In India there are multiple socio-economic disadvantages that members of particular groups experience which limits their access to health and healthcare. The task of identifying the vulnerable groups\(^1\) is not an easy one. Besides there are multiple and complex factors of vulnerability with different layers and more often than once it cannot be analyzed in isolation.

The present document is based on some of the prominent factors on the basis of which individuals or members of groups are discriminated in India, i.e., structural factors, age, disability, mobility, stigma and discrimination that act as barriers to health and healthcare. The vulnerable groups that face discrimination include Women, Scheduled Castes (SC), Scheduled Tribes (ST), Children, Aged, Disabled, Poor migrants, People living with HIV/AIDS and Sexual Minorities. Sometimes each group faces multiple barriers due to their multiple identities. For example, in a patriarchal society, disabled women face double discrimination of being a women and being disabled.

Structural norms are attached to the different relationships between the subordinate and the dominant group in every society. A group's status may for example, be determined on the basis of gender, ethnic origin, skin colour, etc. The norms act as structural barriers giving rise to various forms of inequality. Access to health and healthcare for the subordinate groups is reduced due to the structural barriers. In the next page, Figure 2 explains the structural discrimination faced by the groups and their human right violations.

VULNERABLE GROUPS, THEIR HEALTH AND HUMAN RIGHTS

Human right applies universally to all. The process of identifying vulnerable groups within the health and human right generated from the pressing reality on the ground that stemmed from the fact that there are certain groups who are vulnerable and marginalized lacking full enjoyment of a wide range of human rights, including rights to political participation, health and education. Vulnerability within the right to health framework means deprivation of certain individuals and groups whose rights have been violated from the exercising agency Yamin, 2005. Certain groups in the society often encounter discriminatory treatment and need special attention to avoid potential exploitation. This population constitutes what is referred to as, “vulnerable groups are disadvantaged as compared to others mainly on account of their reduced access to medical services and the underlying determinants of health such as safe and potable drinking water, nutrition, housing, sanitation etc. For example, persons with disabilities often don't gel employment or adequate treatment or people living with HIV/AIDS, face various forms of discrimination that affects their health and reduces their access to health services disability, health status (HIV/AIDS), Civil, political, social or other statuses. All governments are obliged to protect and promote the conditions conducive for the enjoyment of the right to health”.
Participation of the vulnerable groups is essential for securing the public health goals. Human rights approach to health lays emphasis on the inclusion of the needs and concerns of diverse groups and communities. There are several interfaces between public health and human rights. While both the approaches have their separate spaces and adopt contrasting lenses of approaching health, there are innumerable instances where they complement each other. An important step towards increasingly coming closer to each other is perhaps their recognition of the vital role of societal environment to both health and realization of human rights. Both the approaches recognize the fact that there is a complex relation between the individual and the society that impacts their health. For example, the health of an individual or groups may depend on the conditions such as sufficient income, living conditions, access to safe drinking water, etc, and all the

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above factors are heavily influenced by whether or not an individual belongs to a group that suffers discrimination.

Public health is assumed to seek the greatest good for the greatest number of people. Application of human rights principles to public health strategies has expanded the scope of the latter by going beyond averages and focusing attention also on those population groups in society which are considered most vulnerable. The focused attention on vulnerable and disadvantaged groups in the international human rights instruments reinforces the principle of equity. An ideal public health strategy would be the one which addresses the concerns for equity and justice in every society but in practical terms there are limitations of every health system. This necessitates the need to focus on the immediate service delivery by prioritizing the needs. Human rights norms and standards form a strong basis for health systems to prioritize the health needs of vulnerable and marginalized population groups.

Focus on the vulnerable group is very useful for human rights documentation. It allows review of context specific violations, identify the challenges faced by the specific groups and their access in healthcare, gather information on group-specific risk factors, cultural and social differences among groups and its impact on health and health-seeking behaviour, document the negative attitude of the health system resulting in denial, draws attention to how national legislation and development policies impact upon the status of such groups. This facilitates advocacy for Right to Health and empowers the disadvantaged groups by raising awareness about their rights and potential violations.

Different societies have different conditions/situations that generate and perpetrate vulnerability among certain individuals and groups. Hence identifying vulnerable groups within the right to health framework is an ongoing process.
The right to health obliges governments to ensure that “health facilities, goods and services are accessible to all especially the most vulnerable group or marginalized section of the population, in law and in fact without discrimination.

**WOMEN**

In India, members of gender, caste, class, and ethnic identity experience structural discrimination that impact their health and access to healthcare. Women face double discrimination being members of specific caste, class or ethnic group apart from experiencing gendered vulnerabilities. Women have low status as compared to men in Indian society. They have little control on the resources and on important decisions related to their lives. In India, early marriage and childbearing affects women's health adversely. About 28 per cent of girls in India get married below the legal age and experience pregnancy (Reproductive And Child Health - District level Household Survey 2002-04, August 2006). These have serious repercussions
on the health of women. Maternal mortality is very high in India. The average maternal mortality ratio at the national level is 540 deaths per 100,000 live births (National Family Health Survey-2, 2000). It varies between states and regions, i.e., rural-urban. The rural MMR (Maternal Mortality Rate) is 617 deaths of women age between 15-49 years per one lakh live births as compared to 267 maternal deaths per one lakh live births among the urban population (National Family Health Survey-2, 2000). In most cases the deaths occur from preventable causes. A large proportion of women is reported to have received no antenatal care.4 In India, institutional delivery is lowest among women from the lower economic class as against those from the higher class.5

Women face violence and it has an impact on their health. During infancy and growing years a girl child faces different forms of violence like infanticide, neglect of nutrition needs, education and healthcare. As adults they face violence due to unwanted pregnancies, domestic violence, sexual abuse at the workplace and sexual violence including marital rape and honor killings; The experience of violence and its impact on health varies according to the women's caste, class and ethnic identity.

Caste also perpetrates inequality. Caste in Indian society is a particular form of social inequality that involves a hierarchy of groups ranked in terms of ritual purity where members who belong to a particular group or stratum share some awareness of common interest and a common identity. The caste system is linked to the possession of natural resources, livelihood resources and in the Indian context also to land economy and land based power relations.

4 Only 16 Percent of the Women in India Received All the Antenatal Care i.e., at Least 3 Antenatal Check-ups and at Least One Tetanus Toxoid Injection and Supplementary Iron in the Form of Iron flic eAcid Tables/Syrups Daily for 100 Days as Recommended by the RCH Programme. (RCH-DLHS-3 (2002-04)

5 In India, The Percentage of Home Delivery is Highest (59 Percent), Whereas Institutional Delivery (Public and Private Health Institutes) accounts for Only 40.5 percent Home Delivery Assisted by Skilled Birth Attendants Accounts for 71 percent. Institutional Delivery by Background characteristics Shows that Only 22 percent Childbirth of Scheduled Tribes Women Takes Place in Institutions as Compared to 33 Percent Birhts to Scheduled Caste Women. (RCH-DLHS-3. 2002-04, P. 98).
Traditionally, caste relations were based on the hierarchy of occupations where work related to leather, cleaning dead cattle from village grounds, work related to funeral ceremonies, etc were placed at the bottom. People or castes that were performing the task of eliminating the polluted elements from society were considered 'untouchables' vis-a-vis the Brahmins who were highest in the order based on the purity-impurity principle. Structurally the lower castes were economically dependent on the higher castes for existence. The (lower castes) remained economically dependent, politically powerless and culturally subjugated to the upper caste. This impacted their overall lifestyle and access to food, education and health.

A major proportion of the lower castes and Dalits are still dependent on others for their livelihood. Dalits does not refer to a caste but suggests a group who are in a state of oppression, social disability and who are helpless and poor. They were earlier referred as 'untouchables' mainly due to their low occupations i.e., cobbler, scavenger, sweeper.6

In a caste-dominated country like India, Dalits who comprises more than one-sixth of the Indian population (160 million approx), stand as a community whose human rights have been severely violated. Literacy rates among Dalits are only about 24 per cent. They have meager purchasing power; have poor housing conditions; lack or have low access to resources and entitlements. In rural India they are landless poor agricultural labourers attached to rich landowners from generations or poor casual labourers doing all kinds of available work. In the city they are the urban poor employed as wage labourers at several work sites, beggars, vendors, small service providers, domestic help, etc., living in slums and other temporary shelters without any kind of social security. The members of these groups face

6 Dalit in India, are Poor, Deprived and Socially Backward. They have Faced Severe forms of Human Rights Violations. They have been Involved in a Long Struggle to Abolish Untouchability and Caste Discrimination.
systemic violence in the form of denial of access to land, good housing, education and employment.

Structural discrimination against these groups takes place in the form of physical, psychological, emotional and cultural abuse which receives legitimacy from the social structure and the social system. Physical segregation of their settlements is common in the villages forcing them to live in the most unhygienic and inhabitable conditions. All these factors affect their health status, access to healthcare, and quality of health service received. There are high rates of malnutrition reported among the marginalized groups resulting in mortality, morbidity and anaemia. Access to and utilization of healthcare among the marginalized groups is influenced by their socio-economic status within the society.

The issue of participation and prevention of violation is important for understanding the vulnerable groups; their health and human rights. The United Nations Economic, Social and Cultural Rights Committee (ESCR Committee) mentions that an important aspect of implementing the right to health "is the improvement and furtherance of participation of the population in the provisions of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular in political decisions relating to the right to health taken at both the community and national levels."\(^7\) The General Comment 14 of the Article 12 (Right to Health) also proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of

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\(^7\) ESCR Committee General Comment No 14, Para 17.
nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that measures, such as the strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No.3, Paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected. Protecting and fulfilling the rights of the vulnerable groups constitutes the immediate state obligations under the Covenant for Economic Cultural and Social Rights.

There are many and complex linkages between health and human rights of the vulnerable groups. Violations or lack of attention to human rights can have serious health consequences for certain groups (abuse, stigma and discrimination, harmful traditional practices, violence, torture, etc). The manner in which health policies and programmes are designed can either protect or violate human rights of certain groups (accessibility to service, provision of information, respect for integrity and privacy, cultural sensitivity, gender and age sensitivity). The chances of enjoying good health must not be unfairly disadvantaged because of sex, class, religion, age, sexual orientation, ethnic identity; Structural discrimination directly impedes equal access to health services by way of exclusion. The negative attitude of the health professionals towards these groups also acts as a barrier to receiving quality healthcare from the health system. In the case of women, discrimination increases by the complex mix of two factors-being a women and being a member of the marginalized community. A large proportion of Dalit girls drop out of primary school inspite of reservations and academic aptitude, because of poverty, humiliation, isolation or bullying by teachers and classmates and punishment for scoring good grades (National
The scavenger community among the Dalits is vulnerable to stress and diseases with reduced access to healthcare.

The scheduled tribes like the Scheduled Castes face structural discrimination within the Indian society. Unlike the Scheduled Castes, the Scheduled Tribes are a product of marginalization based on ethnicity. In India, the Scheduled Tribes population is around 84.3 million and is considered to be socially and economically disadvantaged. Their percentages in the population and numbers however vary from State to State. They are mainly landless with little control over resources such as land, forest and water. They constitute a large proportion of agricultural labourers, casual labourers, plantation labourers, industrial labourers etc. This has resulted in poverty among them, low levels of education, poor health and reduced access to healthcare services. They belong to the poorest strata of the society and have severe health problems. They are less likely to afford and get access to healthcare services when required.\(^8\) The health outcomes among the Scheduled Tribes are very poor even as compared to the Scheduled Castes. The Infant Mortality Rate among Scheduled Castes is 83 per 1000 live births while it is 84.2 per 1000 per live births among the Scheduled Tribes.\(^9\)

**DOMESTIC VIOLENCE AND HEALTH**

1. According to a household level study on domestic violence in India, 50 percent of married women reported facing spousal violence and among those reporting abuse, 50 per cent reported abuse during pregnancy.

2. According to a community and hospital based study in Maharashtra, India, conducted during 1993-95 almost 16 percent of deaths in

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\(^8\) Women’s Health, Booklet for National Health Assembly 11, Compiled by Sama Resource Group for Women and Health, New Delhi, October 2006.

\(^9\) National Health Policy 2002, Government of India.
pregnancy were caused by domestic violence.

Among the Scheduled Castes and the Scheduled Tribes the most vulnerable are women, children, aged, those living with HIV/AIDS, mental illness and disability. These groups face severe forms of discrimination that denies them access to treatment and prevents them from achieving a better health status. Gender based violence and domestic violence is high among women in general in India. Girl child and women from the marginalized groups are more vulnerable to violence. The dropout and illiteracy rates among them are high. Early marriage, trafficking, forced prostitution and other forms of exploitation are also reportedly high among them. In situations of caste conflict, women from marginalized groups face sexual violence from men of upper caste i.e, rape and other forms of mental torture and humiliation.

**CHILDREN**

Children and the elderly population face different kind of vulnerability. Mortality and morbidity among children are caused and compounded by poverty, their sex and caste position in society. All these have consequences on their nutrition intake, access to healthcare, environment and education. These factors directly impacts food security, education of parents and their access to correct health information and access to health care facilities. Malnutrition and chronic hunger are the important causes of death among children from poor families. Diarrhea, acute respiratory diseases, malaria and measles are some of the main causes of death among children, most of which are either preventable or treatable with low-cost interventions. Tetanus in newborns remains a problem in at least five states: Uttar Pradesh, Madhya Pradesh, Rajasthan, West Bengal, and Assam (UNICEF, India).  

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Poverty has a direct impact on the mortality and morbidity among children. *Neo-natal mortality*\(^{11}\) is about two times higher among people with low standard of living while *Under-5 mortality*\(^{12}\) among children from lower economic class is five times than that of households with high standard of living. 73.4 per cent of children have some form of anemia (National Family Health Survey-2, 2000)\(^{13}\). In India, a girl child faces discrimination and differential access to nutritious food and gender based violence is evident from the falling sex ratio and the use of technologies to eliminate the girl child. Among children the health indicators vary between the different social groups. High mortality and morbidity is reported among children from Scheduled Castes, Scheduled Tribes and Other Backward Classes as compared to the general population.

Infant mortality is higher among the rural population (Rural-62, Urban 42 per one thousand live births in the last five years, National Family Health Survey 3, Fact Sheets). The vaccination coverage is very poor among children who live in rural India. Vaccination coverage among children between 12-23 months who have received the recommended vaccines is only 39 per cent in rural India as compared to 58 per cent in urban India (National Family Health Survey- 3, Fact sheets).

In India, children's vulnerabilities and exposure to violations of their protection rights remain spread and multiple in nature. The manifestations of these violations are various, ranging from child labour, child trafficking, to commercial sexual exploitation and many other forms of violence and abuse. With an estimated 12.6 million children engaged in hazardous occupations (2001 Census), for instance, India has the largest number of child labourers under the age of 14 in the world. Child labour in the agriculture sector

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\(^{11}\) Neonatal Mortality - *The Probability of Dying in The First Month of Life.*

\(^{12}\) Under Five Mortality - *The Probability of Dying Before the Fifth Birthday.*

accounts for 80 per cent of child labour in India and 70 per cent of working children globally (Jaswal, Patro, et al., 2006). In Sivakasi, an estimated 1,25,000 children make the child labour force, comprising 30 per cent of the entire labour force.\textsuperscript{14} Those children working in the brick kilns, stone quarries, mines, carpet and zari industry suffer from occupation related diseases. In India, however there is a huge gap in the industry-specific and exposure-specific epidemiological evidence. Most of the studies are small-scale and community-based studies.

There is a large proportion of children in India who are living with HIV/AIDS. The most common sources of infection among children is the Mother-to-Child Transmission (MCTC), sexual abuse, blood transfusion, unsterilised syringes, including injectable drug use (NACO, 2006). Among children, there are some groups like street children and children of sex workers who face additional forms of discrimination. A large number of children are reportedly trafficked to the neighbouring countries. Trafficking of children also continues to be a serious problem in India. The nature and scope of trafficking range from industrial and domestic labour, to forced early marriages and commercial sexual exploitation. Moreover, for children who have been trafficked and rescued, opportunities for rehabilitation remains scarce and reintegration process arduous? While systematic data and information on child protection issues are still not always available, evidence suggests that children in need of special protection belong to communities suffering disadvantage and social exclusion such as scheduled casts and tribes, and the poor (UNICEF, India).\textsuperscript{15}

\textsuperscript{15} Ibid.
In India, the population of the elderly is growing rapidly and is emerging as a serious area of concern for the government and the policy planners. According to data on the age of India's population, in Census 2001, there are a little over 76.6 million people above 60 years, constituting 7.2 per cent of the population. The number of people over 60 years in 1991 was 6.8 per cent of the country's population. The vulnerability among the elderly is not only due to an increased incidence of illness and disability, but also due to their economic dependency upon their spouses, children and other younger family members. According to the 2001 census, 33.1 per cent of the elderly in India live without their spouses. The widowers among older men form 14.9 per cent as against 50.1 per cent widows among elderly women. Among the elderly (80 years and above), 71.1 per cent of women were widows while widowers formed only 28.9 per cent of men. Vulnerability among the elderly also depends on their living arrangement since the elderly are less capable of taking care of them compared to younger persons and need the care and support of others in several aspects. About 2.9 per cent of elderly in India live alone. More elderly women (4.1 per cent) live alone compared to elderly men (1.8 per cent). The significance of the living arrangement among the elderly becomes evident when seen in the context of their level of economic dependence (Rajan, 2006). Lack of economic dependence has an impact on their access to food, clothing and healthcare. Among the basic needs of the elderly, medicine features as the highest unmet need.

Healthcare of the elderly is a major concern for the society as ageing is often accompanied by multiple illnesses and physical ailments. Pain in the joints, followed by cough and blood pressure, piles, heart diseases, urinary problems, diabetics and cancer are the common ailments reported among

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elderly\textsuperscript{17}. One out of two elderly in India suffers from at least one chronic disease which requires life-long medications. Providing healthcare to elderly is a burden for especially poor households (Rajan, 2006). About 29 per cent of the elderly populations in India are reported to have received no medical attention before death (National Sample Survey, 42nd Round, 1991).

Among the elderly, the widows, poor and disabled constitute those who are more disadvantaged. Widows face structural disadvantages associated with gender and marital status. There is striking gender differential that exists in the ownership of property and assets and in the participation of their management. At all India level, aged women like those in other age groups suffer from lack of ownership of property and financial assets and participation in their management compared to aged men in both urban and rural India (National Sample Survey, 52nd Round, 1998). Lack of property ownership affects their access to resources like food, housing, health etc.\textsuperscript{18} Visual impairment, hearing problem, locomotor problem (difficulty in walking) and problems in speech are common forms of disability among elderly. Senility and neurosis are common mental illness reported among elderly (National Sample Survey, 52nd Round, 1998).

**BONDED LABOUR**

The Bonded Labour\textsuperscript{19} System (Abolition) Act, 1976 has been passed to provide for abolition of bonded labour system with a view preventing the economic and physical exploitation of the weaker sections of the people and for matters connected therewith or incidental thereto. It was stated in the objects and reasons of the Act that there still exists in different parts of the country a system of usury under which the debtor or his descendants or dependants have to work for the creditor without reasonable wages or with

\textsuperscript{17} National Sample Survey, 52nd Round, 1998.


\textsuperscript{19} Labour and Industrial Law Written by Dr. Avtar Singh.
no wages in order to extinguish the debt. At times several generations work under bondage for the repayment of a paltry sum which has been taken by some remote ancestor. The interest rates are exorbitant and such bondage cannot be interpreted as the result of any legitimate contract or agreement. The system implies the infringement of the basic human rights and destruction of the dignity of human labour.

Article 23 (1) of the Indian Constitution prohibits 'begar' and other similar forms of forced labour. It also provides that any contravention of the said prohibition shall be an offence punishable in accordance with law. Article 35 (a) (ii) of the Constitution not only confers the power on Parliament to provide for punishment for the contravention of the said provisions of Article 23 (1) but expressly takes away the power of the State Legislature to make any legislation with regard to the said matter. Accordingly, the Bonded Labours System (Abolition) Ordinance, 1975 was promulgated by the President on 24th October, 1975. By the said ordinance the bonded labour system was abolished and the bonded labourers were freed and discharged from any obligation to render any bounded labour and their bonded debts were also extinguished.

"bonded debt" means an advance obtained, or presumed to have been obtained, by a bonded labourer under, or in pursuance of, the bonded labour system; bonded labour" means any labour or service rendered under the bonded labour system ; "bonded labourer" means a labourer who incurs, or has, or is presumed to have, incurred, a bonded debt; "bonded labour system" means the system of forced, or partly forced labour under which a debtor enters, or has, or is presumed to have, entered in an agreement with the creditor to the effect that,—

i. in consideration of an advance obtained by him or by any of his linear ascendants or descendants (whether or not such advance is evidenced by any document) and in consideration of the interest, if any, due on such advance, or
ii. in pursuance of any customary or social obligation, or

iii. in pursuance of an obligation devolving on him succession; or

iv. for any economic consideration received by him or by any of his linear ascendants or descendants, or

v. by reason of his birth in any particular caste or community, he would - (1) render, by himself or through any member of his family, or any person dependent on him, labour or service, to the creditor.

LEGAL DEFINITION

Vulnerable groups is classically defined as a situation when a person provides a loan to another who uses his or her labor or services to repay the debt; when the value of the work, as reasonably assessed, is not applied towards the liquidation of the debt, the situation becomes one of debt bondage. See United Nations 1956 Supplementary Convention on the Abolition of Slavery. This was very common in Ancient Greece. In ancient Athens, Solon forbade taking out loans using oneself as a security and ended any current such debts, ending debt bondage.

EUROPEAN POSITION: CLASSICAL ANTIQUITY

Debt bondage\textsuperscript{20} was "quite normal" in classical antiquity. The poor or those who had fallen irredeemably in debt might place themselves into bondage "voluntarily"—or more precisely, might be compelled by circumstances to choose debt bondage as a way to anticipate and avoid worse terms that their creditors might impose on them. In the Greco-Roman world, debt bondage was a distinct legal category into which free persons might fall, in theory temporarily, distinguished from the pervasive practice of slavery, which included enslavement as a result of defaulting on debt. Many form of debt bondage existed in both ancient Greece and ancient Rome.

\textsuperscript{20} www.en.wiki.pedia.org/wiki/debt_bondage
ANCIENT GREECE

Debt bondage was widespread in ancient Greece. The only city-state known to have abolished it is Athens, as early as the Archaic period under the debt reform legislation of Solon.\textsuperscript{5} Both enslavement for debt and debt bondage were practiced in Ptolemaic Egypt. By the Hellenistic period, the limited evidence indicates that debt bondage had replaced outright enslavement for debt.\textsuperscript{7}

The most onerous debt bondage was various forms of paramone "indentured labor." As a matter of law, a person subjected to paramon was categorically free, and not a slave, but in practice his freedom was severely constrained by his servitude.\textsuperscript{7} Solon's reforms occurred in the context of democratic politics at Athens that required clearer distinctions between "free" and "slave"; as a perverse consequence, chattel slavery increased.

MIDDLE AGES

In the Middle Ages, feudal and serfdom systems became the predominant political and economic systems in AMERICA

American colonies - Persons bonded themselves to an owner who paid their passage to the New World. They worked until the debt of passage was paid off, often for years. In Peru a peonage system existed from the 16th century until land reform in the 1950s. One estate in Peru that existed from the late 16th century until it ended had up to 1,700 persons employed and had a prison. Persons were expected to work a minimum of three days a week for their landlord and more if necessary to complete assigned work. Workers were paid a symbolic two cents per year. Workers were unable to travel outside of their assigned lands without permission and were not allowed to organise any independent community activity. In the Peruvian
Amazon, debt peonage is an important aspect of contemporary Urarina society.

**MODERN VIEWS: ANTI-SLAVERY APPROACH**

Pawn age or pawn slavery is a form of servitude akin to bonded labor under which the debtor provides another human being as security or collateral for the debt. Until the debt (including interest on it) is paid on; the creditor has the use of the labor of the pawn. Debt bondage has been defined by the United Nations as a form of "modern day slavery and is prohibited by international law. It is specifically dealt with by article 1 (a) of the United Nations 1956 Supplementary Convention on the Abolition of Slavery. It persists nonetheless especially in developing nations, which have few mechanisms for credit security or bankruptcy, and where fewer people hold formal title to land or possessions. According to some economists, for example Hernando de Soto, this is a major barrier to development in those countries - entrepreneurs do not dare take risks and cannot get credit because they hold no collateral and may burden families for generations to come.

Researcher Siddharth Kara has calculated the number of slaves in the world by type, and determined the number of debt bondage slaves to be 18.1 million at the end of 2006.

In India the rise of Dalit activism, government legislation starting as early as 1949, as well as ongoing work by NGOs and government offices to enforce labour laws and rehabilitate those in debt, appears to have contributed to the reduction of bonded labour there. However, according to research papers presented by the United Nations International Labour Organization, there are still many obstacles to the eradication of bonded labour in Index.

- See also
- Debtor's prison
- Student loan
- Human trafficking
- Indentured servitude
- Involuntary servitude

'The right to health does not mean the right to be healthy, nor does it mean that poor governments must put in place expensive health services for which they have no resources. But it does require governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time. To ensure it happens is the challenge facing the human rights community and public health professionals.'

**DISABLE PERSON**

Disability poses greater challenges in obtaining the needed range of services. Persons with disabilities face several forms of discrimination and have reduced access to education, employment and other socio-economic opportunities. In India, there is an increase of proportion of disabled population. The proportion of disabled population in India is about 21.9 million. The percentage of disabled population to the total population is about 2.13 per cent. There are two broad categories of disability, one is acquired which means disability acquired because of accidents and medical reasons the other is disability since the onset of birth. According to the National Sample Survey Organization Report (58th Round), about one-third of the disabled population have disability since their birth. There are interstate and interregional differences in the disabled population. The disabled face various types of barriers while seeking access to health and health services. There are different types of disability and the needs of the
disabled differ accordingly. Among those who are disabled women, children and aged are more vulnerable and need attention.

Mental illness is a prominent form of disability.\textsuperscript{21} Five out often leading causes of disability and premature death worldwide are due to psychiatric conditions.\textsuperscript{22} Depression and anxiety are the most common mental disorders. Psychotic disorders such as schizophrenia and bipolar disorder, although less common are profoundly disabling. The other area of concern is the mental health of women and the elderly. Neurotic and stress related cases are reportedly higher among women than men though among men there is reporting of higher number of cases of serious illness. Dementia and major depression are two of the leading contributors to mental diseases in older people. But in spite of such proportion of mental illness, the health care provisions for persons with mental illness are very poor in India. People with mental illness face severe forms of human rights violations. In Special Homes, Hospitals and Asylums, they are kept in chains, denied basic needs like food, clothing and face different forms of abuse. There is social stigma attached to mental illness. Women with mental illness are subjected to physical and sexual abuse both within families and the institutions.

There are 42 mental hospitals in the country with bed availability of 20,893 in the government sector and another 5096 in the private sector hospital settings to take care of an estimated 1,02,70,165 people with severe mental illness and 5,12,51,625 people with common mental disorders. Psychiatric medicines are supplied only in a few primary health, centers, community centers and district hospitals. Services like child guidance and rehabilitative services are also available only in mental hospitals and in big cities. Several states do not have mental hospitals (Mental Health in India-An Overview, 2007).

\textsuperscript{21} Census Reported on \textit{Mental Illness as a Form of Disability}, 2001.
\textsuperscript{22} \textit{World Health Organisation}, 2002.
The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, commonly referred as the PWD Act came into force on Feb. 7, 1996. Mental illness has been considered in the Act, but there is no reference to any provision within the Act to be given or set aside for people with mental illness. The Act also does not assure the right to treatment.