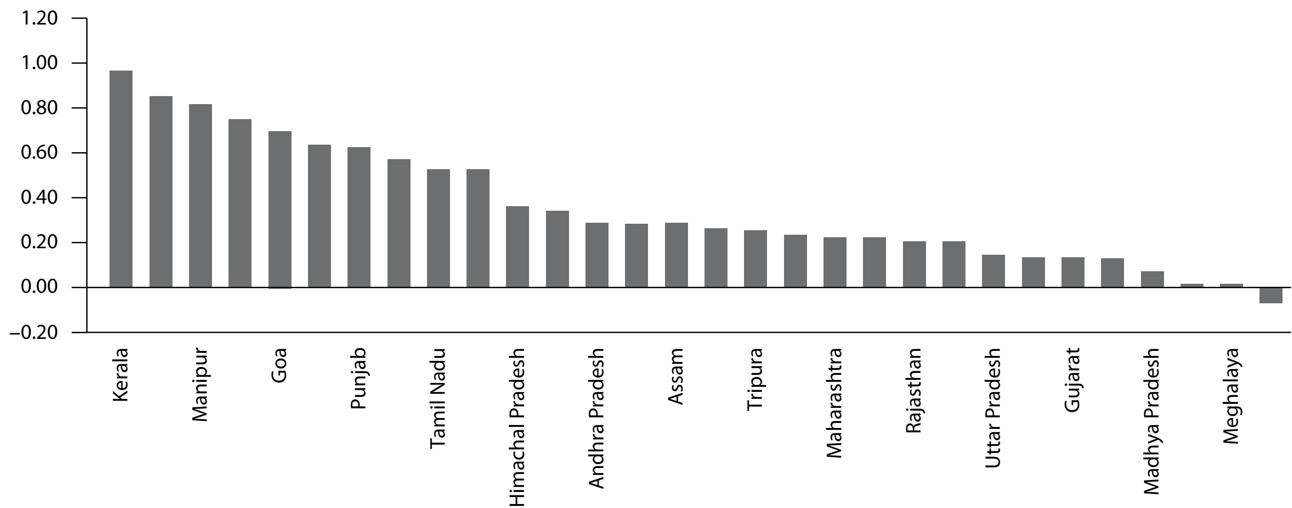

Figure 18.13 Male SDI Scores

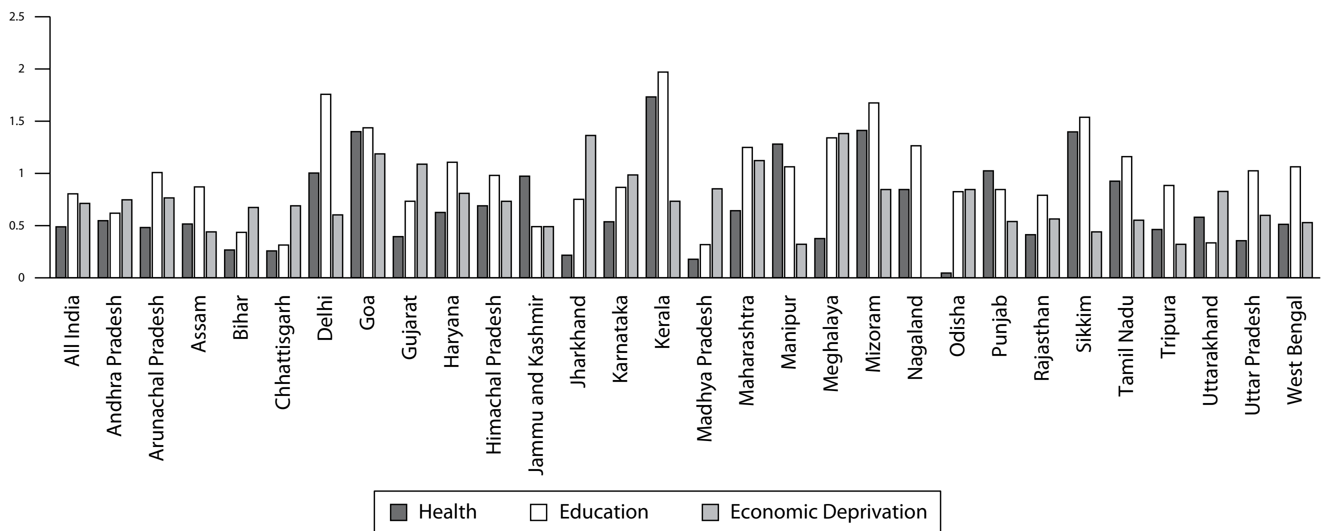

Figure 18.14 Male SDI in Individual Dimensions

respectively. The state's rankings in three separate dimensions reveal that Kerala has ranked high among states in health and education but lagged behind in economic provision for both the genders. The male as well as female class have performed well on the health and education dimension in Sikkim and Goa, but a specific gender, viz., males in Sikkim and females in Goa fell behind their counterparts on the economic ranking in both the states. In Mizoram, both the genders seem to have done consistently well in all the three dimensions. However, Manipur depicted a case where both the male and female gender excelled in the health aspect but suffered equally in education and economic dimensions. It may also be observed that states like Jharkhand, Uttar Pradesh, Rajasthan, Madhya Pradesh, Gujarat, or Chhattisgarh may have remained progressive enough in providing economic opportunities to females, but are also the worst performers in the areas of female health and education. On the contrary, Delhi, Goa and Punjab seem to have achieved success in the remaining dimensions alongside progress made in women's economic freedom. Table 18A.17 provides state's rankings in all the three individual dimensions for both the sexes.

The comparison of the PCA scores and rankings of SDI-Male and SDI-Female of individual states are provided in Table 18A.18. We use this information to examine the uniformity between the SDI rankings of males and

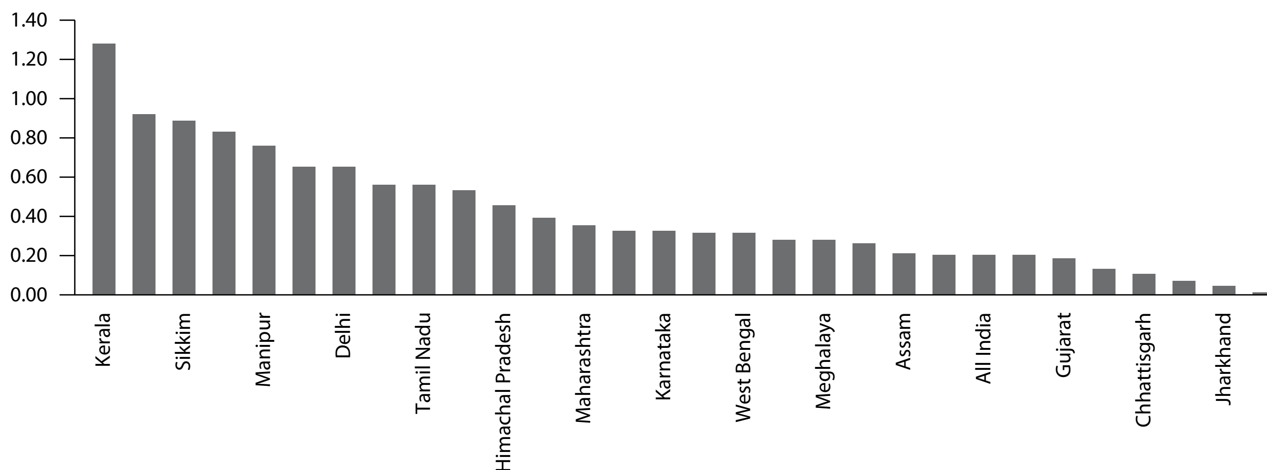

Figure 18.15 Female SDI Scores

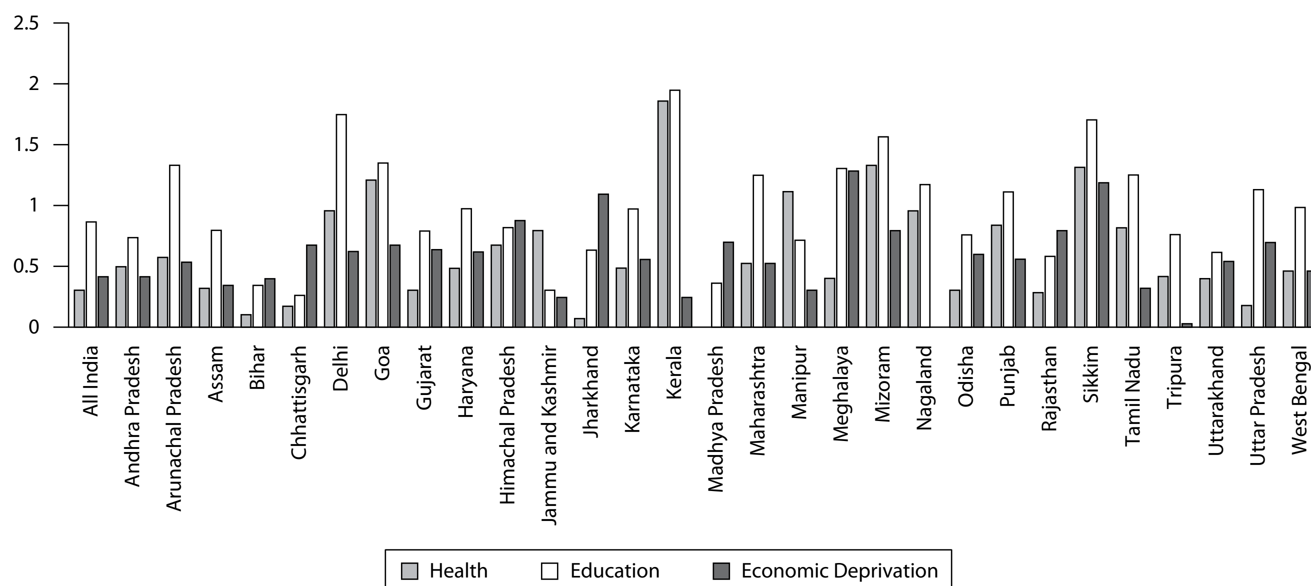

Figure 18.16 Female SDI in Individual Dimensions

females in various states. A sharp divergence between the two rankings may imply unequal development outcomes between male and females. It can be seen that the SDI for female moving behind SDI for male-indicating gender disparity against female in social development—is apparent only in ten out of twenty-nine states as well as in all-India. Thus, there are nineteen states in India, viz., six from north-east India (Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Sikkim, and Tripura), four from south (Andhra Pradesh, Karnataka, Kerala, Tamil Nadu), three each from north (Delhi, Haryana, Himachal Pradesh), east (Jharkhand, Odisha, West Bengal) and west (Goa, Gujarat, and Maharashtra) exhibited superior social development ranks for women. While the discrepancy between the SDI rankings of male and females remains insignificant for some states, Jharkhand, Maharashtra, and Mizoram revealed the highest degrees of gap between the two in this respect.

* * *

A composite social development index clearly remains one of the better alternatives to measure social development across states of India. This is so because the practice of using a single indicator such as the state level per capita income on the assumption that development is synonymous with rising income levels has been subjected to sharp criticisms.

Furthermore, the multi-dimensional nature of the indices offers a broader framework of social development and allows us to rank the states of India on the basis of their performances in individual as well in aggregate indicators. It is relevant to recall that the HDI—as a measure—laid emphasis upon individual capabilities and therefore accounted only for health, education and levels of income. The Human Development Report, 2015, positioned India at 130th among 186 countries on HDI ranking (UNDP, 2015 a). This clearly conveys that India has much catching up to do in providing people the access to health and education. Recently, GOI [2016] indicated that investment in human capital by way of education, skill development, training and provision of health care would enhance the productivity of the workforce, and therefore argued that social infrastructure with its positive externalities would bear a significant role in the economic development and welfare of the Indian population (GOI 2016). Further, several studies and policy documents have highlighted the need for empowering the disadvantaged classes in economic and social outcomes in achieving the inclusive development goals (GOI, 2009, GOI 2013; UNDP 2015 b).

The social development index (SDI) is conceived in a wider spectrum of development characteristics and therefore combined additional indicators of development in the measure. The aspects, such as social discrimination, gender inequality or lack of basic amenities can have some major bearing on whether individuals are able to attain the central dimensions of human life. We provide the social indicators of development by synthesizing about six dimensions, such as demographic, health, education, basic amenities of life, income, and employment and social inclusion, and covering twenty-one indicators. Further, to properly understand the unequal progresses made by Indian states in the overall social development, we have worked out disaggregated SDIs from three different perspectives of inequality, viz., areas of residence, social groups and male vis-à-vis female.

The states that have performed well in the overall SDI-2016 include Goa, Kerala, Sikkim, Mizoram, and Delhi, while states like Chhattisgarh, Rajasthan Odisha, Madhya Pradesh, Jharkhand, Uttar Pradesh, and Bihar continue to rank low in many indicators of social development. The social development in the states of Himachal Pradesh and Punjab appears to be driven largely by the rural sector, while there is an obvious urban orientation in the social developments of Delhi and Mizoram. The states of Kerala, Goa, Sikkim, Himachal Pradesh, Delhi, Tamil Nadu and Gujarat have done well in supporting the marginalized groups (SCs and/or STs), whereas Bihar, Jharkhand, Uttar Pradesh, Odisha, Madhya Pradesh, and Rajasthan continue to record social deprivation for both the disadvantaged groups. Finally, there are states, viz., Kerala, Mizoram, Sikkim, Goa and Manipur, which performed well in reducing the gender discrimination of social development, while states like Madhya Pradesh, Jharkhand, Bihar, Chattisgarh, Uttar Pradesh, and Odisha lagged quite noticeably in female-specific social development. Kerala as well as Goa have excelled in various scales of social development indicators and projected figures way above the national average in all respects. The functioning of social development in the north-eastern states of Mizoram and Sikkim remained convincing in many dimensions. Finally, although the seven states from the *Hindi-Belt* are frequently placed low in the aggregate SDI ranking due to their poor display in nearly all the development dimensions, one can identify some areas of progress for the same states in specific dimensions. The disaggregated dimension-specific ranking of aggregate SDI helps us to recognize improvements for Chhattisgarh in the social dimension, and similarly for Rajasthan in health and economic dimensions, Odisha in demographic, health and educational dimension, Uttar Pradesh in the educational dimension and Uttarakhand in the basic amenities dimension.

Table 18.4 provides comparison among SDI-2016, SDI-2014, SDI-2012, MDI-2011-12, and HDI-2010 rankings. It may be noted that while the three SDI sequences remains comparable, they are not strictly analogous with the MDI or HDI series for their obvious differences in definition, coverage and data-point of reference. The HDI is conceived simply over domains of health, education and income attainments; whereas the MDI goes on to consider several physical infrastructural indicators. In spite of the differences, one can notice a broad similarity in the ranking orders, that is, the top two positions are occupied by Goa and Kerala in both the SDI and MDI rankings, whereas the first five ranks remain uniform in both the SDI and HDI series. One can also observe that the lowest ranked states in SDI, viz., Bihar, Uttar Pradesh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, and Chhattisgarh are also placed at the bottom in both the HDI and MDI rankings. Table 18.4 reveals that the nature of ranking in aggregate SDI 2016 did not change much from the same in SDI 2014. As the ranking movements from SDI 2012 to SDI 2016 are concerned, we note that the Goa and Kerala remain the top ranking states in SDI-2014 as well as in SDI 2016. The other two top-ranking states, viz., Sikkim and Mizoram are placed ahead of Delhi, which had been the top-ranking state in SDI-2012. There is however no

Table 18.4 Comparison of State Rankings in SDI, MDI, and HDI

States	SDI-2016	SDI-2014	SDI-2012	MDI -2011–12	HDI-2010*
Goa	1	1	2	1	4
Kerala	2	2	3	2	1
Sikkim	3	4	–	9	–
Mizoram	4	3	–	12	–
Delhi	5	5	1	–	2
Punjab	6	9	5	4	5
Himachal Pradesh	7	6	4	7	3
Tamil Nadu	8	7	6	3	8
Maharashtra	9	8	9	5	7
Manipur	10	10	–	18	–
Karnataka	11	11	10	10	12
Tripura	12	13	–	11	–
Meghalaya	13	14	–	21	–
Nagaland	14	15	–	17	–
Andhra Pradesh	15	12	11	15	15
Haryana	16	16	12	8	9
Arunachal Pradesh	17	20	–	23	–
West Bengal	18	19	14	16	13
Jammu & Kashmir	19	18	7	14	10
Uttarakhand	20	17	8	6	14
Gujarat	21	21	13	13	11
All India	22	22	16	–	16
Assam	23	23	15	22	17
Chhattisgarh	24	24	17	25	24
Rajasthan	25	25	18	19	18
Odisha	26	26	19	28	23
Madhya Pradesh	27	27	20	27	21
Jharkhand	28	28	22	24	20
Uttar Pradesh	29	29	21	20	19
Bihar	30	30	23	26	22

Source: Author's Calculations, GOI [2013] for MDI and GOI [2011] for HDI.
*The 6th rank in HDI belongs to the combined north-eastern states (excluding Assam), which is not included here.

major change on the nature of the state's ranking at the bottom of the sequences of SDI-2014 and SDI-2016.

The aspect of regional disparity in India is so apparent that the per capita net state domestic products (NSDP) of richer states remain at more than three times of the same in poorer states. We therefore inquire whether the states that are economically progressive in India are also the ones with top ranks in social developments. Figure 18.17 provides a scatter-plot of the Aggregate-SDI and per capita NSDP of all twenty-nine states plus all-India, along with the information on correlation coefficient and the statistical trend line fitted around the observations. We observe a high positive correlation between the two indicating social developments progressing along with rising per capita income, so that the fitted trend also yielded a reasonably positive sloped line. By following the

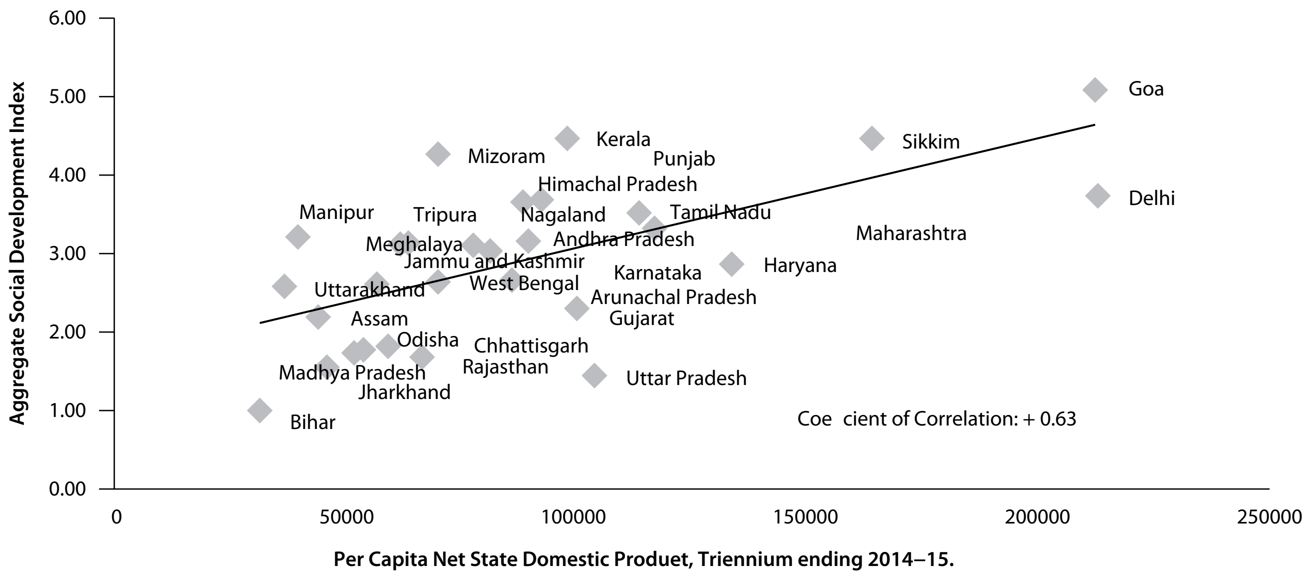

Figure 18.17 Economic Growth and Social Development

contribution of Ranis, Stewart and Ramirez [2000], the scatter-plot of Figure 18.17 can be demarcated into four quadrants, distinguishing patterns of social development achievements and per capita income levels.

These are: (1) high per capita income with high SDI, (2) low per capita income with low SDI, (3) low per capita income with high SDI, and (4) high per capita income with low SDI. The states of Goa (ranked 1st), Sikkim (ranked 3rd) and Delhi (ranked 5th) would definitely fall in the category of virtuous cycle of growth, whereas, Bihar (ranked 29th), Assam (ranked 22nd), Madhya Pradesh (ranked 25th), Odisha (ranked 24th) and Jharkhand (ranked 27th) belong to the vicious cycle of growth. The other two patterns incorporate cases where either growth or social development remains lopsided. Thus, Manipur (ranked 10th) or Mizoram (ranked 4th) are examples of lopsided social development featuring high social development and low per capita income, whereas Uttar Pradesh (ranked 28th) is featured with lopsided growth marked with high per capita income and low social developments. The poor performances in social development for a particular state in India has often been linked to the ineffectiveness of various government schemes and programmes on account of their leakages in delivery mechanism. The various SDIs constructed in this chapter are functional tools that can be used to determine the dimensions of deprivation in individual states and help in setting specific development priorities.

Table 18A.1 Correlation among Dimensions of Rural SDI

	Demographic	Health	Education	Basic amenities	Economic	Social
Demographic	1					
Health	0.62	1				
Education	0.43	0.53	1			
Basic amenities	0.52	0.63	0.59	1		
Economic	0.40	0.49	0.48	0.81	1	
Social	0.16	0.06	0.55	0.18	0.16	1

Table 18A.2 Correlation among Dimensions of Urban SDI

	Demographic	Health	Education	Basic amenities	Economic	Social
Demographic	1					
Health	0.74	1				
Education	0.67	0.64	1			
Basic amenities	0.33	0.55	0.50	1		
Economic	0.34	0.48	0.36	0.76	1	
Social	0.51	0.49	0.78	0.32	0.13	1

Table 18A.3 Correlation among Dimensions of Aggregate SDI

	Demographic	Health	Education	Basic amenities	Economic	Social
Demographic	1					
Health	0.70	1				
Education	0.49	0.61	1			
Basic amenities	0.53	0.74	0.67	1		
Economic	0.36	0.53	0.46	0.81	1	
Social	0.23	0.16	0.62	0.29	0.12	1

Table 18A.4 Correlation among Dimensions of Social SDI: Scheduled Caste

	Demographic	Health	Education	Basic amenities	Economic
Demographic	1				
Health	0.66	1			
Education	–0.47	–0.18	1		
Basic amenities	0.49	0.45	–0.20	1	
Economic	–0.13	0.32	0.19	0.43	1

Table 18A.5 Correlation among Dimensions of Social SDI: Scheduled Tribe

	Demographic	Health	Education	Basic amenities	Economic
Demographic	1				
Health	0.67	1			
Education	–0.04	–0.06	1		
Basic amenities	0.51	0.66	0.12	1	
Economic	0.04	–0.14	–0.24	0.01	1

Table 18A.6 Correlation among Dimensions of Social SDI: Non SC-ST

	Demographic	Health	Education	Basic amenities	Economic
Demographic	1				
Health	0.75	1			
Education	–0.55	–0.36	1		
Basic amenities	0.59	0.58	–0.61	1	
Economic	0.49	0.41	–0.70	0.68	1

Table 18A.7 Correlation among Dimensions of Gender SDI: Male

	Health	Education	Economic
Health	1		
Education	0.71	1	
Economic	–0.23	–0.01	1

Table 18A.8 Correlation among Dimensions of Gender SDI: Female

	Health	Education	Economic
Health	1		
Education	0.73	1	
Economic	–0.14	0.14	1

Table 18A.9 State Rankings in Individual Indicators of Aggregate SDI

Sr. no.	States	Demographic	Health	Education	Basic amenities	Economic	Social
1	Andhra Pradesh	5	8	22	14	9	17
2	Arunachal Pradesh	26	23	27	18	15	3
3	Assam	28	19	15	24	27	6
4	Bihar	29	28	30	30	28	23
5	Chhattisgarh	23	30	23	26	29	13
6	Delhi	15	13	14	2	2	25
7	Goa	1	4	4	1	1	10
8	Gujarat	19	26	24	22	10	18
9	Haryana	17	14	19	10	8	28
10	Himachal Pradesh	12	12	8	8	4	11
11	Jammu & Kashmir	16	11	11	19	14	26
12	Jharkhand	18	29	29	29	26	22
13	Karnataka	10	10	13	11	16	16
14	Kerala	2	2	5	9	5	2
15	Madhya Pradesh	22	21	26	25	23	27
16	Maharashtra	24	9	12	5	11	14
17	Manipur	4	7	9	16	25	8
18	Meghalaya	30	27	6	13	3	1
19	Mizoram	11	3	3	3	12	7
20	Nagaland	9	24	2	15	19	5
21	Odisha	14	17	17	28	30	19
22	Punjab	3	6	16	6	7	24
23	Rajasthan	25	16	28	23	17	30
24	Sikkim	13	1	1	4	6	9
25	Tamil Nadu	8	5	10	7	13	15
26	Tripura	6	15	7	17	24	4
27	Uttar Pradesh	27	25	18	27	21	29
28	Uttarakhand	20	22	21	12	18	20
29	West Bengal	7	18	20	21	22	12
30	All India	21	20	25	20	20	21

Source: Author's Calculation.

Table 18A.10 State Rankings in Individual Indicators of Rural SDI

Sr. no.	States	Demographic	Health	Education	Basic amenities	Economic	Social
1	Andhra Pradesh	4	7	21	14	9	18
2	Arunachal Pradesh	27	25	27	19	12	3
3	Assam	26	18	13	24	26	6
4	Bihar	29	27	30	30	27	22
5	Chhattisgarh	21	29	20	25	29	13
6	Delhi	20	14	23	2	6	17
7	Goa	1	5	3	1	1	9
8	Gujarat	19	26	25	17	16	16
9	Haryana	14	13	19	8	7	28
10	Himachal Pradesh	12	9	7	3	4	12
11	Jammu & Kashmir	16	15	10	4	10	26
12	Jharkhand	15	30	29	29	28	15
13	Karnataka	9	10	14	18	18	20
14	Kerala	2	2	5	5	5	2
15	Madhya Pradesh	17	20	26	26	25	27
16	Maharashtra	28	8	11	11	19	14
17	Manipur	5	6	9	12	22	7
18	Meghalaya	30	28	6	20	3	1
19	Mizoram	18	11	4	10	14	11
20	Nagaland	8	24	2	13	13	4
21	Odisha	13	12	15	28	30	19
22	Punjab	3	4	16	7	2	25
23	Rajasthan	22	17	28	23	11	30
24	Sikkim	10	1	1	6	8	8
25	Tamil Nadu	7	3	12	16	15	23
26	Tripura	6	16	8	15	21	5
27	Uttar Pradesh	23	23	17	27	20	29
28	Uttarakhand	25	22	18	9	17	24
29	West Bengal	11	19	22	22	24	10
30	All India	24	21	24	21	23	21

Source: Author's Calculation.

Table 18A.11 State Rankings in Individual Indicators of Urban SDI

Sr. no.	States	Demographic	Health	Education	Basic amenities	Economic	Social
1	Andhra Pradesh	9	7	18	14	9	17
2	Arunachal Pradesh	13	14	15	15	18	3
3	Assam	19	18	9	22	24	6
4	Bihar	30	29	30	30	29	23
5	Chhattisgarh	21	30	24	28	28	16
6	Delhi	26	25	20	6	8	27
7	Goa	2	3	7	4	3	12
8	Gujarat	23	23	21	13	4	21
9	Haryana	22	24	26	11	5	29
10	Himachal Pradesh	5	13	5	7	2	7
11	Jammu & Kashmir	6	4	12	12	15	20
12	Jharkhand	18	26	28	27	26	26
13	Karnataka	12	11	11	9	14	10
14	Kerala	1	2	4	17	6	2
15	Madhya Pradesh	20	22	22	25	22	24
16	Maharashtra	24	10	13	10	7	13
17	Manipur	8	9	8	24	30	11
18	Meghalaya	29	20	14	1	12	4
19	Mizoram	4	1	1	3	10	1
20	Nagaland	15	27	2	21	27	5
21	Odisha	11	16	25	29	25	22
22	Punjab	7	6	17	5	11	25
23	Rajasthan	27	17	29	16	16	30
24	Sikkim	10	8	3	2	1	14
25	Tamil Nadu	14	5	10	18	13	9
26	Tripura	3	12	6	20	21	8
27	Uttar Pradesh	28	28	23	26	23	28
28	Uttarakhand	17	21	27	8	20	18
29	West Bengal	25	15	16	23	19	15
30	All India	16	19	19	19	17	19

Source: Author's Calculation.

Table 18A.12 SDI Scores and Ranks of Individual States, Rural, Urban and Aggregate

Sr. no.	States	SDI rural		SDI urban		SDI aggregate	
		Scores	Ranks	Scores	Ranks	Scores	Ranks
1	Andhra Pradesh	2.69	13	3.52	13	3.02	15
2	Arunachal Pradesh	2.25	19	3.81	8	2.66	17
3	Assam	1.97	22	3.20	18	2.19	23
4	Bihar	1.01	30	1.47	30	1.01	30
5	Chhattisgarh	1.59	26	2.36	26	1.82	24
6	Delhi	3.12	6	2.85	22	3.74	5
7	Goa	4.67	1	4.59	3	5.10	1
8	Gujarat	2.16	20	3.31	16	2.29	21
9	Haryana	2.73	12	2.74	23	2.87	16
10	Himachal Pradesh	3.64	4	4.46	5	3.65	7
11	Jammu & Kashmir	2.86	7	3.61	12	2.59	19
12	Jharkhand	1.38	28	2.04	28	1.54	28
13	Karnataka	2.37	17	3.83	7	3.16	11
14	Kerala	4.13	2	4.66	2	4.46	2
15	Madhya Pradesh	1.48	27	2.45	24	1.73	26
16	Maharashtra	2.37	16	3.62	11	3.33	9
17	Manipur	2.85	8	3.25	17	3.22	10
18	Meghalaya	2.54	15	3.90	6	3.12	13
19	Mizoram	2.74	11	5.45	1	4.26	4
20	Nagaland	2.84	9	3.40	15	3.11	14
21	Odisha	1.60	25	2.42	25	1.77	25
22	Punjab	3.45	5	3.44	14	3.68	6
23	Rajasthan	1.61	24	2.09	27	1.68	27
24	Sikkim	3.92	3	4.54	4	4.46	3
25	Tamil Nadu	2.64	14	3.65	10	3.51	8
26	Tripura	2.81	10	3.79	9	3.14	12
27	Uttar Pradesh	1.38	29	1.87	29	1.45	29
28	Uttarakhand	2.30	18	3.04	19	2.56	20
29	West Bengal	2.09	21	2.94	21	2.64	18
30	All India	1.80	23	3.02	20	2.26	22

Source: Author's Calculation.

Table 18A.13 State Rankings in Individual Indicators of Social SDI-Scheduled Castes

Sr. no.	States	Demographic	Health	Education	Basic amenities	Economic
1	Andhra Pradesh	8	7	18	14	11
2	Arunachal Pradesh	24	2	4	28	4
3	Assam	16	22	7	21	27
4	Bihar	28	28	1	27	26
5	Chhattisgarh	22	25	12	20	28
6	Delhi	13	8	28	2	1
7	Goa	7	4	16	1	2
8	Gujarat	14	14	20	5	3
9	Haryana	15	21	23	9	14
10	Himachal Pradesh	9	16	27	4	8
11	Jammu & Kashmir	18	18	2	17	6
12	Jharkhand	26	27	3	24	23
13	Karnataka	12	11	17	16	9
14	Kerala	1	1	26	10	25
15	Madhya Pradesh	23	26	21	23	15
16	Maharashtra	6	9	24	8	16
17	Manipur	11	3	11	15	12
18	Meghalaya	19	15	9	6	5
19	Mizoram	–	–	–	–	–
20	Nagaland	–	–	–	–	–
21	Odisha	17	17	8	26	24
22	Punjab	10	13	22	7	18
23	Rajasthan	25	23	6	19	7
24	Sikkim	5	6	5	3	19
25	Tamil Nadu	3	5	14	12	22
26	Tripura	4	10	25	11	20
27	Uttar Pradesh	27	24	15	25	17
28	Uttarakhand	22	20	19	13	10
29	West Bengal	2	12	10	22	13
30	All India	20	19	13	18	21

Source: Author's Calculation.

Table 18A.14 State Rankings in Individual Indicators of Social SDI–Scheduled Tribes

Sr. no.	States	Demographic	Health	Education	Basic amenities	Economic
1	Andhra Pradesh	4	13	9	14	4
2	Arunachal Pradesh	17	8	17	10	12
3	Assam	13	5	10	19	23
4	Bihar	22	17	16	25	25
5	Chhattisgarh	15	23	20	20	6
6	Delhi	–	–	–	–	–
7	Goa	6	4	1	2	16
8	Gujarat	12	19	13	13	18
9	Haryana	–	–	–	–	–
10	Himachal Pradesh	2	6	2	3	14
11	Jammu & Kashmir	16	12	3	16	1
12	Jharkhand	26	24	5	24	26
13	Karnataka	9	9	22	11	3
14	Kerala	1	1	25	8	21
15	Madhya Pradesh	18	25	19	22	11
16	Maharashtra	7	16	21	12	10
17	Manipur	23	7	4	9	13
18	Meghalaya	25	14	7	5	9
19	Mizoram	–	–	–	–	
20	Nagaland	21	10	14	7	24
21	Odisha	19	21	6	26	17
22	Punjab	–	–	–	–	–
23	Rajasthan	20	15	18	23	8
24	Sikkim	5	3	26	1	20
25	Tamil Nadu	3	2	11	4	7
26	Tripura	9	11	12	15	22
27	Uttar Pradesh	24	26	24	17	5
28	Uttarakhand	10	22	23	6	2
29	West Bengal	8	20	8	21	19
30	All India	14	18	15	18	15

Source: Author's Calculation.

Table 18A.15 State Rankings in Individual Indicators of Social SDI–Non SC-ST

Sr. no.	States	Demographic	Health	Education	Basic amenities	Economic
1	Andhra Pradesh	3	6	18	13	18
2	Arunachal Pradesh	24	27	9	17	11
3	Assam	23	29	4	23	28
4	Bihar	29	28	5	29	20
5	Chhattisgarh	11	13	15	25	19
6	Delhi	6	8	28	2	2
7	Goa	4	3	26	1	3
8	Gujarat	8	14	12	21	8
9	Haryana	14	17	25	9	9
10	Himachal Pradesh	2	15	27	7	4
11	Jammu & Kashmir	17	5	19	18	5
12	Jharkhand	25	24	6	28	29
13	Karnataka	9	10	23	10	17
14	Kerala	1	2	1	8	7
15	Madhya Pradesh	20	21	20	24	21
16	Maharashtra	10	12	22	5	16
17	Manipur	12	9	3	15	12
18	Meghalaya	26	26	2	12	13
19	Mizoram	–	–	–	–	–
20	Nagaland	27	25	13	14	14
21	Odisha	16	11	7	27	26
22	Punjab	7	4	29	5	1
23	Rajasthan	22	20	8	22	10
24	Sikkim	21	7	11	3	23
25	Tamil Nadu	5	1	21	6	15
26	Tripura	13	18	17	16	27
27	Uttar Pradesh	28	23	14	26	22
28	Uttarakhand	19	19	24	11	6
29	West Bengal	15	22	10	20	25
30	All India	18	16	16	19	24

Source: Author's Calculation.

Table 18A.16 Social SDI Scores and Ranks of Individual States, SC, ST and Non-SC-ST

Sr. no.	States	SDI SC		SDI ST		SDI Non-SC-ST	
		Scores	Ranks	Scores	Ranks	Scores	Ranks
1	Andhra Pradesh	1.50	13	1.57	9	1.76	12
2	Arunachal Pradesh	0.22	27	1.34	13	1.24	20
3	Assam	1.01	20	1.11	17	0.85	25
4	Bihar	0.05	28	0.38	25	0.18	29
5	Chhattisgarh	0.90	21	0.81	20	1.11	22
6	Delhi	2.31	3	–	–	2.90	1
7	Goa	2.40	2	2.40	4	2.90	2
8	Gujarat	1.89	6	1.43	11	1.43	16
9	Haryana	1.58	12	–	–	1.91	8
10	Himachal Pradesh	1.91	5	2.47	2	2.57	4
11	Jammu & Kashmir	1.29	17	0.85	19	1.46	13
12	Jharkhand	0.44	25	0.24	26	0.52	28
13	Karnataka	1.40	14	1.62	8	1.84	9
14	Kerala	2.55	1	2.44	3	2.08	5
15	Madhya Pradesh	0.86	23	0.69	21	1.00	24
16	Maharashtra	1.82	7	1.63	7	2.06	6
17	Manipur	1.32	15	1.20	15	1.45	15
18	Meghalaya	1.69	9	1.28	14	1.32	19
19	Mizoram	–	–	–	–	–	–
20	Nagaland	–	–	1.37	12	1.17	21
21	Odisha	0.70	24	0.41	24	0.81	26
22	Punjab	1.73	8	–	–	2.59	3
23	Rajasthan	0.87	22	0.56	23	1.04	23
24	Sikkim	2.09	4	2.62	1	1.80	10
25	Tamil Nadu	1.59	11	2.29	5	2.01	7
26	Tripura	1.65	10	1.43	10	1.45	14
27	Uttar Pradesh	0.43	26	0.64	22	0.57	27
28	Uttarakhand	1.28	18	1.77	6	1.77	11
29	West Bengal	1.31	16	1.15	16	1.36	17
30	All India	1.03	19	1.00	18	1.32	18

Source: Author's Calculation.

Table 18A.17 State Rankings in Individual Indicators of Gender SDI, Male and Female

Sr. no.	States	Health		Education		Economic	
		Male	Female	Male	Female	Male	Female
1	Andhra Pradesh	16	15	26	23	14	23
2	Arunachal Pradesh	21	13	15	7	13	18
3	Assam	18	22	19	19	28	25
4	Bihar	27	29	28	29	19	24
5	Chhattisgarh	28	28	30	31	18	11
6	Delhi	8	8	2	2	20	13
7	Goa	3	4	6	6	3	10
8	Gujarat	24	26	25	20	6	12
9	Haryana	14	17	11	15	12	14
10	Himachal Pradesh	12	12	16	18	15	4
11	Jammu & Kashmir	9	11	27	30	26	28
12	Jharkhand	29	30	24	25	2	3
13	Karnataka	17	16	18	16	7	16
14	Kerala	1	1	1	1	16	29
15	Madhya Pradesh	30	31	31	28	10	8
16	Maharashtra	13	14	9	10	4	20
17	Manipur	6	6	13	24	29	27
18	Meghalaya	25	20	7	8	1	1
19	Mizoram	2	2	3	4	9	7
20	Nagaland	11	7	8	11	31	31
21	Odisha	31	23	21	22	8	15
22	Punjab	7	9	20	13	24	17
23	Rajasthan	23	25	23	27	22	6
24	Sikkim	4	3	4	3	27	2
25	Tamil Nadu	10	10	10	9	23	26
26	Tripura	22	19	17	21	30	30
27	Uttar Pradesh	26	27	14	12	21	9
28	Uttarakhand	15	21	29	26	11	19
29	West Bengal	19	18	12	14	25	21
30	All India	20	24	22	17		22

Source: Author's Calculation.

Table 18A.18 Gender SDI Scores and Ranks of Individual States, Male and Female

Sr. no.	States	SDI Male		SDI Female	
		Scores	Ranks	Scores	Ranks
1	Andhra Pradesh	0.31	13	0.35	14
2	Arunachal Pradesh	0.22	22	0.41	12
3	Assam	0.31	15	0.23	21
4	Bihar	0.14	26	0.08	28
5	Chhattisgarh	0.15	24	0.12	27
6	Delhi	0.55	10	0.68	7
7	Goa	0.73	5	0.87	4
8	Gujarat	0.15	25	0.20	25
9	Haryana	0.31	14	0.34	16
10	Himachal Pradesh	0.38	11	0.48	11
11	Jammu & Kashmir	0.67	6	0.57	10
12	Jharkhand	–0.01	28	0.05	29
13	Karnataka	0.24	20	0.34	15
14	Kerala	1.01	1	1.33	1
15	Madhya Pradesh	0.09	27	0.00	30
16	Maharashtra	0.24	19	0.37	13
17	Manipur	0.86	3	0.80	5
18	Meghalaya	–0.02	29	0.29	19
19	Mizoram	0.79	4	0.95	2
20	Nagaland	0.60	8	0.68	6
21	Odisha	–0.08	30	0.22	22
22	Punjab	0.66	7	0.59	8
23	Rajasthan	0.23	21	0.21	24
24	Sikkim	0.90	2	0.93	3
25	Tamil Nadu	0.56	9	0.59	9
26	Tripura	0.28	17	0.30	18
27	Uttar Pradesh	0.16	23	0.14	26
28	Uttarakhand	0.36	12	0.28	20
29	West Bengal	0.28	16	0.33	17
30	All India	0.26	18	0.21	23

Source: Author's Calculation.

Note

1. It may be noted that different states governments are also simultaneously bringing out their respective 'State Human Development Report'. The state's plan section of the Planning Commission website provides the State Human Development Reports for about 21 states, viz., Arunachal Pradesh (2005), Assam (2003), Chhattisgarh (2005), Delhi (2006), Gujarat (2004), Himachal Pradesh (2002), Karnataka (2005), Kerala (2005), Madhya Pradesh (2002), Maharashtra (2002), Nagaland (2004), Orissa (2004), Punjab (2004), Rajasthan (2002), Sikkim (2001), Tamil Nadu (2003), Tripura (2007), Uttar Pradesh (2003) and West Bengal (2004). Refer www.planningcommission.nic.in.

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