AREAS OF PHILANTHROPIC SOCIAL WORK-II

UNIT 1
HIV Infected and Social Work Intervention 5

UNIT 2
Leprosy 18

UNIT 3
Displaced People Migrants, Refugees, Asylum Seekers, Stateless People 32

UNIT 4
Victims of Disasters 54
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<table>
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<tr>
<th>Name</th>
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<th>Institution</th>
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Welcome to block 4 of the course entitled ‘Working Among the Poorest of the Poor’. This block on, “Areas of Philanthropic Social Work-II” is the fourth block of MSW-011. It is comprised of four units.

Unit 1 on ‘HIV Infected and Social Work Intervention’ discusses the nature of HIV/AIDS in terms of the stages of infection, the mode of transmission, and HIV test. The unit concludes with discussing the impact of HIV/AIDS on various sectors of vulnerable groups, and the areas of social work intervention.

Unit 2 is on ‘Leprosy’. This unit focuses on the concepts, definition and various aspects of treatment related to leprosy. The unit also examines the various rehabilitation aspects of leprosy.

Unit 3 on ‘Displaced People, Migrants, Refugees, Asylum Seekers, Stateless People’ explains the complex phenomenon of displaced people. The unit describes the various issues of the displaced people, migrants, refugees and landless and bonded labourers.

The fourth unit on ‘Victims of Disasters’ explains the meaning and types of disaster. The unit provides a basic understanding of the impacts of disasters on the common people. Some of the responses made by the Government, NGOs, INGOs and humanitarian aid agencies are also mentioned in this unit.

On the whole, this block will provide you an overview of the different areas of philanthropic social work.
Areas of Philanthropic Social Work-II
UNIT 1 HIV INFECTED AND SOCIAL WORK INTERVENTION

Structure
1.0 Objectives
1.1 Introduction
1.2 Understanding HIV/AIDS
1.3 Transmission of HIV and the Vulnerable Sectors
1.4 Impact of HIV/AIDS on Various Sectors
1.5 HIV/AIDS and Social Work Intervention
1.6 Let Us Sum Up
1.7 Further Readings and References

1.0 OBJECTIVES

HIV/AIDS is an epidemic of global proportions and hence a concern for the entire world. As an epidemic, HIV/AIDS affects not just the individual suffering from the disease, but the entire family, the community and the country. Prevention of the transmission of HIV, which causes AIDS, is the most important strategy to reduce the impact of the epidemic. Knowledge about HIV and AIDS, and how HIV is transmitted is very important in preventing the spread of the epidemic. Still more important is the challenge in helping those affected by HIV and AIDS to live positively and to care for themselves. Infact the infected have become a disadvantages section of the society in the 21st century.

On completing this unit, you will be able to understand:
• the nature of HIV/AIDS in terms of the stages of infection, the mode of transmission, and HIV test;
• the impact of HIV/AIDS on various sectors vulnerable groups, and the areas of social work intervention.

1.1 INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) emerged as the most dreaded disease of the 20th century. This is dreaded not because of the fact that death is certain, but it is also due to the stigma and social ostracism that is attached to its very name. HIV/AIDS continues to be a major concern of research, which requires broad ranging structural analysis of the overall health care sector as well as the social, political and economical forces that influence its shape and content both in the western world and in the developing countries. HIV/AIDS is just the tip of an iceberg of a host of social problems ranging from poverty, accessibility to adequate health care, disenfranchisement and discrimination. The time has come not just to say “no” to unwanted sex or unprotected sex or unwanted conception, it is time to say “no” to inequity, to discrimination and lack of choice.
1.2 UNDERSTANDING HIV/AIDS

The disease AIDS was first detected in 1981. AIDS is a medical condition. People develop AIDS because HIV has damaged their natural defenses against diseases. It is caused by a virus which was isolated and identified in 1983 as the Human Immunodeficiency Virus (HIV). HIV is a virus belonging to a family of viruses called retroviruses (known to mutate randomly) and lentiviruses (long acting i.e., once they enter the human body, the individual is infected for life and can transmit the virus to others). HIV can be passed from one person to another. Anyone can become infected with HIV through contact with the bodily fluids of someone who has already contracted HIV. HIV stands for the ‘Human Immunodeficiency Virus’. Someone who is diagnosed as infected with HIV is said to be ‘HIV+’ or ‘HIV positive’. HIV has number of tricks that helps it to evade the body’s defences, including very rapid mutation. This means that once HIV has been contracted, the immune system can never fully get rid of it.

There isn’t any way to tell just by looking if someone’s been infected by HIV. In fact a person infected with HIV may look and feel perfectly well for many years and may not know that they are infected. But as the person’s immune system weakens they become increasingly vulnerable to opportunistic illnesses, many of which they would have fought off easily in the past. The only reliable way to tell whether someone has HIV is for them to take a blood test which can detect infection from a few weeks after the virus first entered the body.

Stages of Infection

When a person is infected with HIV, it usually takes about 3 weeks to 6 months for the antibodies to show themselves in a blood test. This period is commonly referred to as the ‘window period’. When a blood test detects the presence of antibodies, the person tested is referred as ‘sero-positive’ or ‘anti-body positive’. During this ‘window period’ an infected person can unknowingly infect others. The progress of HIV infection varies and should not be viewed as a definitive cycle of events. However, it is possible to identify the key elements of the clinical stages of HIV infection. They can be broadly classified into three categories.

i) Initial Symptoms of HIV infection

In the early stages of HIV infection (within few weeks), the person may develop a flu like illness, similar to glandular fever with symptoms of body ache, rash and swollen lymph glands. The person appears to get well after a few days. By this time the person may be considered a carrier capable of readily passing on the virus to another person. However, not all infected people (carriers) develop this kind of initial illness.

ii) Asymptomatic HIV Infection Latent Period

As with some other illnesses, this is a period in which the person who is living with HIV shows no apparent symptoms. This period, Called the latency period, may range from several months to several years and differ from individual to individual. The person with HIV may look and feel healthy, and remains so for many years. But, the person can pass on the virus to another person even while he or she looks healthy.
iii) **Symptomatic HIV Infection**

People with HIV begin to feel sick with minor illnesses such as rashes, infections of the mouth such as oral thrush, loss of weight (about 10% of the body weight), persistent fever, night sweats, loss of energy and extreme tiredness, easy bruising and bleeding and prolonged diarrhea. This period of symptomatic illness is sometimes referred to as “AIDS Related Complex’ (ARC) or as the period of active HIV infection.

### 1.3 TRANSMISSION OF HIV AND THE VULNERABLE SECTORS

HIV is transmitted only when contaminated blood and body fluids come in contact with the blood and mucous membranes of healthy individuals. Semen and vaginal secretions, in particular, contain substantial concentrations of HIV. Though sweat, tears and saliva, are also body fluids, they contain very low concentrations of the virus and hence do not present a risk of transmission of HIV. Most of the HIV infected in the third world countries fall among the poorest of the poor. They include sex workers, drug addicts, street children, child labours and migrant labours.

Ways in which one can be infected with HIV:

- **Sexual relations with an infected person**
  
  Sexual activities with an infected person is risky because the virus, which is present in an infected person’s sexual fluids, can pass directly into the body of his/her partner. This is true for vaginal, oral and anal sex.

- **Contact with an infected person’s blood**
  
  If infected blood from an infected person enters a healthy person’s body, then it can pass on the virus

- **Mother to Child transmission**
  
  From a mother to her child HIV can be transmitted (if the mother is infected) during pregnancy (HIV can cross placenta and infect the foetus), delivery (contact with the mother’s infected blood) and breastfeeding (breast milk being fluid contain a certain concentration of the virus).

- **Use of infected blood product**
  
  If blood or blood product is contaminated, HIV can be transmitted during transfusion of blood or blood products. Therefore, blood from all donors should be screened. Similar precautionary screening should be done in case of organ or issue transplants. Many people in the past have been infected with HIV by the use of blood transfusion and blood products which were contaminated with the virus in hospitals, for example. In advanced countries this is no longer a significant risk, as blood donations are routinely tested.

- **Injecting drugs**
  
  People who use injected drugs are also vulnerable to HIV infection. In many parts of the world, often because it is illegal to possess them, injecting equipment or works are shared. A tiny amount of blood can transmit HIV, and can be injected
directly into the bloodstream along with the drugs. Usually people who inject drugs are also found to be sharing the same needles and syringes. Some of the contributing factors are discussed below.

i) **Culture of silence**

The socio-cultural milieu of Indian society does not encourage the overt communication about sexual issues. These issues are NOT supposed to be discussed; talking about sex is a taboo. Parents, teachers and other adults often do not tell the children and adolescents about sex and sexuality. The only source of information they have is their peer group who are not capable of providing scientific and accurate information they have is their peer group— who are not capable of providing scientific and accurate information. This ‘misinformation’, is compounded by myths and misconceptions that indeed add to the vulnerability to sexually transmitted infections including HIV. A myth such as “having sex with a virgin will cure STDs” is often illogical and is of disastrous consequences.

ii) **Changing family patterns, functioning and roles**

Forces of social change such as urbanization, modernization and globalization have brought about significant changes in the family patterns and functioning. The nuclear family system is replacing joint families; alternate family patterns such as single parent families, women headed families, childless families are becoming increasingly visible in the society. Family cohesion is decreasing and family disintegration is on the rise. The family’s role to provide solace, comfort, recreational opportunity, protection, catharsis of pent of emotions is increasingly being taken over by outside agencies such as peers, colleagues, recreational clubs, television, cinema and the like. Monogamy and faithfulness of marriage partner cannot be ensured as, extra-marital sex is on the rise often in a clandestine manner. All these factors increase the risk of HIV infection.

iii) **Sex at workplace**

Forces of social change described above have also brought change to the workplace culture, ethos and patterns. Especially in cosmopolitans and metropolitans, workplace is characterized by cut throat ruthless competition, fast pace of work, pressures to meet deadlines, little time to relax and rest, late working hours, resulting in excessive stress and tension and lack of time and energy to be spent creatively with family members. Career oriented families are emerging where both husband and wife are equally aspiring to quickly ride the ladder of success, may be at the cost of decision to remain childless. Corporate life, BPOs have given the opportunity to both sexes to mix freely and be together for longer working hours. At workplace, casual sex is becoming quite common for various reasons like – for many it acts as a stress buster, for some it is opportunity to meet unfulfilled needs due to failed marriage and for others it may be the price to be paid for out of turn promotions and other incentives. This makes people more vulnerable to HIV infection.

iv) **Men buying sex**

Data project that almost 85 percent of HIV infection are through sex outside marriage, which includes men buying sex or having sex with commercial
sex workers. Men across the world buy sex for various reasons – wanting to avoid emotional involvement, lack of sex or not enough sex in marriages, wanting to experience power, variety or certain kinds of sexual experiences, thrills, loneliness or old age. These men are usually ordinary citizens and not sexual deviants. In societies with equitable gender relations, men respect the right of their wives or partners to refuse sex and visiting sex workers is like a ‘safety valve’ that lessened the strain on their modern relationships. In some societies, going to a sex worker is often a mark of the onset of manhood, with young boys being taken to brothels by their peers. Young boys generally visit sex workers for ‘experimentation’ and for learning skills of sexual intimacy, which increases the risk of HIV transmission. In patriarchal societies, where rigid sexual segregation, silence and taboo around sex are the norms, where sex is limited to procreation and there is lack of communication on sexuality with spouse. Visiting sex workers is considered as the only possible way of getting close to women without upsetting social norms. In societies like India, males buying sex often have highly moral positions on women; they consider sex workers as bad and promiscuous women but do not think it incongruous or immoral for themselves to visit sex workers.

iv) **Attitude towards sexuality**

In societies like India, socialization process, in myriad of ways, tend to develop negative attitude towards sex, sex organs and sexuality. A culture of silence and the lack of accurate information regarding sexual anatomy and physiology make adolescents ignorant about sexuality, developing a negative emotional attitude toward sex organs and matters related to sexuality. It is not uncommon for adolescents to perceive their sexual organs as dirty and to refrain even from looking at them. Such negativism is particularly very common among females, and to certain extent with the males. As a consequence, many myths crop up around sexual issues making adolescents and youth prone to reproductive tract infections (RTI) and sexually transmitted infections (STI). Adolescents are likely to be curious and yet ill-informed, with sources of knowledge being peers or unscientific literature, which may cause irreparable harm later in life. Many adolescents adopt high risk behaviour due to the numerous myths and lack of skills-especially ability to deal with peer pressure effectively. Thus, ignorance about sexual functioning and STI, unhealthy curiosity about sex, peer pressure and lack of appropriate skills may facilitate transmission of STI/HIV, particularly in the backdrop of low levels of literacy.

v) **Adolescence and vulnerability**

Research findings show that, most often than not, adolescents and youth, both males and females, display an abysmal lack of knowledge on sexual health issues. Also, adolescents initiating their sex life early are more likely to have multiple and high risk partners. Further, experimentation with alcohol and drugs are associated with high-risk sexual acts. Youth may not be candid about their sexual experiences out of fear of stigma and labels especially in case of same sex behavior. Young people often lack information they need to affect safe, healthy decision; this may lead to serious consequences such as teenage pregnancy and childbirth, unsafe abortions and STIs including HIV, to mention a few.
vi) **Violence on women as the mark of manhood**

Studies have indicated that violence on women, both physical and sexual, has been a predominant aspect of social construct of manhood. It is equally noteworthy, that even many of the women ‘accept’ being victims of violence and treat manifestations of violence as socially accepted behaviour that threaten the physical as well as mental well-being of perpetrator as well as victim, including increased risk of HIV infection. Thus, a woman’s vulnerability is far more than her male counterpart.

It is not possible for one to become infected with HIV through:

- Sharing crockery and cutlery
- Insect/animal bites
- Touching, hugging or shaking hands
- Eating food prepared by someone with HIV
- Toilet seats, telephone/mobile etc.

### Check Your Progress I

**Note:** Use the space provided for your answer.

1) Briefly explain how social workers can intervene in reducing the risk of HIV transmission among adolescents.

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### Tests for HIV

The body defends itself against each new viral infection by manufacturing proteins called ‘antibodies’. The presence of these antibodies is a positive indicator of infection. It is similar to HIV. However, after a person is infected with HIV, it may take up to 3 months for the antibodies to develop and detected. A person should be tested only after the window period. To detect HIV antibodies in the blood, a number of different tests have been developed. Two of the most widely used tests are ELISA (Enzyme Linked Immuno Sorbent Assay) and the Western Blot Kit Test. Yet, another method of detecting and identifying the HIV virus in the blood is called “polymerase chain reaction test” (PCR). However this test is very rarely available even in most of the Indian cities. Further, this test is very costly and would not be an option for the poorest of the poor.

### 1.4 Impact of HIV/AIDS on Various Sectors

At the micro-level, economic constraints due to HIV infection are quite obvious and visible. Income losses, at the household level are on various accounts: reduced work capacity, expenditure for treatment and care, reduced time to work and
earn, caregivers’ inability to work full time, premature death of an HIV infected member of the household, funeral costs and so on.

At the household level, the most frequently felt impact of HIV is increased spending on treatment and care, even if the cost of anti-retroviral therapy is not taken into account. Stated otherwise, meeting the cost of management of opportunistic infections is quite an uphill task especially for families with financial constraints. Further, affordability of anti-retroviral drugs is not easy for most of the households affected with HIV/AIDS.

Next, HIV most often attacks the productive age group of 15 to 40 years, designated as youth. It consequently affects the ability to work and earn and there is substantial loss of earning and income of households having members infected with HIV. There is reduced earning due to frequent ailments and reduced ability to work due to the infection. Another dimension of this accentuated vulnerability is reduced employability due to stigma associated with the infection. So, people afflicted by HIV, and face problems in getting job due to stigma and discrimination associated with HIV, and also retaining it because of deteriorating body’s health and immunity. In India, in consonance with many of the other developing nations, almost 93 percent of the people are engaged in unorganized sector and more often than not, engaged in physically strenuous and hazardous jobs. With HIV infection, stamina and energy drops significantly and affects the ability to work.

i) Agriculture Sector

There is widespread agreement that HIV/AIDS exacerbates economic vulnerability. HIV/AIDS is assumed to bring the proportions of devastation similar to those such as droughts and floods, thereby threatening the sustainability of rural communities. Loss of labour power due to HIV/AIDS destroys family life as well as agriculture patterns.

Poverty adds to HIV/AIDS vulnerability to many fold. It lowers the income and food purchasing-power of households and HIV/AIDS lowers household food and cash crop production. Small farmers may have to mortgage or sell off their piece of land for want of money. When they are left with no money to make initial investment for crop production, they often migrate to urban centers. This is an emerging trend in the state of Manipur where the infection rate is about ten percent. Another pull factor for migration is better healthcare infrastructure in urban areas. Cities often provide hostile environment to these migrants and many, especially women, are left with no choice but to engage themselves in sex work for survival. These factors further accentuate transmission of HIV infection. With increasing numbers and proportions of workforce in agriculture giving into morbidity and mortality due to HIV/AIDS, this primary sector shrinks in meeting the requirement of food production of the nation and contributing its share to GDP.

ii) Education

HIV/AIDS threatens educational institutions by precipitating a shortage of both teachers and students. The direct effects of the disease on the health and numbers of teachers and students are perhaps most obvious. The effects may be classified to be on the demand side or supply side. Impact that lower
the demand for education may be listed as – the premature mortality of women of reproductive age due to HIV/AIDS, reducing the number of children ever born. Infected children dying of HIV/AIDS reduces the number of primary school enrollers. The economic burden of an HIV infected parent may reduce the ability of households to afford school fees and uniforms or force children to engage in income-generating activities and food production instead of attending school which are evident in several African countries and in Manipur in India.

iii) Health

Health services play a crucial role in HIV/AIDS prevention, care, and treatment. While in the developed nations, the health care system has taken prime responsibility for providing palliative care for AIDS patients, in heavily affected developing countries such formal care is almost non-existent. Instead, households, families, and kin are the primary caregivers of people afflicted with HIV/AIDS. Nonetheless, the epidemic has had an obvious and profound effect on the healthcare institutions in the developing world. Demands for public health education and treatment can place burdens on health care institutions that shift infrastructure, personnel, and financial resources away from meeting other basic healthcare needs.

iv) Market Economy

HIV/AIDS has general impact on markets as it reduces substantially the number of consumers as well as their financial resources. There are myriad direct costs for firms and employers whose workforce is drawn from a population with high rate of HIV prevalence. These costs include lower productivity due to poor health, absenteeism and sick leave; absenteeism of ill workers or workers with infected family members; absenteeism by healthy workers attending the funerals of co-workers; health claims costs borne by employers; the costs of training and recruiting workers meant to replace the still or dying, instability due to increased turnover, recruitment as well as escalated training costs and so on. There are indirect costs to firms due to HIV/AIDS including the psychological effects on uninfected workers that may result in lowered morale due to high turnover, fear of death, and loss of interest. Responses to direct and indirect costs may vary, but include voluntary and mandatory testing of current and potential employees, provision of health care and anti-retroviral drugs (either directly or through a health plan), as well as awareness generation programmes.

It may be noted that these responses of the corporate sector may not be entirely humanitarian, as firms realize that it may be less expensive to provide drug treatment than endure the costs of a sick workforce with a high mortality rate. Pre-employment HIV screening are illegal, but firms sometimes use them to reduce HIV –related costs by avoiding the hiring of infected employees. Some firms may respond to these costs in less compassionate ways, by terminating employees found to be infected, limiting or eliminating health insurance coverage, and changing the terms of retirement pension. At times, individual firms tend to reduce the costs on account of HIV/AIDS to individual firms by shifting responsibility for dealing with the impact of AIDS to their workforce, their families and households, communities, governments and other organizations.
High prevalence of HIV may lead to shortage of skilled labour and often makes both types of labour—skilled and unskilled—more costly and less productive. Status and skill level of the infected workers determine, to some extent, the response of the firm. Companies may provide treatment cost, health care and other benefits to highly skilled and professional workers, while limiting these benefits or even terminating the services of unskilled or semi-skilled infected employees as it is more difficult to replace skilled and qualified staff due to a general shortage of skilled workers. In addition, HIV holds the potential to erode the skill base of future workers, as young people leave school to engage in economically productive activities to support their family which has lost a breadwinner to HIV/AIDS. HIV infection can change the cost of acquiring human capital, which may lead organizations to depend on a generation of new workers with lower skills.

v) **Armed Forces**

Infection rates among the armed forces have been found to be higher than in the general population. It may be attributed to several factors: the military forces are highly mobile, face frequent dislocation, are prone to casual sex and are deployed in socially disrupted and conflict zones that make the armed forces indulge in risky behaviours. It suggests that the spread of the diseases in the armed forces will have both direct impacts on national and regional security. Further, high rates of prevalence may weaken the army, and may reduce the ability of the nations to engage in local and regional peace-keeping activities.

### 1.5 HIV/AIDS SOCIAL WORK INTERVENTION

When we talk of care and support of people living with HIV and AIDS, there is a whole lot of intervention that comes under the umbrella of care and support. Social workers are the mainstay in all the intervention. They are the ones who are providing care and support to the PLHA without any discrimination. The primary aim of providing care and support is to prevent the spread of HIV including risk behavior change for HIV+ve persons. Provision of support include practical assistance and advocacy including palliative care and hospice care. Lobbying for and mobilization of minorities and stigmatized groups to ensure equitable delivery of services, and development of resources where they do not exist also form part of social work intervention.

**Counselling**

Let us first talk about counselling as a medium of providing care and support. Counselling is a professional area of work and only a trained and skilled person can give counseling. All social workers are trained in the area of counselling and are qualified to give counseling even to PLHA. In fact trained social workers are the best choice to provide counselling to PLHA as they have developed the required skill and have the right knowledge about the disease.

Counselling refers to leading the client to understand and face up to real life situations and from there to make choices based on such understandings (Baruth, G and Robinson, H, 1978). Counselling as a process is concerned with influencing behaviour change on the part of the client which is solely voluntary. Social workers who are experienced counselors significantly help the people living with HIV
Areas of Philanthropic Social Work-II

and AIDS to learn how to confront certain interpersonal, emotional and decisional problems. They ensure passing on correct information, provide support at times of crises, and encourage change when change is needed for the prevention or control of infection.

The techniques used by social work counselors may vary and perhaps also within countries depending on the background of the people being counseled and the type of health or social services locally available. Effective counseling need not follow any set pattern or approach. It should certainly not be restricted to a clinic or a structured doctor – patient situation. The most successful counseling often takes place outside the context of formal relationship. Social work Counsellors feel that counseling people living with HIV infection is important because infection with HIV is lifelong as of now. Besides a diagnosis of HIV infection can create enormous psychological pressures and anxieties that can delay constructive change or worsen illness, especially as HIV epidemic has given rise to fear, lack of understanding and discrimination. Further, most importantly counseling also promotes behaviour change which can prevent a person from acquiring HIV infection or transmitting it to others.

International Non-Government Organisation

International Non-Government Organizations (INGOs) also play an important role in providing care and support for PLHA and the social workers working with the INGOs are well equipped and informed with regard to the disease. One such example of the INGO working for the prevention and control of HIV and AIDS is: The Global Fund. The Global Fund to fight AIDS, Tuberculosis and Malaria is an international financing institution, invests the world’s money to save lives.

Hospice and Palliative Care

Hospice and palliative care is one of the most recent interventions by social workers all over for taking care of the infected. Social workers have always felt the need to incorporate the principles and practices of social work into management of patients with advanced HIV infection and AIDS through the hospice and palliative care and have been successful till date. However, HIV/AIDS and hospice and palliative care have had a chequered history. In the early days, accepting hospice and palliative care was equate with “giving up”. Then as the death rates increased in the early 1990s, hospice and palliative care became a little more acceptable. But what actually is hospice care? In layman’s term Hospice care treats the person rather than the disease. Hospice, in the earliest days, was a concept rooted in the centuries-old idea of offering a place of shelter and rest, or “hospitality” to weary and sick travelers on a long journey. In 1967 Dame Cicely Saunders at St. Christopher’s Hospice in London, first applied the term “hospice” to specialized care for dying patients. Today, hospice care provides humane and compassionate care for people in the last phases of incurable disease so that they may live as fully and comfortably as possible. In layman’s term Palliative Care may be defined as care intended to keep the person with HIV/AIDS healthy for as long as possible.

WHO has defined Palliative Care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of
early identification and impeccable assessment and treatment of pain and other problems: physical, psychosocial and spiritual. Palliative care according to WHO includes the following among others:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patients illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- Will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

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<td>1) Briefly discuss the social workers role in the prevention and control of HIV/AIDS with regards to the care and support of PLHA.</td>
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Social Work intervention through educating on HIV/AIDS

Several schools of Social Work taking a cue from the success of IGNOU have initiated awareness programmes and counseling services on HIV/AIDS. An example of such a school is the Sacred Heart College, Tirupatur as well as Loyola College, Trivandrum. Tata Institute of Social sciences has also introduced a certificate course in social work apart from their graduate, postgraduate courses and M.Phil and Ph.D in social work. The main objective of the certificate in social work programme is to throw open the doors of professional social work education to those who cannot engage in full-time study. This course was developed in response to the need for more front-line workers to work at direct service delivery level in social welfare organizations. The University Grants Commission (UGC), which is the apex body for higher education in the country
Areas of Philanthropic Social Work-II

has proposed the introduction of a compulsory course on HIV/AIDS at the undergraduate level. Heeding to this, several schools of social work in the country have introduced HIV/AIDS as a unit in their social work curricula. In 1991, ‘Universities Talk AIDS’ was started by the National Services Scheme, Department of Youth Affairs and Sports in collaboration with the WHO and Ministry of Health and Family Welfare in several universities across India. The programme included seminars, workshops, and debates apart from role-plays to sensitize the youth.

The school of social Work has made valuable contribution in planning, designing and developing HIV/AIDS curriculum in higher education system. IGNOU has programmes of study on HIV/AIDS from certificate to doctoral level. Several of these courses and programmes are available at undergraduate and post graduate levels and are being pursued by students from all over the country and several foreign countries.

**Social work intervention through advocacy and policy planning**

The advocacy activities undertaken by the social workers should aim to protect the rights of PLHA and it should be able to bring a balance between the long term and short term goals of intervention for HIV and AIDS. It should also concentrate on the prevention, control, care and support of PLHA. The objectives of advocacy worked upon by the social workers must relate to approaches and activities shown by research to be effective in addressing HIV and AIDS but it should fit the social, cultural, political and legal context of the society and bring about the involvement, to the extent possible, of PLHA in the planning, implementation and evaluation of programmes.

The social workers are furthermore, responsible for positioning various national, international as well as organizational policies to the advantages of PLHA. The annual national seminar on social work response to HIV/AIDS being organized by the school of Social Work at IGNOU in collaboration with the National Association of Professional Social Workers (NAPSWI) and other schools of social work since 2004 bring together social work professionals: academics, practitioners, students and the HIV infected. In each seminar, prominent citizens who have access to policy making participate. The participation of eminent person like Padmabhushan Anna Hazare, Padmashree Dr. Arole, Padmashree and Magssonry award winner Rajendra Singh, Dr. Mehdha Patkar, State and Central Ministers, Member of Parliament and State Assemblies, diplomats and representatives from international donor agencies and media help in bringing about impact on policy formulation for the HIV infected and the affected.

### 1.6 LET US SUM UP

In this unit on HIV/AIDS and Social Work intervention, we have given a brief introduction to what is HIV and AIDS, how HIV is spread from one person to another; several factors associated with HIV/AIDS particularly in the Indian context and most importantly the impact of HIV on various sectors such as agriculture, education, and the armed forces. We have also discussed some of the associated factors such as the culture of silence, changing family patterns, sex at workplace, men buying sex, attitude towards sexuality, adolescence and vulnerability and violence on woman as mark of manhood. The main Focus of
the unit is on areas of Social Work intervention which have been discussed in
detail towards the end of the unit. Counseling forms part of Social Work
intervention. The involvement of social workers through International non-
government organization, (INGOs), hospice and palliative care, advocacy and
policy planning as well as initiatives being made for HIV curriculum at higher
education have been elaborately described in this unit.

1.7 FURTHER READINGS AND REFERENCES

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UNIT 2  LEPROSY

Structure
2.0 Objectives
2.1 Introduction
2.2 Concepts and Definition
2.3 Historical Perspectives of Leprosy
2.4 Classification, Sign and Symptoms and Causes
2.5 Treatment of Leprosy
2.6 Rehabilitation of Leprosy
2.7 Let Us Sum Up
2.8 Further Readings and References

2.0 OBJECTIVES

After reading this unit, you will be able to:

• Discuss the concept and definition of leprosy
• Identify the various causes of leprosy
• Explain the treatment procedure of leprosy
• Explain the various rehabilitation aspects of leprosy

2.1 INTRODUCTION

This unit is focusing on the concepts, definition and various aspects of treatment related to leprosy. The most important aspect related to the persons suffering from leprosy is their rehabilitation, which is also very much reflected in this unit. There are many approaches through which, these persons are treated and rehabilitated in the society. Conceptually, leprosy is more a Social problem rather than Medical Problem. Commonly speaking, leprosy is an infectious disease characterized by disfiguring skin lesions, peripheral nerve damage, and progressive debilitation. Leprosy is common in many countries in the world, and in temperate, tropical, and subtropical climates. Approximately 100 cases per year are diagnosed in the U.S. Most cases are limited to the South, California, Hawaii, and U.S. island possessions. In India, around 120,000 leprosy patients existed in 1881. The central government passed the Lepers Act of 1898, which provided legal provision for forcible confinement of leprosy sufferers in India.

The term leprosy originates from ancient Greek which denotes, “A disease which makes the skin scaly”, in turn a nominal derivation of the verb, “to peel, scale off”. The word entered into the English language via Latin and Old French. The first attested English use is in the Ancrene Wisse, a 13th-century manual for nuns (“Moyseses hond..bisemde o þe spitel uuel & þuhte lepruse.” The Middle English Dictionary, s.v., “leprous”). A roughly contemporaneous use is attested in the Anglo-Norman Dialogues of Saint Gregory, “Esmondez i sont li lieprous” (Anglo-Norman Dictionary, s.v., “leprus”). The first mention about leprosy is found in Leviticus 13:2 - “When a man shall have in the skin of his flesh a rising, a scab,
Leprosy or bright spot, and it be in the skin of his flesh like the plague of leprosy; then he shall be brought unto Aaron the priest, or unto one of his sons the priests."

The word *Tzaraath* from the Hebrew Bible was, commonly translated as leprosy, although the symptoms of Tzaraath were not entirely consistent with leprosy rather refers to a variety of disorders other than Hansen’s disease. There is also the well known Bible story of the Syrian Naaman, “captain of the host of the king of Syria” who suffered from this severe and savage skin disease. This disease leprosy is also called Hansen’s disease named after physician Gerhard Armauer Hansen.

### 2.2 CONCEPT AND DEFINITION

Leprosy is a slowly progressing bacterial infection that affects the skin, peripheral nerves in the hands and feet, and mucous membranes of the nose, throat and eyes. It is not easily communicable and by itself has few noticeable effects, but it destroys nerves, which can lead to a loss of sensation in affected areas. This loss of sensation means that small cuts can go unnoticed and become extensively infected. The leper may not notice the cut until the infection is severe enough to be visually obvious. This can result in the loss of fingers or toes or in other visible deformities from optimistic infections.

In brief, it may be defined as chronic, potentially disability disease, mainly affecting the nerves, skin and eyes caused by a bacillus *mycobacterium lepra* which microscopically resembles the organism of tuberculosis. The more clear understanding of this complex disease could be understood by:

1. **Long incubation period (usually 2-5 years)**
2. **The remarkable diversity with reference to the level of immunity of different individuals**
3. **Increased frequency of adverse immunological reactions based on either cell mediated or antigen mechanisms.**
4. **Its propensity to produce disability and deformity which may be severe in some cases affecting eyes, face or limbs,**
5. **Social and Psychological consequences of leprosy for the patent, family and community, in some cases it leads to outright stigmatization and rejection.**

The world map shows the prevalence of leprosy in somewhat tropical, but in the past leprosy has been quite widespread in Europe, Scandinavia, China, Korea, and Japan. The likelihood contributions in development and spread are mainly poverty, poor socio-economic condition, malnutrition, lack of clean water and inadequate basic health services including immunization.

Leprosy or Hansen’s disease (HD), named after physician Gerhard Armauer Hansen, is a chronic disease caused by the bacteria *Mycobacterium lepra* and *Mycobacterium lepromatosis*. Leprosy is primarily a granulomatous disease of the peripheral nerves and mucosa of the upper respiratory tract; skin lesions are the primary external sign. Leprosy can be progressive disease, causing permanent damage to the skin, nerves, limbs and eyes. Contrary to folklore, leprosy does not cause body parts to fall off, although they can become numb and/or diseased as a result of infection.
Though the mode of transmission of Hansen’s disease is remains uncertain and yet to be established but most of the researchers think that Mycobacterium leprae is usually spread from person to person in respiratory droplets. The minimum incubation period reported is as short as a few weeks and this are based on the very occasional occurrence of leprosy among young infants. The maximum incubation period reported is as long as 30 years, or over, as observed among war veterans known to have been exposed for short periods in endemic areas but otherwise living in non-endemic areas. It is generally agreed that the average incubation period is between two to five years. It is now proved to a extent that leprosy is neither sexually transmitted nor highly infectious after required treatment. Approximately 95% of people are naturally immune and sufferers are no longer infectious after as short period as 2 weeks of treatment.

It is observed from the available evidences that leprosy has affected humanity for more than 4,000 years, and was well-recognized in the civilizations of ancient China, Egypt, and India. DNA taken from the shrouded remains of a man discovered in a tomb next to the Old City of Jerusalem shows to be the earliest human proven to have suffered from leprosy. In 1995, the World Health Organization (WHO) estimated that between 2 and 3 million people were permanently disabled because of leprosy at that time. In the past 20 years, approximately 15 million people worldwide have been cured of leprosy. Although the forced quarantine or segregation of patients is not necessary in the places where adequate treatments are available. Many leper colonies still remain around the world in countries such as India, where the more than 1,000 leper colonies are still exiting. The condition is more or less remains same in China, Romania, Egypt, Nepal, Somalia, Liberia, Vietnam, and Japan. There was a time, when leprosy was believed to be highly contagious and sexually transmitted, and was treated with mercury—all of which applied to syphilis which was first described in 1530. It is now thought that many early cases of leprosy could have been syphilis.

The much old social stigma, in other words, leprosy stigma associated with the advanced form of leprosy lingers in many areas, and remains a major obstacle to self-acceptance and reporting, early diagnosis and early treatment. Effective treatment for leprosy appeared in the late 1930s with the introduction of dapsone and its derivatives. Leprosy bacilli resistant to dapsone soon evolved and, due to overuse of dapsone, became widespread. It was not until the introduction of multidrug therapy (MDT) in the early 1980s that the disease could be diagnosed and treated successfully within the community.

MDT for multibacillary leprosy consists of rifampicin, dapsone, and clofazimine taken over 12 months. Dosages adjusted appropriately for children and adults are available in all Primary Health Centers in the form of blister packages. Single dose MDT for single lesion leprosy consists of rifampicin, ofloxacin, and minocycline. The move towards single dose treatment strategies has reduced the prevalence of disease in some regions since prevalence is dependent on duration of treatment.

### 2.3 HISTORICAL PERSPECTIVE OF LEPROSY

After the end of the 17th century, Norway and Iceland were the only countries in Western Europe where leprosy was a significant problem. During the 1830s, the
number of lepers in Norway rose rapidly, causing an increase in medical research into the condition, and further the disease became a political issue. As a corrective step, Norway appointed a medical superintendent for leprosy in 1854 and established a national register for lepers in 1856, and the first national patient was register in the world.

*Mycobacterium leprae*, the causative agent of leprosy, was discovered by G. H. Armauer Hansen in Norway in 1873, making it the first bacterium to be identified as causing disease in humans. In the same way, Hansen observed a number of non refractile small rods in unstained tissue sections. The rods were not soluble in potassium lye and they were acid and alcohol fast. In 1879 he was able to stain these organisms with Ziehl’s method and the similarities with Koch’s bacillus (*Mycobacterium tuberculosis*) were noted. There were three significant differences between these organisms: (1) the rods in the leprosy lesions were extremely numerous (2) they formed characteristic intracellular collections (*globii*) and (3) the rods had a variety of shapes with branching and swelling. These differences suggested that leprosy was caused by an organism related to distinct from *Mycobacterium tuberculosis*. He also worked at St. Jørgens Hospital in Bergen, founded early in the fifteenth century. St. Jørgens is today a museum, *Lepramuseet*, probably the best preserved leprosy hospital in Northern Europe.

The word *leprosy* comes from ancient Greek, “a disease which makes the skin scaly”, in turn a nominal derivation of the verb, “to peel, scale off”. The word came into the English language via Latin and Old French. The first attested English use is in the *Ancrene Wisse*, a 13th-century manual for nuns (“Moyseses hond..bisemde o þe spitel uuel & þuhte lepruse.” *The Middle English Dictionary*, s.v., “leprous”). A roughly contemporaneous use is attested in the Anglo-Norman *Dialogues of Saint Gregory*, “Esmondez i sont li lieprous” (*Anglo-Norman Dictionary*, s.v., “leprus”).

Historically, individuals with Hansen’s disease have been known as *lepers*; however, this term is falling into disuse as a result of the diminishing number of leprosy patients and the pejorative connotations of the term. Because of the stigma to patients, some prefer not to use the word “leprosy,” though the term is used by the U.S. Centers for Disease Control and Prevention and the World Health Organization.

Historically, the term *Tzaraath* from the Hebrew Bible was, erroneously, commonly translated as leprosy, although the symptoms of Tzaraath were not entirely consistent with leprosy and rather referred to a variety of disorders other than Hansen’s disease. The first mention of leprosy recorded is found in Leviticus 13:2 - “When a man shall have in the skin of his flesh a rising, a scab, or bright spot, and it be in the skin of his flesh like the plague of leprosy; then he shall be brought unto Aaron the priest, or unto one of his sons the priests.” There is also the well known Bible story of the Syrian Naaman, “captain of the host of the king of Syria” (2 Kings 5:1), who suffered from this severe and savage skin disease.

In particular, tinea capitis (fungal scalp infection) and related infections on other body parts caused by the dermatophyte fungus *Trichophyton violaceum* are abundant throughout the Middle East and North Africa today and might also have been common in biblical times. Similarly, the related agent of the disfiguring
skin disease favus, *Trichophyton schoenleinii*, appears to have been common throughout Eurasia and Africa before the advent of modern medicine. Persons with severe favus and similar fungal diseases (and potentially also with severe psoriasis and other diseases not caused by microorganisms) tended to be classed as having leprosy as late as the 17th century in Europe. This is clearly shown in the painting *The Regents of the Leper Hospital in Haarlem 1667* by Jan de Bray (Frans Hals Museum, Haarlem, the Netherlands), where a young Dutchman with a vivid scalp infection, almost certainly caused by a fungus, is shown being cared for by three officials of a charitable home intended for leprosy sufferers. The use of the word “leprosy” before the mid-19th century, when microscopic examination of skin for medical diagnosis was first developed, can seldom be correlated reliably with Hansen’s disease as we understand it today.

In the West, the earliest known description of leprosy was made by the Roman encyclopedist Aulus Cornelius Celsus (25 BC – 37 AD) in his *De Medicina*; he called leprosy “*elephantiasis*”. The Roman author Pliny the Elder (23–79 AD) mentioned the same disease. Although “*sara’t*” of Leviticus (Old Testament) is translated as “*lepra*” in the 5th century AD Vulgate, the original term *sara’t* found in Leviticus was not the *elephantiasis* described by Celsus and Pliny; in fact, *sara’t* was used to describe a disease which could affect houses and clothing. Katrina C. D. McLeod and Robin D. S. Yates state that *sara’t* “denotes a condition of ritual impurity or a temporary form of skin disease.” The Persian polymath Avicenna (c. 980–1037) was the first outside of China to describe the destruction of the nasal septum in those suffering from leprosy.

So far as the Indian historical perspective of leprosy is concerned, it is evident that *the Oxford Illustrated Companion to Medicine* holds the mention of leprosy, as well as cures for it, were already described in the Hindu religious book *Atharva-veda*. Writing in the *Encyclopedia Britannica 2008*, Kearns & Nash state that the first mention of leprosy is in the Indian medical treatise *Sushruta Samhita* (6th century BC). *The Cambridge Encyclopedia of Human Paleopathology* (1998) holds that: “The *Sushruta Samhita* from India describes the condition quite well and even offers therapeutic suggestions as early as about 600 BC” The surgeon Sushruta lived in the Indian city of Kashi by the 6th century BC, and the medical treatise *Sushruta Samhita*—attributed to him—made its appearance during the 1st millennium BC. The earliest surviving excavated written material which contains the works of Sushruta is the *Bower Manuscript*—dated to the 4th century AD, almost a millennium after the original work. Despite the existence of these earlier works the first generally considered accurate description of the disease was that of Galen of Pergamum in 150 AD.

In 2009, a 4,000-year-old skeleton was uncovered in India that was shown to contain traces of leprosy. The discovery was made at a site called Balathal, which is today part of Rajasthan, and is believed to be the oldest case of the disease ever found. This pre-dated the previous earliest recognized case, dating back to 6th-century Egypt, by 1,500 years. It is believed that the excavated skeleton belonged to a male, who was in his late 30s and belonged to the Ahar Chalcolithic culture. Archaeologists have stated that not only does the skeleton represent the oldest case of leprosy ever found, but is also the first such example that dates back to prehistoric India. This finding supports one of the theories regarding the origin of the disease, which is believed to have originated in either India or
Africa, before being subsequently spread to Europe by the armies of Alexander the Great.

In 1881, around 120,000 leprosy patients existed in India. The central government passed the Lepers Act of 1898, which provided legal provision for forcible confinement of leprosy sufferers in India.

2.4 CLASSIFICATION, SIGN AND SYMPTOMS AND CAUSES

Classification of Leprosy

There are several different approaches for classifying leprosy, however, parallels exist.

- The World Health Organization system distinguishes “paucibacillary” and “multibacillary” based upon the proliferation of bacteria (“pauci-” refers to a low quantity.)
- The SHAY scale provides five gradations.
- The ICD-10, though developed by the WHO, uses Ridley-Jopling and not the WHO system. It also adds an indeterminate (“I”) entry.
- In MeSH, three groupings are used.

Tuberculoid: It is characterized by one or more hypopigmented skin macules and anaesthetic patches, where skin sensations are lost because of damaged peripheral nerves that have been attacked by the human host’s immune cells.

Borderline: Borderline leprosy is of intermediate severity and is the most common form. Skin lesions resemble tuberculoid leprosy but are more numerous and irregular; large patches may affect a whole limb, and peripheral nerve involvement with weakness and loss of sensation is common.

Lepromatous: It is associated with symmetric skin lesions, nodules, plaques, thickened dermis, and frequent involvement of the nasal mucosa resulting in nasal congestion and epistaxis (nose bleeds) but typically detectable nerve damage is late. There is a clearcut difference in immune response to the tuberculoid and lepromatous form.

Signs and symptoms

Skin lesions are the primary external sign. Left untreated, leprosy can be progressive, causing permanent damage to the skin, nerves, limbs and eyes. Contrary to folklore, leprosy does not cause body parts to fall off, although they can become numb and/or diseased as a result of the disease.

The most common symptoms of leprosy are:

- skin lesions that have decreased sensation to touch, heat, or pain and are are lighter than your normal skin color
- skin lesions that do not heal after several weeks to months
- numbness or absent sensation in the hands and arms, or feet and legs
- muscle weakness
Leprosy can eventually cause cosmetic disfigurement, nerve damage in the extremities, and sensory loss in the skin and muscle weakness. People with long-term leprosy may lose the use of their hands or feet due to repeated injury resulting from lack of sensation.

**Causes**

Leprosy is caused by the organism Mycobacterium leprae. *Mycobacterium leprae*, one of the causative agents of leprosy. As acid-fast bacteria, *M. leprae* appear red when a Ziehl-Neelsen stain is used. Main article: Mycobacterium leprae

*Mycobacterium leprae* and *Mycobacterium lepromatosis* are the causative agents of leprosy. *M. lepromatosis* is a relatively newly identified mycobacterium which was isolated from a fatal case of diffuse lepromatous leprosy in 2008.

An intracellular, acid-fast bacterium, *M. leprae* is aerobic and rod-shaped, and is surrounded by the waxy cell membrane coating characteristic of *Mycobacterium* species.

Due to extensive loss of genes necessary for independent growth, *M. leprae* and *M. lepromatosis* are unculturable in the laboratory, a factor which leads to difficulty in definitively identifying the organism under a strict interpretation of Koch’s postulates. The use of non-culture-based techniques such as molecular genetics has allowed for alternative establishment of causation.

While the causative organisms have to date been impossible to culture *in vitro* it has been possible to grow them in animals. Charles Shepard, chairman of the United States Leprosy Panel, successfully grew the organisms in the footpads of mice in 1960. This method was improved with the use of congenitally athymic mice (‘nude mice’) in 1970 by Joseph Colson and Richard Hilson at St George’s Hospital, London. Eleanor Storrs at the Gulf South Research Institute discovered that wild armadillos in Louisiana were naturally infected with leprosy. Naturally occurring infection also has been reported in non-human primates including the African chimpanzee, sooty mangabey, and cynomolgus macaque.

### 2.5 TREATMENT OF LEPROSY

All the patients must be bought under the network of the centre for the treatment. Adequate specific and regular treatment should be ensured. Maintenance of treatment records is obligatory as it helps in follow up and tracing the defaulters.

Side by side, the patient should be explained the advantages of the treatment of leprosy and its effect on control and progress of the disease. Furthermore, it is important to create facilities for indoor, treatment of acute complications of the disease. In addition facilities for dressing deformities should be made available. Similarly referral centre may be created for specialized treatment where complications and deformities can also be effectively managed. Treatment through medicinal intervention is also having great importance in the treatment of leprosy. All the medicinal interventions include chemotherapy.

**Chemotherapy**

Treatments are aimed to eliminate the microorganism that causes leprosy and to reduce the symptoms. Common treatments include: Dapsone, Rifampin, Clofazimine, Ethionamide, Aspirin, Prednisone, and Thalidomide.
Earlier, treatment of leprosy was restricted to Dapsone mono therapy. It predisposed to the emergence of secondary and subsequent primary Dapsone resistant bacilli. In order to check the spread of drug resistant mutants, WHO recommended the multi drug therapy with the objective i) to cure the patient ii) to interrupt the transmission of the infection in the community iii) to stall the emergence of drug resistant mutants and iv) to prevent the deformities.

Short course chemotherapy for 6 months is recommended for pauci-bacillary patients and it is administered to all freshly diagnosed cases of pauci bacillary and also to that dapsone treated pauci-bacillary patients, who have relapsed. The treatment is stopped after 6 months.

The proposed chemotherapeutic regimen for multi bacillary (MB) leprosy is recommended for i) Freshly diagnosed MB cases ii) Patient, who have responded satisfaction by to previous dap some mono therapy iii) Patients, who have not responded satisfaction to previous dap some mono therapy iv) Patient, who have relapsed after cessation of dap some mono therapy. The treatment is recommended for minimum 2 years.

Many newer anti-leprosy drugs have been introduced such as Fluroguinotones, Mynocycline Macrolides and Phenazine, which are effectively treating and diagnosing the leprosy patients.

2.6 REHABILITATION OF LEPROSY

Rehabilitation

The rehabilitation of the patient should start from the day of diagnosis. Physiological rehabilitation of the patient is very important, along with the sympathetic attitude and understanding of the patient is of considerable assistance. It helps in gaining the confidence of the patient and changing has attitude towards leprosy. The leprosy workers should help in finding suitable jobs for the patients so that they become self sufficient and useful for the society. Financial assistance through welfare agencies would also be helpful for their rehabilitation.

Philosophy and Approach

The transition of leprosy rehabilitation from medical to psycho social, and from institutional to community-based processes, in line with the move towards promoting rights and inclusion, would need to be accompanied by certain changes. Traditionally, health care institutions used a ‘top-down’ approach in service delivery and governance. In some cases the systems became so autocratic that the ‘needs’ of clients were ignored and they never became empowered enough to choose their goals. In contrast, ‘community- based organizations’ do not have highly differentiated structures or systems of communication that are imposed on clients. They use a ‘bottom-up’ approach that allows client participation in strategy development. Leprosy rehabilitation programmes till the recent time, tended to be more institution-based and top-down. However of late, some of these programmes have started adopting ‘bottom-up’ approaches, using ‘participatory needs analyses, ‘participatory decision making’ etc. They have started moving from a charity based rehabilitation philosophy to an enabling, developmental one, focusing on inclusion, self help and so on. There may be a need for training to build capacity of programme personnel to adopt these approaches.
Community Based Rehabilitation

The major change in strategy in rehabilitation of persons suffering from leprosy and also people with disabilities over the past 25 years has been the expansion of services into the community. This has slowly gathered momentum and has developed into a differentiated programme called ‘Community Based Rehabilitation’ (CBR). Among the recent strategies adopted for rehabilitation of leprosy-affected persons, ‘community based rehabilitation’ is of special interest because this strategy has been found to be a viable alternative for large populations of persons with disability from rural areas, who are unable to access currently available services. The following section provides a brief history of CBR.

The World Health Organization and other UN agencies promoted CBR in the early 1980s to provide services at affordable costs for people with disabilities and leprosy cured persons in developing countries. Implementation of this method involved shifting rehabilitation interventions to the homes of and their communities, to be carried out by minimally qualified volunteers, including families and other community members. In the early 1980s, CBR was conceptualized and evolved primarily as a service delivery method with a medical focus was already well established by then. Subsequently CBR changed its focus from a medical to a comprehensive approach, including interventions such as education, vocational training, social rehabilitation, prevention and so on. Another simultaneous change was the shift in focus from restoration of functional ability in an individual, to modifying community attitudes and contextual factors. It was felt that mere change in an individual to ‘fit’ him into his community was not enough but that it was equally important to change contextual factors around the individual as well. Changes in contextual factors involved changing attitudes of others to accept people with disabilities and promote their social integration. It also meant provision of equal opportunities in education, employment, protection of rights etc.,

In 1994, the joint position paper of WHO, ILO and UNESCO, which was updated in 2002, further changed the focus of CBR from a service delivery approach to a community development process, by defining it thus: ‘Community-based rehabilitation is a strategy within community development, for rehabilitation, equalization of opportunities and social integration of all people with disabilities and leprosy cured persons. CBR is implemented through combined efforts of affected people themselves, their families and communities, and with appropriate health education, vocational and social services’. This moves away from the view that CBR is merely a form of ‘therapy in community’, to an approach that promotes inclusion, community participation and community ownership of programmes. It also recognises that disabled people should have access to all services that are available to others in the community, such as community health services, child health services, social welfare, education etc. More recent changes in the field of CBR are the planners’ emphasis on inclusion, equal opportunities, protection of rights of persons with disabilities and the rapid growth of organizations of persons with disabilities to advocate for themselves. The common goals of CBR today can be enumerated as:

1) Enhancement of functional ability of persons with disability and leprosy cured to the extent possible;
2) Achievement of barrier-free environments, information and communication methods in order to create an inclusive society in which people with disabilities including leprosy cured have equal opportunities and enjoy full participation; and

3) Empowerment of people with disabilities and leprosy cured people and their families as decision-makers at all levels, and creation of public awareness in order to ensure that people with disabilities have full access to all aspects of community life While these goals may be common across different contexts, the way they are translated into activities depend on the local situation, needs and resources. Programmes and projects at various levels have formulated different strategies to achieve these goals. These include interventions for individuals with disabilities and leprosy, for families and for the wider communities, utilizing resources available within the communities to the extent possible.

There is greater emphasis now on information sharing and networking in the field, sometimes facilitated by donor agencies through their partner networks. More published literature is also available in journals and newsletters on CBR practice and results. Many more training programmes are available in different countries for different levels of CBR personnel.

Issues to be addressed in CBR for persons affected by Leprosy

Who needs Rehabilitation?

Different writers have indicated that there will continue to be demands for care by persons affected by leprosy. However, what is not yet clear is who will need rehabilitation and which services are best suited for different groups of affected persons. In an analysis of studies on leprosy, Srinivasan reported that 21% to 45% of all persons affected by the disease deteriorated economically. A high proportion of this group had deformities. Yet, not all persons with deformities deteriorated economically. Conversely, some persons without deformities deteriorated economically. The dilemma is to identify ‘who amongst leprosy-affected persons will need community level rehabilitation to address the economic and other psychosocial impact of the illness. Are they persons with deformities? Or are they persons who will require to be classified according to other parameters that are not yet identified?

Likewise, it is yet unclear what kind of rehabilitation is most acceptable to leprosy-affected people. For example, only a very small number of people with deformities may be finally eligible and willing to undergo reconstruction surgery. Similarly, a substantial number of economically deteriorated leprosy-affected people may show no interest in seeking available rehabilitation schemes. Objective evidence on acceptance and appropriateness of rehabilitation services in leprosy is scanty.

Implication for Leprosy Rehabilitation Programmes

With the use of ‘Multiple Drug Therapy’ (MDT), leprosy-affected persons now develop less disfiguring disabilities compared to a decade earlier and as a result, stigma attached to leprosy, especially enacted stigma, has begun to diminish. The integration of leprosy services into general health services has initiated a transformation in leprosy programmes from being a vertical, stand-alone service, based on a single etiological factor, to a service integrated into general health
Areas of Philanthropic Social Work-II

services. Leprosy rehabilitation programmes are also using decentralized and community-based strategies such as those adopted by other health and development services.

These shifts have in turn led to changes in rehabilitation philosophy and practice moving from a medical model where prevention and reversal of deformities were the prime focus of interventions, to a psychosocial model with emphasis on inclusion, economic rehabilitation, and access to services and human rights. Interventions in leprosy rehabilitation, particularly in the Asian region, are beginning to shift beyond traditional prevention, treatment and surgical reconstruction to others such as community-based rehabilitation, socio-economic rehabilitation and formation of self-help groups for affected persons and families. Thus, leprosy rehabilitation is changing its emphasis from a purely ‘client-centred programme’ to a ‘client and community centred programme’.

The biggest disease today is not leprosy or tuberculosis, but rather the feeling of being unwanted. — Mother Teresa

Check Your Progress I

1) Fill in the blanks

a) The most important aspect related to the persons suffering from leprosy is their ............................................................

b) The word leprosy derives from ancient Greek which means, “a disease which makes ..........................”.

c) Leprosy is a slowly progressing ......................... that affects the skin, ......................... in the hands and fact, and ......................... of the nose, throat and eyes.

d) Although the mode of .........................remains uncertain, most investigators think that M. leprae is usually spread from person to person in .........................

e) The transition of leprosy rehabilitation from medical to psycho social, and from institutional to community-based processes, in line with the move towards promoting .................................

2) Describe about the concept of Leprosy in about 100 words?

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3) When the Leprosy was first discovered as a disease and what was the further action initiated for the treatment?

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4) Briefly describe about the various classification of leprosy?

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5) How community based rehabilitation is important for rehabilitation of persons suffering from leprosy? Discuss in briefly.

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2.7 LET US SUM UP

Leprosy is common in many countries in the world, and in temperate, tropical, and subtropical climates. Approximately 100 cases per year are diagnosed in the U.S. Most cases are limited to the South, California, Hawaii, and U.S. island possessions. In India, around 120,000 leprosy patients existed in 1881. The central government passed the Lepers Act of 1898, which provided legal provision for forcible confinement of leprosy sufferers in India. The word leprosy derives from ancient Greek which means, “a disease which makes the skin scaly”, in turn a nominal derivation of the verb, “to peel, scale off”. The word came into the English language via Latin and Old French. In brief, it may be defined as chronic, potentially disability disease, mainly affecting the nerves, skin and eyes caused by a bacillus mycobacterium leprae, which microscopically resembles the organism of tuberculosis. Historically, individuals with Hansen’s disease have been known as lepers; however, this term is falling into disuse as a result of the diminishing number of leprosy patients and the pejorative connotations of the term. Because of the stigma to patients, some prefer not to use the word “leprosy,”
though the term is used by the U.S. Centers for Disease Control and Prevention and the World Health Organization

- The World Health Organization system distinguishes “paucibacillary” and “multibacillary” based upon the proliferation of bacteria (“pauci-” refers to a low quantity).
- The SHAY scale provides five gradations.
- The ICD-10, though developed by the WHO, uses Ridley-Jopling and not the WHO system. It also adds an indeterminate (“I”) entry.
- In MeSH, three groupings are used.

**Tuberculoid:** It is characterized by one or more hypopigmented skin macules and anaesthetic patches, where skin sensations are lost because of damaged peripheral nerves that have been attacked by the human host’s immune cells.

**Borderline:** Borderline leprosy is of intermediate severity and is the most common form. Skin lesions resemble tuberculoid leprosy

**Lepromatous:** It is associated with symmetric skin lesions, nodules, plaques, thickened dermis.

Treatments are aimed to eliminate the microorganism that causes leprosy and to reduce the symptoms. Common treatments include, **Dapsone, Rifampin, Clofazimine, Ethionamide, Aspirin, Prednisone, Thalidomide**

The transition of leprosy rehabilitation from medical to psycho social, and from institutional to community-based processes, in line with the move towards promoting rights and inclusion, would need to be accompanied by certain changes. The major change in strategy in rehabilitation for people with disabilities over the past 25 years has been the expansion of services into the community. This has slowly gathered momentum and has developed into a differentiated programme called ‘Community Based Rehabilitation’ (CBR). Among the recent strategies adopted for rehabilitation of leprosy- affected persons, The World Health Organization and other UN agencies promoted CBR in the early 1980s to provide services at affordable costs for people with disabilities in developing countries. Implementation of this method involved shifting rehabilitation interventions to the homes of people with disabilities and their communities, to be carried out by minimally qualified volunteers, including families and other community members. In the early 1980s, with the use of ‘Multiple Drug Therapy’ (MDT), leprosy-affected persons now develop less disfiguring disabilities compared to a decade earlier and as a result, stigma attached to leprosy, especially enacted stigma, has begun to diminish. The integration of leprosy services into general health services has initiated a transformation in leprosy programmes from being a vertical, stand-alone service, based on a single etiological factor, to a service integrated into general health services. Leprosy rehabilitation programmes are also using decentralized and community-based strategies such as those adopted by other health and development services.

### 2.8 FURTHER READINGS AND REFERENCES


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UNIT 3 DISPLACED PEOPLE, MIGRANTS, REFUGEES, ASYLUM SEEKERS, STATELESS PEOPLE

Structure
3.0 Objectives
3.1 Introduction
3.2 Displaced People
3.3 Migrants
3.4 Refugees
3.5 Landless Labourers
3.6 Bonded Labourers
3.7 Let Us Sum Up
3.8 Further Readings and References

3.0 OBJECTIVES

Taking into consideration all these factors, an attempt is made in this unit to understand the complex phenomenon of displaced people. We will also see that though ‘displaced people’ is given as a common category, there are vast differences among the various groups that fall under this name. This unit would provide you with the explanation of the following:

- The different people who are grouped under the category called, ‘Displaced People’ and the various understandings of it;
- Who are specifically the displaced people or what today has come to be known as IDPs, that is, internally displaced people;
- An understanding of the issue of migration and the different types of migrants;
- Who is the person or the communities what are called refugees today and what are the various effects on the refugees;
- Who are the landless labourers and bonded labourers, the reasons for their being bonded and what is being done etc;
- Finally we will see what are some of the humanitarian responses to these groups of people.

As these aspects are discussed, you will get an idea about each of these groups of people and what are similar and different between these, what are some of the national and international responses to these groups of people.

3.1 INTRODUCTION

Displaced people or what has come to be known in the international arena, ‘people on the move’ are people who are either migrants, refugees, internally displaced persons (IDPs) or asylum seekers and stateless people. In a broader sense, these groups of people have been also called, “People in Need, People of Concern,
People on the Move”. What is more significant is that the number of people who are generally called displaced people are on the increase. Another important fact to be kept in mind is though humanitarian assistance has been provided for this group of people, the response is inadequate as we would see in the following pages.

Further, many individuals and organizations have been working for the welfare of these groups of people. But not much systematic study has been done so far. This is due to the fact that refugee studies and displaced people’s study is a new discipline altogether. Also, it is often difficult to study the status of the refugees, displaced people etc. Study of migrants is not a problematic issue. But the study of refugees, displaced people, stateless peoples and asylum seekers are froth with its own problems and risks.

Since the dawn of civilization, millions of people have been drive from their homes and displaced or dislocated or moved from their original habitation within the borders of their own countries. This kind of displacement of these people takes place for various natural and human-made reasons. There are studies which show that over the last two decades, the number of such internally displace persons (IDPs) has reached to over 25 million, dispersed in more than 40 countries. Displacement of these groups of people may be coerced or involuntary movements caused by development projects, armed conflicts, situations of generalized violence, violations of human rights, and natural or human made disasters.

In the name of country, nation, religion, region, identity and homeland many governments, military forces and rebels of the world have drawn great circles in the earth’s sand. From inside these circles, millions are being thrown out. They are known variously as “refugees,” “displaced persons,” “expellees,” “returnees,” “asylum seekers” and “economic migrants.” The one difference is that migration can be a voluntary movement in most cases. But displacements are in most often involuntary in nature.

Even a cursory glance on the international arena reveals the fact that millions are being forced to move. This is sometimes because of the deliberate policies of the governments and at others because of the failure of governments to protect the weaker sections of the society, from the violence of the powerful. Internal conflicts and border wars, the continuing abuse of human rights at times by the state and at other times by the rebels and intolerable conditions of poverty are some of the factors responsible for forced movement of populations. Not all uprooted people cross international borders. In fact the number of persons who remain displaced within their home state is much larger than those who move out of their national boundaries.

There are also various terms which have been used by different agencies to describe groups affected by displacement and migration. The meaning of some of these terms is not always self-evident. Significantly, they are at sometimes misleading and are not necessarily mutually exclusive. This problem of different meanings to the terminologies of displaced people is mostly revolved by resorting to the understanding given by the United Nations. But even here, there is no unanimity. To locate the discussion properly, let us try to present the definitions of these terms as given by the United Nations.
• **Internally Displaced Persons (IDPs):** ‘persons who have been forced to flee their homes suddenly or unexpectedly in large numbers, as a result of armed conflict, internal strife, systematic violations of human rights or natural or man-made disasters, and who are within the territory of their own country.’ [This was the definition that was given by the UN Secretary General in 1992.]

• **Migrants:** Migrants are persons who leave their countries of origin purely for economic reasons not in any way related to the refugee definition, or in order to seek material improvements in their livelihood. Economic migrants do not fall within the criteria for refugee status and are therefore not entitled to benefit from international protection as refugees.

• **Refugees:** A person, who is outside his country of origin and who due to well-founded fear of persecution, is unable or unwilling to avail himself of that country’s protection.

[Source: UNHCR. Protecting Refugees: A Field Guide for NGOs. UNHCR.]

Along with these people one can also talk about asylum seekers and stateless people. There are two other categories of people who are displaced in some sense and need humanitarian assistance. The government of India has special focus on these groups. This unit tries to give some preliminary understanding of these various categories of people who are clubbed under the broad category called the displaced people.

### 3.2 DISPLACED PEOPLE

The term displaced people are displaced person was first widely used during World War II due to the resulting refugee outflows from Eastern Europe. At this time, the term was used to specifically refer to a person who was removed from his or her native country as a refugee, prisoner or a slave labourer. The meaning has significantly broadened in the past five decades. In most discussions, a displaced person may also be referred to as a forced migrant. The term “refugee” is also commonly used as a synonym for displaced person, causing confusion between the general descriptive class of anyone who has left their home and habitation.

The discussion on displaced persons or displaced people in the course of time, focused on internal displacement. In that sense, internal displacement refers to involuntary movement of people inside their own country. This movement may be due to a variety of causes. These causes could be natural or human made disasters, crisis leading to conflict, armed conflict or situations of generalized violence. For example, after the Kosi Floods in Bihar in the year 2008, few thousands of people moved to Mumbai, Punjab and Haryana. This is due to the fear that cultivation is not possible in their place any more due to the sand that covered the agricultural land. To cite another example, many people from the Scheduled Tribe community have been displaced due to construction of dams and setting up of mines.

Thus, the discussion did not limit itself to displaced people but moved to internally displaced persons. Thus, we have in the UN Guiding Principles on Internal Displacement the definition of an internally displaced person: “Internally
displaced persons (IDPs) are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.”

Interestingly, for the United Nations and its organization, United Nation’s High Commission for Refugees (UNHCR) internally displaced persons include only conflict-generated IDPs to whom the Office extends protection and/or assistance. Thus, the definition of IDP by the UN agencies is very much limiting, that is, displacement of people does not take place only due to conflict but due to many other factors too. This is also the case, when it comes to the perception of the governments. Many government term the displacement of the people as migration.

However, studies have shown that an overwhelming majority of displaced persons in the Third World, who are generally classified as “voluntary migrants” by host governments and international agencies, belong to the minorities and economically backward sections of the society. For example, between 1950 and 1990 approximately 21 million people were displaced in India by projects like big dams, mines, industries and wildlife reserves. Of these, nearly 40 per cent were Scheduled Tribes or Indigenous Peoples as the UN calls them. Though the Scheduled Tribes constitute over eight per cent of India’s population, yet among the internally displaced people, they constituted almost half of the population.

As these persons did not cross any international border, they remained displaced within India. However, in the mid-sixties more than 1,00,000 Chakma tribal people were displaced due to the Kaptai dam, built in the Chittagong hill tracts of then East Pakistan, now Bangladesh. Nearly 52,000 people displaced by the dam, belonging to the Chakma and Hajong tribes, crossed over to India. Though these persons would not have been recognised by the UNHCR as “refugees,” India gave them shelter. This puts the 1,00,000 Chakma population in a fix. If they had remained within Bangladesh, they would have been considered as internally displaced persons. Since they crossed the territory of Bangladesh, they should have been considered as refugees by UNHCR as refugees. But since their displacement due to the construction of dam, UNHCR does not see them as refugees. Thus, the issue gets more complicated.

It is significant to note that there are people who sometimes referred to as ‘internal refugees’, who are in similar need of protection and assistance as refugees but do not have the same legal and institutional support as those who have managed to cross an international border. While the UNHCR as an international agency which assists the refugees, due to the lack of specifically-mandated body to provide assistance to IDPs, the IDPs are in difficult situations. Although they are guaranteed certain basic rights under international humanitarian law (the Geneva Conventions), ensuring these rights are secured is often the responsibility of authorities which were responsible for their displacement in the first place, or ones that are unable or unwilling to do so.

The number of IDPs around the world is estimated to have risen from 1.2 million in 1982 to 14 million in 1986. However, it is likely that earlier estimates are woefully low, as little systematic counting was being conducted at the time. Estimates on numbers of IDPs continue to be controversial, due to debate over
Areas of Philanthropic Social Work-II
definitions, and to methodological and practical problems in counting. At the end of 2001, the IDPs were estimated to be 22 million worldwide, although this is likely to be a conservative figure. According to the latest figures released by the Norwegian Refugee Council (NRC), there were 26 million IDPs around the world in 2008.

Types of Displacement

It is expedient at this juncture to describe different types of displacement and also to identify different types of displaced people.

1) **Conflict-Induced Displacement:** People who are forced to flee their homes for one or more of the following reasons: armed conflict including civil war; generalized violence; and persecution on the grounds of nationality, race, religion, political opinion, region or social group are on the move due to conflict induced displacement. In most of these cases, the state authorities are unable or unwilling to protect them.

Some try to remain within the country. But a large proportion of these displaced people flee across international borders in search of refuge. Some of them may seek asylum under international law, whereas others may prefer to remain anonymous, perhaps fearing that they may not be granted asylum and will be returned to the country from whence they fled. Since the end of the Cold War, there has been an escalation in the number of armed conflicts around the world. Many of these more recent conflicts have been internal conflicts based on national, ethnic or religious separatist struggles. There has been a large increase in the number of refugees during this period as displacement has increasingly become a strategic tactic often used by all sides in the conflict. Since the end of the Cold War there has also been an even more dramatic increase in the number of internally displaced persons (IDPs), who currently far outnumber the world’s refugee population. In the South Asian context, the Tamils of Sri Lanka who have crossed over the sea from Sri Lanka to India are displaced people but they are considered as refugees. The Kashmiri Pandits who were displaced from Kashmir to other parts of the county are internally displaced people due to conflict.

2) **Development-Induced Displacement:** These are people who are compelled to move as a result of policies and projects implemented to supposedly enhance ‘development’. Examples of this include large-scale infrastructure projects such as dams, roads, ports, airports; urban clearance initiatives; mining and deforestation; and the introduction of conservation parks/reserves and biosphere projects. They are also called Project Affected People (PAP).

Development affected people usually remain within the borders of their home country. Although some are resettled, evidence clearly shows that very few of them are adequately compensated. While there are guidelines on restoration for affected populations produced by some major donors to these types of projects, such as the World Bank, there continues to be inadequate access to compensation. This tends to be the responsibility of host governments, and interventions from outside are often deemed inappropriate.
As stated above, development induced displacement disproportionately affects indigenous and ethnic minorities, and the urban or rural poor. It has been estimated that during the 1990s some 90 to 100 million people around the world were displaced as a result of infrastructural development projects. It has also been reported that on an average 10 million people a year are displaced by dam projects alone. It has also been reported that in most cases, the development induced displaced people are not adequately compensated. What is more important to take note of the fact is that since there is no specific institution at the national and international levels, these are the worst victims among the displaced people.

3) **Disaster-Induced Displacement:** This category includes people displaced as a result of natural disasters (floods, volcanoes, cyclones, landslides, earthquakes, tsunami), environmental change (deforestation, desertification, land degradation, global warming) and human-made disasters (industrial accidents, radioactivity). Clearly, there is a good deal of overlap between these different types of disaster-induced displacement. For example, the impact of floods and landslides can be greatly exacerbated by deforestation and agricultural activities. Tsunami was one of the disasters which affected over 3 million people living in Indian Ocean region. What is more disheartening is that due to the costal regulatory legislations of the governments in the post tsunami phase, the coastal people who had lived near the sea were denied the right to settle in their original places.

Estimating trends and global figures on people displaced by disaster is even more disputed and problematic than for the other two categories. A 1995 report claimed that there were at least 25 million environmental refugees. Several international organizations provide assistance to those affected by disasters, including the International Federation of the Red Cross and Red Crescent Societies, and the World Food Programme. But most of these assistances fall short of the demand for assistance.

To sum up our discussion on IDPs, it can be stated that the IDP situation is complex and multifaceted. Further, the issue of internal displacement also has serious ramifications for inter-state relations as today’s IDPs may become tomorrow’s refugees. Thus, over the last few decades, IDPs have become a major issue of international concern.

In April 1998, the Representative of the UN General Secretary on IDPs, Francis Deng, presented to the United Nations Commissioner for Human Rights (UNCHR) a set of *Guiding Principles on International Displacement*. This document has four principles:

- protection from displacement
- protection during displacement
- humanitarian assistance
- return, resettlement and reintegration
Check Your Progress I

Note: Use the space provided for your answer.

1) What are some of the salient features of displacement in India?
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2) How can the issue of displacement of people can be addressed by social workers?
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3.3 MIGRANTS

Migration means movement of people in space. Migrants are people who move and settle down temporarily or permanently in new settlements. One can raise a series of questions to understand the issue of migration. They are: Why do people migrate? Why do they leave their homeland to settle down in a different place? It requires no great imagination to assert that human beings in general have a natural attachment to the place of their birth. What makes them overcome this attachment? All available empirical data leads to only one conclusion: it is the concern for improving one’s material lot.

Migration is a multi facetted and complex global issue, which today touches every country in the world. All 190 or so sovereign states of the world are now either points of origin, transit or destination for migrants; often all three at once. The UN’s current official estimate remains at 175 million migrants globally. While these estimates are presented and contested, migration of people both internal and international is going on unabated.

In general, a migrant is a person on the move, either voluntarily or involuntarily, in the person’s own country, internationally, or both. Unlike refugees, migrants are commonly considered free to return home whenever they wish because their lives are not in danger there. Those who move from their country to some other country are called immigrants. Among the immigrants too there are two types: a) those who are documented or often what is wrongly called ‘legal’ and b) those who are not documented or what is wrongly called ‘illegal’. Now more and more instead of calling a migrant illegal, he or she is called non-documentarian.
Eisenstadt defines migration ‘as the physical transition of an individual or group from one society or another. This transition usually involves abandoning one social setting and entering another and different one.’ Weinberg points out ‘Human migration is the changing of place of abode permanently or when temporarily, for an appreciable duration as e.g. in the case of seasonal workers.’

M.S.A. Rao in his discussion points out to three areas of focus of migration studies. First, the nature of the process of migration. This can be raise in the form of a question, ‘why people move and how migration occurs?’ He examines mainly the economic explanation and notes that economic factors provide only the necessary conditions of migration while the non-economic factors such as the information flow resource networks, brokers and personality of the migrants ‘provide the sufficient conditions for people’s decision to migrate. The second area of study includes questions such as who migrates and what role factors of selectivity like age, sex marital status and educational status play in migration? What happens to the migrants at the place of destination? How do they adjust themselves to the new social and physical environment”? What changes have followed in their own life-styles and in their relation to other groups and situations? In this context, Rao considers- new social formations such as caste, class and ethnicity, and cultural pluralism playing important role in the decision for migration.

Migration has been classified into the following types: a) internal migration: This refers to the movement within one’s national boundary; b) external migration or immigration: This type of migration refers to moving from one’s own country to another country and in this the national boundaries are crossed; c) migration may be forced i.e. involuntary, that is, not based on the will of the person to move out; d) voluntary i.e. based on choice. Though these kinds of classifications are presented by various analysts, it is difficult to find a neat category of migrants.

Taking the example of Hyderabad Sudhir Kakar writes, ‘In the eighteenth and nineteenth centuries, many cultural groups migrated to Hyderabad from other parts of the country. The trading communities of the Muslim Bohras from Gujarat and the Hindu Marwaris from Rajasthan became prominent in the city’s commercial life. Then there were the Kayasthas and Khatris from North India, traditionally the backbone of many an Indian state’s administration, who played a similar role in the Nizam’s affairs of state. These groups tended to cluster together in separate conclaves where they could follow their own ways of religious and community life ... on the whole, the lifestyles of the various groups - their customs, mores, architectural styles, food habits - remained distinctive ... shared activities and experiences in the public realm even though in private they were completely segregated.... In short, it was a multicultural coexistence rather than any merger into a single, composite culture. They were more than strangers, not often enemies, but less than friends.

One often hears about pull and push factors in the discussion on migration. While discussing about the Tribal girls who come to urban centres of India to eke out a living as domestic help it is often argued that the girls seeing the better dress, style of living of other Tribal girls who are working in the cities attract the others to come to urban centres. But what they forget to state is that the backward economy of the Tribal region also forces them to move out to earn a living. Thus, it is not one phenomenon or cause which motivates or restricts migration. Migration is an outcome of multiple factors.
Migration, especially internal migration has many shades. Migration from rural to urban areas within the same state is a regular feature all over India. Migration from one region of the state to another region and one state to another by the rich in pursuit of better prospects in agriculture and expansion of their business has been going on unhindered. The currents and cross currents in a country like India are many and varied. Hence, it is sociologically untenable to try to fix migration in one single box.

Two types of migrations are noticeable in Punjab - of the rich Punjabi Jats migrating to Uttar Pradesh and Madhya Pradesh for agriculture, where land is cheaper and the prospects of owning bigger land holdings lure them. After the bifurcation of Chattisgarh from Madhya Pradesh, this process is witnessed again. Another significant migration is towards Punjab - that of the poor sections of society from Uttar Pradesh, Bihar and Rajasthan. These people have been migrating to Punjab in search of better earnings. One sees so many of these people daily flowing into Punjab. Most of them get absorbed in the cities as vendors, rickshaw pullers and manual help in the shops and small wayside hotels and as construction workers. These city dwellers mostly hail from Uttar Pradesh, Bihar and Rajasthan. Punjab has accepted this helping hand to do minor chores. They are universally called ‘Bhaiya - an address to brother in Hindi but in Punjab ‘bhaiya’ is synonymous with a migrant labour. This way bhaiya in Punjab is not an address of a status and never for brother. Punjabis do not look at them separately as Biharis, Rajasthanis or Upites and so they all are bhaiyas.

Salient Features of Migration

From the various studies on Migration in India, we can identify some salient features of migration in India.

- internal migration often involves longer working hours, poor living and working conditions, social isolation and poor access to basic amenities.

- while there seems to be some positive impact on incomes and investment, the major function of internal migration is to act as a ‘safety valve’ in poor areas. In some cases, due to caste and village conflict individuals and in some cases even families migrate to some other place.

- most migrant labourers in India are employed in the unorganised sector, where the lack of regulation compounds their vulnerability. They are largely ignored by government and the NGOs.

- legislation regarding migrants fails because regulatory authorities are overstretched; the state sees migrants as a low priority; and migrant workers have little support from civil society.

- international migrants have mainly come from Kerala, Tamil Nadu, Andhra Pradesh and Punjab. Those who fall under the international migrants consists of people with professional expertise of technical qualifications migrating to industrialised countries; and skilled and semi-skilled workers migrating to the Middle East.

- overseas migrants account for less than one per cent of the total workforce of India, so have little direct impact on the national labour market; however, the effects are significant in major sending regions such as Kerala, where there emigration has reduced unemployment.
• remittances are the main benefit of external migration, providing scarce foreign exchange and scope for higher levels of savings and investments.

• in Kerala, remittances made up 21 per cent of state income in the 1990s, and immigration appears to have increased the wealth of the state.

Negative Impact of Migration
Along with the above stated facts, one should also point out the negative impact of migration of those who are from the vulnerable and weaker sections:

1) work situations and living conditions of most of these migrants are deplorable. Since they are from the vulnerable communities they have to save every penny they earn. Moreover, since they are from the weaker sections, there is no one to take up their cause and bring redressal.

2) effect of migration on women if they migrate or not is very serious. It was reported from some studies, since the men from Bihar migrate to Punjab in a bid way, their women are left to fend for themselves and their family members. Many women have become the sole bread winners for families and this has many adverse effects on them and their children.

3) migrants from the labouring class, construction workers and unorganized sector workers keep moving from one work site to another. Due to this, the probability of children getting education is less.

4) due to poor work situations and living conditions the migrants suffer physically. Since they cannot afford to go for costly health care, they suffer poor health situation. Interestingly, now the focus is mostly or only on HIV – AIDs and not on sicknesses like TB, Malaria etc.

5) migrants also suffer due to loss of citizenship. Since they keep moving from one place to another in search of work, they cannot get proper documents. In between their place of origin and place of destination, they loose out their rights as citizens of the country.

Measures to Address Issues of Migration
Taking into account the various issues that are there regarding the migrants, some measures have been proposed. It was recognized there is a need to better ensure that the rights and welfare of migrants be protected. Respect for migrants’ human rights is one of the basic determinants of their well-being, and thus could lead to achieving greater social and economic development. There is a need to increase efficiency of regulatory mechanisms so as to prevent abusive practices.

It was noted that international migration is an intrinsic part of development, resulting from economic and demographic disparities between countries. International migration is a growing phenomenon and has become a structural element of societies and economies in Asia and the Pacific. But if countries cling on to their boundaries and restrict people from migrating to other countries, this could lead to many problems. At the same time, both the countries of origin and destination should have regulatory mechanisms to enable both migration and development go unhindered.
Human trafficking has become entrenched in the region and requires effective counter-trafficking policies and programmes which address critical aspects in both areas of origin and destination. In the name of migration people especially women, young girls and boys are trafficked for flesh trade. This happens both within the country and in the international arena. This evil practice cannot be stopped only by legislations but by mobilizing the communities to address the issue of trafficking seriously. As has been pointed out many times, a linkage between the place of origin and place of destination would provide scope for tracing any migrant and this would put a block for trafficking.

It was also noted that, because of its multidisciplinary nature, addressing the challenges of international migration requires policy coherence. Migration policies need to be internally consistent and integrated into the socio-economic development agenda, including poverty reduction strategies. Many studies have reaffirmed that management of international migration should aim at maximizing the positive effect and minimizing risks for both country of origin and destination, and the migrants themselves.

Check Your Progress II

Note: Use the space provided for your answer.

1) What are the various types of migration that take place in India?

2) What are some the reasons for migration?

3.4 REFUGEES

Traditionally, any person who has been forced to flee his or her home for fear of life or lack of subsistence is regarded as a refugee. However, according to international law those who have lost the protection of their home states and as a result have crossed international borders to seek refuge in another country are accepted as refugees. Faced with the problem of a vast number of displaced and uprooted persons after the World War I, western nations created international instruments for the protection, return and resettlement of these persons in other
countries. The Nansen passport was created to provide these stateless persons with a temporary identity. Between 1922 and 1926, under the auspices of the League of Nations, several treaties were concluded to recognise displaced people as refugees. As these treaties created certain obligations on the contracting states, it was necessary to define the term refugee.

The League of Nations treaties initially defined refugees as a category or group of persons who were (a) outside their country of origin and (b) without the protection of the government of their home state. (LNTS No. 2204: May 12, 1926). Later, in 1938 the definition was restricted to only such persons who had left their countries of origin from fear of persecution. The 1938 instrument excluded those who had left their homeland for purely personal reasons. It was also decided to exclude the victims of natural disasters as the governments of their home states did not forcibly expel them. While the disaster victims required humanitarian aid, those who had lost the protection of their home state required protection, asylum and rehabilitation and hence these were the only people to be regarded as refugees under the international treaties.

Though these initial efforts bore some fruits to respond to the ever increasing number of refugees, yet the need to have an international organization was strongly felt by many around the world. Hence, in 1951 United Nation’s High Commissioner for Refugees (UNHCR) was set up to help over 1 million people still uprooted after World War II to return home. Since then, UNHCR has helped find durable solutions for some 50 million refugees and they remain the core constituency of UNHCR.

The latest figures available show that the number of refugees of concern to UNHCR stood at 10.5 million refugees at the beginning of 2009. But this does not mean that the number of refugees in the world are only 10.5 million. It means that the mandate of UNHCR covers only 10.5 million refugees but there are much more refugees today. For example, over 73,000 Srilankan refugees in Tamilnadu do not under the humanitarian assistance of UNHCR, since the Indian Government has declared that the Srilankan refugees are part of it and it would take care of them. Where as UNHCR works among the IDPs in Sri Lanka who are also affected by the conflict and war in Sri Lanka.

The refugee thus, finally came to be defined as any person, “who owing to well founded fear of being persecuted for reasons of race, religion, nationality or political opinion is outside the country of his nationality and is unable or, owing to such fears or for reasons other than personal convenience, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owning to such fear or for reasons other than personal convenience, is unwilling to return to it.” (1967 UN Protocol Relating to the Status of Refugees). This definition is being questioned today by social scientists and human rights activists.

Reconceptualisation of the Refugees

Clearly there is an urgent need to reconceptualise the definition of refugees. It is not being argued that those who have been forced to flee their home and hearth because of political persecution and direct threat to their life should be equated with those who have been forced to move by loss of livelihood, man-made disasters and natural calamities. At the same time we can no longer ignore the
fact that certain governmental policies have impoverished vast masses of their people, particularly those belonging to minority communities and economically backward sections. Studies have shown that some of the development projects implemented with international support have had adverse impact on the economy and livelihood of people within the country and at times across international borders forcing thousands to move elsewhere in search of livelihood.

The international community has attempted to provide refugees with protection and assistance. International covenants, protocols, regional mechanisms, laws and organisations have been established for the protection of refugees as well as the promotion of a lasting solution of the refugee problem. At the international level, protection and rehabilitation of refugees is funded by the United Nations and other multilateral organisations. The industrialised countries of the west contribute most of the funds for this work.

Asia is the largest refugee-hosting continent with 41 per cent of the total refugee population. In particular, South Asia hosts the fourth largest concentration of refugees in the world. Non-governmental and semi-governmental agencies, working with refugees and the displaced, claim that the number of persons living in refugee-like situations in the region is much higher than the official estimate. Large number of the displaced, who have crossed international borders in South Asia, are treated as undesirable aliens or illegal immigrants by host governments. South Asian states have no national laws which define or distinguish refugees from those who cross the borders. Moreover, none of the South Asian governments have signed the 1951 UN Convention Concerning the Status of Refugees and its 1967 protocol. These are the main UN mechanisms for the protection and rehabilitation of refugees.

It is also significant to note that those recognized as refugees are better off than other forced migrants, as they have a clear legal status and are afforded the protection of the United Nations High Commissioner for Refugees (UNHCR). UNHCR has a budget of over 800 million USD and a presence in some 100 countries. The vast majority of refugees are in the world’s poorest countries in Asia and Africa. The global refugee population grew from 2.4 million in 1975 to 14.9 million in 1990. A peak was reached following the end of the Cold War with 18.2 million in 1993. At the end of 2001, there were estimated to be some 14 million refugees around the world.

The United Nations Convention Relating to the Status of Refugees put in use in 1951, has been one of the international instruments to address the issues of refugees. Though India has not ratified the 1951 United Nations (UN) and 1967 Protocol Relating to the Status of Refugees, it provides shelter to over 300,000 refugees from neighboring countries.

The plight of refugees in India generally depends upon the extent of protection they receive from either the Indian Government or the United Nations High Commissioner for Refugees (UNHCR). Below is brief definition of the three primary categories followed by a description of the living conditions faced by each refugee category:

a) Refugees who receive full protection according to standards set by the Government of India. Srilankan Refugees residing in the camps of Tamilnadu fall under this category;
b) Refugees whose presence in Indian territory is acknowledged only by UNHCR and are protected under the principle of non-refoulement. The Burmese refugees who mostly reside in the Delhi region fall under this category;

c) Refugees who have entered India and have assimilated into their communities. Their presence is not acknowledged by either the Indian Government or UNHCR.

The domestic NGOs and UNHCR are complimentary to each other. In a situation where Government of India denies access to UNHCR and other foreign humanitarian agencies, domestic NGOs play the most crucial role to provide “protection” to the refugees. Along with relief to be provided to the refugees, it is important to work for the durable solution of the refugees. In most cases, the refugees have three options. They are: a) repatriation, b) local integration, c) resettlement. Whichever option is before them they need protection from national and international governments and agencies.

As we sum up this section, it can be stated that the plight of the refugees irrespective of whether they are looked after either by the UNHCR or the Government of India is deplorable to say the least. The condition of the refugees who are not recognized either by UNHCR or the Government of India is the worst. In that sense it can be stated that refugees are a group of people who are stripped of citizenship, legal protection, dignity and rights as citizens and human beings.

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**Check Your Progress III**

**Note:** Use the space provided for your answer.

1) What is your understanding of the refugees in India?

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2) What are the various types of refugees in India?

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Tenth Five Year Plan (2002-07), as approved by the National Development Council (NDC), envisaged an average annual growth rate of 8 per cent which is much higher than 5.5 per cent achieved during the Ninth Five Year Plan (1997-2002). Accepting that growth rate cannot be the only objective of plan efforts, the Tenth Plan has set monitorable targets for a few key indicators of human development in addition to the 8 per cent growth target. These, inter alia, include

- reduction of poverty ratio by 5 percentage points by 2007,
- providing gainful employment to at least the addition to labour force over the plan period,
- all children in school by 2003 and
- increase in the literacy rate to 75 per cent within the plan period.

Thus, the reduction of poverty and providing gainful employment and addressing illiteracy and enhancing education was the goals of Tenth Five year plan. This goal has direct reference to this section where we are dealing with the landless labourers.

Landless labourers, refers to those people who are in need of land, without distinction for what purpose they need the land. Most of the landless, however, do need it for reasons pertinent to basic lively needs such as housing, farming, and industry. Some of the landless have presented requests for access to land to government because they no longer can support themselves, and their families, with industrial work pay, self-employment. As unemployment and under employment is rampant, more and more people are becoming landless labourers.

India’s workforce comprises nearly 92 per cent in the unorganised sector. It is significant to note that the entire agricultural sector falls under the informal category. Only one-fifth of the non-farm workers are found in the organised segment. As far as the agricultural sector is concerned, the landless labourers are the most discriminated and deprived. Since these are in the unorganized sector, they do not have any bargaining power and thus they have to be content with whatever wages are determined by the landed class. Further analysis reveals that there is no social security scheme for this group of the workers.

What needs to be understood is that the labourers in the organized sector whether it is public or private have some bargaining power. But those in unorganized sector do not have bargaining power, since they are not organized under any union. Even the labourers like the construction workers or domestic workers due to the type of work can demand their rights, the landless labourers loose out on all grounds.

From census data 2001, it can be gathered that the cultivators are 31.7 percentage, while the agricultural labourers are 26.5 percent. But this picture changes when it comes to the Scheduled Caste population. Among the Scheduled Caste population, 20.0 percent are cultivators, while 45.6 percent are landless agricultural labourers. Renowned Historian Irfan Habib argues that the Scheduled Castes were barred from holding land and were compelled to work as landless labourers. In the case of the Scheduled Tribes, there is some difference. They have been owners of land. But from the time, their land and resources were
taken for development projects, they are alienated from their land and most of them become landless labourers.

For the last thirty years, there has been discussion to enact an act to address the issues of the unorganized workers. If this was done, it would have addressed the needs of the landless labourers. But due to various reasons this has not been done. Taking into account this fact, the United Progressive Alliance government, in 2004 set up the National Commission for Enterprises in the Unorganised Sector (NCEUS). The Commission after much discussion presented some recommendations to the Government of India. Based on the recommendations, the Unorganised Workers Security Bill 2007 was formulated by the government. It is only in 2008, this bill was enacted into an act to provide security to the unorganized workers.

It is also important to take note of the fact that the landless labourers do not even have the basic right like the minimum wages for the work they do. This is something that has become discussion point for the last sixty years. Interestingly, the Government of India formulated, the Minimum Wages Act in the year 1948. In 1950, it also came up with the Minimum Wages (Central) Rules, 1950. Though these are on papers, in reality these are not put into practice.

This is all the more the case with the women. The Constitution of India recognised the right of women to employment and included a number of articles to give direction to the state policy. Article 14 laid down the equality before law of all citizens of the country, and Article 15 prohibited discrimination on the grounds of sex, religion, race etc. Article 16 (1) and (2) emphasised equal opportunities for all in the matter of employment and prohibited discrimination in employment. Over and above, the Equal Remuneration Act, 1976 provides for the prevention of discrimination on the ground of sex against women in the matter of employment and for matters connected therewith or incidental thereto. The Act also prohibits discrimination while recruiting men and women workers for the same or similar nature of work except where the employment of women in such work is restricted or prohibited by or under any law for the time being. But the situation of the women from the landless labour community is pathetic.

**The ILO Convention Recommendations**

Let us briefly look at the some of the provisions that are highlighted in the International Labour Organization conventions. The ILO Conventions presented the following recommendations to the governments with regard to labour issues:

- Basic human rights to be adhered to
- Appropriate and equal employment opportunity to all
- Conditions of work and social policy
- Social security be integral to policy
- Industrial relations be appropriate
- Employment of women – safety and remuneration
- Employment of children and young persons be prohibited
- Labour administration to ensure the legal provisions are followed
- Tripartite consultation so as to respect the rights of all
While, the situation of the landless labourers is deteriorating day by day, they are also trying to organize themselves to ensure their employment, wages and dignity. The All India Labourers Movement is an indication of this fact. Interestingly, this is the case in other parts of the world. In South Africa there is the Landless People’s Movement. The objective of this movement is to strengthen the capacity of the rural landless to organise effectively and advocate for themselves; to speed up land reform and hold the government to account on their promises; and to develop public awareness nationally and internationally about the needs of rural landless communities.

Check Your Progress IV

Note: Use the space provided for your answer.

1) How can we understand the issue of the landless labourers?

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3.6 BONDED LABOURERS

Bonded labour system traps millions of women and men, and their daughters and sons, in deep poverty in south Asia and in other regions of the world. It is a violation of human rights and an affront to human dignity. Impoverished families, most often members of the most socially-excluded groups in the population, find themselves unable to escape from labour exploitation to which they are bound by debts, threats and sometimes outright violence. For many, this seems to be their only option.

Bonded labourers constitute one of the poorest of the poor and one of the most exploited segments of Indian population. Due to years of dependency and bondage, they are unaware of their rights and entitlements. Even if they come to know their rights they are not able to exercise their rights. Leave alone their rights but their basic needs are not fulfilled irrespective of working in bondage for ages and even for generations. Since they are economically deprived and discriminated, they have no other option but to lend themselves to servitude and slavery. This economic dependence on their own exploiters makes the bonded labour system one of the most unique, most prevalent and most problematic issues to be addressed by the state, the bonded labourers and the civil society.

Given the unequal and exploitative nature of Indian society and polity, a vast segment of the population is deprived of basic minimum facilities or resources to maintain themselves. It is this group of the population which in course of time is forced to enter into servile relationship with the local landlords, money lenders and powerful people of the area. Since sheer economic survival became a very important struggle of their lives, they were willing to be bonded to someone
who at that particular time was willing to provide some material support. This led to indebtedness. Interestingly, this debt was something that cannot be paid back by any means. Often time, this economic support whether in cash or kind was meager but the bonded labourers have to work in servitude for a long period and in most cases for generation.

**Bonded Labour System (Abolition) Act 1976**

The **Bonded Labour System (Abolition) Act 1976** was passed by the Indian Parliament. Though this was passed in 1976, the administrative apparatus could not make the desirable progress in identification, release and rehabilitation of bonded labourers. The failure cannot be attributed merely to the inherent dysfunctional quality of the administrative system but predominantly to its structurally in-built non-reform and non-emancipatory character. What is emerging as an area of investigation is that it is important to examine the institutional constrains and possibilities in addressing this issue of bonded labour.

Ironically, bonded labour system has been abolished in paper but in reality it exists in the most cruel form. According to a study carried out by Gandhi Peace Foundation in 1981, in 10 states of India, there were over 26 lakh bonded labourers. Someone with enormous cynicism would state in a country of crores of population, 26 lakhs is nothing significant. But they miss the bus once again. This number is what is identified by this study. But there were more unidentified bonded labourers too. This study also revealed that states like Andhra Pradesh there were more than 3,25,000 bonded labourers.


- **25%** of the bonded labourers belong to the age group below 20 years, a fact which means that child and youth being bonded is a reality.

- **30%** of the bonded labour families are forced to send two or more of their family members into bondage. This is evidence that mass pauperization of landless labourers is a dynamic, growing process.

- **About 20%** of the bonded labourers did not take any loan *de jure*. This means that there are various forms of bondage – inter-generational bondage, child bondage, loyalty bondage, bondage through allotment of land etc.

The Government of India has consistently maintained a proactive approach to the issue of forced or bonded labour in the country. It recognises this evil system as a gross infringement of the fundamental Human Rights of the affected citizens and is implacably committed to its total eradication in the shortest possible time.

India has ratified ILO Convention No.29 (Forced Labour Convention 1930) on 30.11.1954. Following the ratification, the bonded labour system was abolished by law throughout the country w. e. f. 25th October 1975 by an Ordinance. Subsequently, Bonded Labour System (Abolition) Act was passed by the Parliament in 1976 but given effect to from 25.10.75, the date when the Ordinance was promulgated. The Act provides for the abolition of bonded labour, bonded labour system and bonded debt. ‘Bonded labour stands abolished and would be
illegal wherever it exists’ - this is how the subject figures as an item in the old 20 Point Programme for national reconstruction, which goes to show the primacy and centrality attached to this subject at the national level.

Institutional mechanisms in the form of vigilance committees at the district and sub-divisional levels under the Chairmanship of District and Sub-Divisional Magistrates have been provided for, in the statute. Anyone who wants to file a complaint under the law about existence of bonded/forced labour in any part of the territory of India should file it before the vigilance committee. Executive Magistrates have been empowered under the Act to conduct summary trial of offences, to release the bonded labourers(s) and to issue release certificates. The Act also lays down stringent penal provisions against offending employers.

With a view to supplement the efforts of the state governments; a centrally sponsored plan scheme for rehabilitation of bonded labour was launched by the Ministry of Labour in May, 1978. Under the scheme, state governments are provided central assistance on matching grants (50:50) basis for the rehabilitation of bonded labour. The said plan scheme has been drastically modified in May 2000 to provide for 100% assistance for conducting district wise surveys for identification of bonded labour, awareness generation activities, and evaluatory studies. The rehabilitation grant has also been raised from Rs.10,000/-per identified bonded labour to Rs.20,000/-per identified bonded labour.

Besides, the state governments have also been advised to integrate the centrally sponsored scheme for rehabilitation of bonded labour with other ongoing poverty alleviation schemes. Some of the major components of this programme are:

- Allotment of house-site and agricultural land
- Land development
- Provision of low cost dwelling units
- Animal husbandry, dairy, poultry, piggery etc.
- Training for acquiring new skills; developing existing skills
- Wage employment, enforcement of minimum wages etc.
- Collection and processing of minor forest products
- Supply of essential commodities under targeted public distribution system
- Education for children; and
- Protection of civil rights

Thus, we see that bonded labour system is caste, class and rural based. Those who are socially, economically and politically deprived and discriminated are the ones who become bonded labourers. It is clear that bonded labourers are a special group of people who have special needs that should be met for their well being. It is heartening that there is a growing awareness about these people and also attempts are made to release them from bondage and settle them properly.
3.7 LET US SUM UP

In this unit, we tried to understand who are the displaced persons, what are the various categories or types of persons and which are the regions that produce more displaced persons.

We also saw that the term displaced persons is a general category for internally displaced persons, migrants, refugees, asylum seekers and stateless persons.

Briefly, we saw what are some of the reasons for some segment of the population of a country around the world to become displaced persons, refugees and migrants. We realized that there is no single cause for this but there are multiple factors behind people becoming displaced.

Along with these, we tried to identify the various humanitarian responses made by the UN agencies, humanitarian agencies, NGOs and INGOs. In this section we also saw that though the response is praiseworthy but due to the nature and volume of the problem, these responses are inadequate and wanting.

In passing, we presented the humanitarian responses made by the United Nations and also by its various agencies.

Along with these people, there are also the landless labourers and bonded labourers. They are also in deplorable condition and need humanitarian assistance both nationally and internationally.

It becomes clear to us that there is the need for national and international mechanisms, provisions and standards to protect and assist internally displaced persons various categories. This way, we would respond to tens of millions uprooted within the borders of their own countries and move to international borders.

Finally, it can be stated that the displaced people are people on the move, people at risk, people in need of assistance and protection.
3.8 FURTHER READINGS AND REFERENCES


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UNIT 4  VICTIMS OF DISASTERS

Structure
4.0 Objectives
4.1 Introduction
4.2 Types of Disasters
4.3 Impacts of Disasters
4.4 Response to Disasters
4.5 The National Disaster Management Authority
4.6 National NGO Task Force on Disaster Management
4.7 Let us Sum Up
4.8 Further Readings and References

4.0 OBJECTIVES

In this Unit, you shall be introduced to a new and emerging sociological enquiry, that is disaster and the victims of disaster. Though disaster itself is as old as humankind, but a study of disaster and the various types of disaster, responses to disaster victims are rather an emerging area of inquiry within social sciences and social work. In the last five decades much more work has been done on disasters, disaster management, disaster risk reduction etc. By the end of this Unit, you should be able to:

• Understand what is meant by disaster;
• Comprehend the various types of disasters that take place in India and the region;
• Identify the different groups of people, especially those who are most vulnerable who are affected by the different types of disasters;
• What are some of the impacts of disasters on the population that disaster strikes;
• What are some of the responses made by the Government, NGOs, INGOs, humanitarian aid agencies etc;
• A brief understanding of the National Institute of Disaster Management constituted by the Government of India and the role of National NGO Task Force on Disaster Management.

4.1 INTRODUCTION

Disaster in common parlance is understood as an event or incident which causes great loss to life and property. Usually disasters are natural or human made. The Websters’ Dictionary defines disaster as ‘a grave occurrence having ruinous results’. That is to say that disaster is a calamity which affects a large portion of the population.
The World Health Organisation (WHO) describes disaster as an occurrence that causes damage, economic destruction, loss of human life and deterioration in health and health services on a scale sufficient to warrant an extraordinary response from outside the affected community or the area. In this definition along with the various effects of disasters, the type of disaster is also indicated. In almost all the disasters, it is the external emergency relief and support which enables the affected population to come back to life.

P.C. Sinha is of the view that disaster is “an occurrence arising with little or no warning, which causes or threatens serious disruption of life, and perhaps death or injury to large number of people, and requires therefore a mobilisation of efforts in excess of that normally provided by the statutory emergency services.” This definition focuses not only on the effects of disasters but also points to proper warning or lack of warning before disasters strike. Pre-disaster warning enables the people to escape to safety, thus saving lives of people knowing well the property would be damaged.

Thus the word “disaster” has been defined contextually by various authorities. However for convenience, disasters may be termed as extreme events which cause great loss to life and property. They pose a serious threat to the normal life as well as the process of development and strike with sudden violence, tearing bodies, destroying lives and structures and throwing apart families. Natural disasters, which are both sudden and powerful, damage national economy and cause hardships to a large section of the population. They are the single largest concern for most of the nations as they take a heavy toll of human life, destroy belongings and infrastructures and have far-reaching economic and social consequences for communities. Thus, the impact of disasters on human life is multi-dimensional, affecting it in all aspects - domestic, social, economic, educational, cultural, political etc.

Developing countries suffer the greatest costs when a disaster hits. According to disaster studies, more than 95 percent of all deaths caused by disasters occur in developing countries. Further, losses due to natural disasters are 20 times greater in developing countries than in industrialized countries. This goes to say that the countries that suffer due to resource crunch are further pushed to disaster response due to which much of the money that would have gone into development have to be diverted to emergency relief. This is all the more true for countries like India and Bangladesh.

For more than a century researchers have been studying disasters as an issue that affects the humanity. Moreover, for more than forty years disaster research has been institutionalized through the Disaster Research Centers. The studies reflect a common opinion when they argue that all disasters can be seen as being human-made, their reasoning being that human actions before the strike of the disaster can prevent it developing into a disaster of great impact. It is also argued that since the human beings play with nature, nature in turn also strikes back. Hence, it is argued that all disasters are the result of human failure to build a symbiotic relationship with nature. Further, knowing fully well, that disasters are regular features, human beings have not introduced appropriate disaster management measures.
India has been very vulnerable to natural hazards and calamities. The Gujarat earthquake of January 26, 2001, which stuck Bhuj in a major way accounted for 13,805 deaths, the super cyclone in Orissa accounted for 9,885 deaths. Government is of the view that if appropriate mitigation measures had been taken these casualties could have been reduced significantly. Tsunami that struck the Indian Ocean on 26th December 2004, left 12,000 people dead and made over 3 million people homeless. Due to immediate rescue and relief of the Government, more casualties were avoided.

Some of the major disasters in India in the recent past are as follows:

- The infamous, Bhopal gas disaster, which took place on 3rd December 1984, due to the leakage of deadly methyl isocyanate gas of the Union Carbide plant resulted in the death of 3,787 people and over 500,000 were exposed to this deadly gas.

- When a massive earthquake stuck Latur and Osmanabad districts in Maharashtra on 30th September 1993, it flattened 69 villages. Over 7,928 people died and about 16,000 wounded.

- In 1998, Rajasthan suffered due to draught in which over 18,506 villages were affected, 6.1 million hectares of crop area was affected and a population of 19.98 million was severely affected.

- The super cyclone of Orissa which devastated it on 29th October 1999, decimated over 90% of the houses, killed over 10,000 people and affected over 15 million population.

- The unparalleled tsunami that stuck the Indian Ocean on 26th December 2004, left 12,000 people dead and made over 3 million people homeless. Many families have not come out of the shock of tsunami even after five years.

- A breach in Eastern Afflux Bund of Kosi Embankment at Birpur on 18th August 2008 flooded vast area of Supaul, Madhepura, Araria, Purnea and Saharsa districts of Bihar. In this devastating flood, over 977 villages of 5 districts were affected. More than 3 million people were rendered homeless resulting in exodus of thousands of them moving out of their places once and for all.

The above examples are presented here to give you an idea of what were some of the major disasters in some parts of India. These are not the comprehensive list of disasters but are examples of various disasters that affect India.

Bhopal gas tragedy is considered to be one of the most severe disasters that affected India. On December 2nd 1984, due to the leaking of poisonous gas leak from the Union Carbide India Ltd. (UCIL) an American company located in Bhopal over 2,000 people died on that day and many more thousands were affected. The effect of this gas leak is still suffered by the people who lived near this company. After 16 years, the Government of India once again took up the case and is attempting to do justice to all those who were affected by this disaster.
Out of the 600 districts in India, over 125 districts are multi-hazard prone districts. The other districts are also prone to different types of disasters. It is also a fact that in a country like India at times a single region can be affected by two types of disasters. For example, there are some parts of India which witness flood and draught. Hence, multi-hazard disaster risk management, response and mitigation plans should be put in place in the multi-hazard prone districts and a national level disaster risk reduction, management and mitigation have to be undertaken. Thus, a comprehensive picture of disasters that affect the people of India need to be kept in mind while planning for response to disaster.

4.2 TYPES OF DISASTERS

A global analysis of calamities and disasters, point to the fact that South Asia is among the world’s most vulnerable regions to both natural and human made disasters. A tough mesh of poverty, lack of education, rampant and unplanned urbanization, destruction of environment, chronic malnutrition, nightmarish population densities have trapped the people of South Asia to be extremely vulnerable to disasters. Among all the countries, as stated above, India I much more prone to disasters.

In general, on the basis of their origin, disasters have been categorised as natural or human-made. However there is no clear cut boundary and it is observed that in most of the cases, disasters have a hybrid origin, that is, multiple causes. A natural disaster may be initiated or accelerated by the human induced activities as is in the case of landslide, drought, flood etc. For example, if forests are denuded by human beings this results in nature’s fury in terms of draught and flood.

As stated above, disasters are commonly divided into natural disasters and human-made disasters. This is a common persons understating because disasters are complex and it is difficult to assign a single root cause. This is all the more the case in the developing countries. For example, due to the conflict between India and Nepal, the river basins are not cleaned and the river beds are not fortified. This led to the breach in Kosi river in 2008 resulting in flooding of five districts of Bihar, in which over 3 million population was affected. After the floods, due to settlement of sand on the land, agriculture could not be done. It has also been recorded that a specific disaster may spawn a secondary disaster that increases the impact. A classic example is an earthquake that causes tsunami which in turn floods the coastal areas resulting in disasters.

**Natural disaster:** A natural disaster is a consequence when a natural hazard or destruction (for example, earthquake or flood) affects human beings. This devastation affects the particular population who are subjected to disaster. Over and above, due to lack of appropriate emergency relief and disaster management policies and programmes people are subjected to greater hardships. This increases human vulnerability. The resulting loss depends on the capacity of the population to support or resist the disaster, their resilience. A glimpse of various natural disasters are presented in Table 4.1.
<table>
<thead>
<tr>
<th>S.N.</th>
<th>Disaster Type</th>
<th>Natural</th>
<th>Man-made</th>
<th>Hybrid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Avalanche/Rock-fall</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td>Air Transport</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3.</td>
<td>Road Transport</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4.</td>
<td>Marine Transport</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5.</td>
<td>Rail Transport</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6.</td>
<td>Climatic</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>7.</td>
<td>Drought</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>8.</td>
<td>Famine</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>9.</td>
<td>Epidemic</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>10.</td>
<td>Plague</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>11.</td>
<td>Earthquake</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>12.</td>
<td>Fire</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>13.</td>
<td>Explosion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>14.</td>
<td>Flooding</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>15.</td>
<td>Mining</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>16.</td>
<td>Volcanic Activity</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>


**Human-made disaster**: Disasters caused by human action, negligence, error, or involving the failure of a system are usually referred to as human-made disasters. Human-made disasters are in turn categorized as technological or sociological. Technological disasters are the results of failure of technology, such as engineering failures, transport disasters, or environmental disasters. Social disasters have a strong human motive, such as criminal acts, stampedes, riots and war. Table 1 presents some of the human made disasters.

It is pertinent at this juncture to examine the Bhopal gas disaster that took place in 1984. Every conscious citizen of the country maintains that the worst environmental disaster in US caused by British Petroleum oil spill on April 20, 2010, the bombing of World Trade Centre and Love Canal contamination, New York or several such cases of man-made disasters look like petty offences in comparison to the enormity of Bhopal’s industrial disaster. This clearly shows that corporations have become bigger than democratically elected governments especially in India. When culprits are corporations they play hide and seek by taking recourse to corporate veil in the absence of the political and judicial will to pierce through the veil.

The earthquake that took place in Bhuj region of Gujarat on 26th January 2001 is also one of the major disasters that affected the people of India. According to various reports over 19,000 people were reported dead, 68,478 injured. The damage to other productive assets was as follows:
• More than 23,000 dwellings were reduced to rubble and more than 98,000 dwellings suffered moderate to heavy damage;
• 45 power substations in Kutchh, either totally destroyed or seriously damaged, supply to 255 feeders affected, 9 towns and 925 villages blacked out;
• A total of 1,340 villages in 18 towns of Kutchh, Rajkot, Jamnagar, Ahmedabad, and Surendranagar faced serious disruption in water supply;
• More than 3,000 health facilities damaged;
• A total of 7,132 educational institutions including primary classrooms, secondary/higher secondary schools, technical institutions, as well as collages were totally destroyed and another 45,949 were damaged;
• Surajbari Bridge linking Kutchh to Rajkot was damaged, and 900 kms. of roads as well as 1254 kms. of state roads suffered heavy damage;
• Thousands of artisans, salt workers as well as small businessmen as well as more than 90,000 farmers lost their livelihoods;
• Other infrastructure such as earthen dams, embankments of percolation tanks, office and other buildings, were damaged and district as well as taluka administration paralysed.

These two examples are given here to give an idea of the type and the volume of disaster that India is exposed to.

What is emerging as areas of further study is that disasters can not be neatly categorized as natural and human made. As stated above, any tinkering with nature has its adverse consequence in terms of nature unleashing its fury. As stated above, if human beings destroy forests, the forest in turn is not able to generate rain and thus draught affects human beings. Similarly, human beings can reduce the impact of disasters if they adhere to the rules of nature. If mangroves are not destroyed but promoted, then the impact of tsunami would be controlled by mangroves.

**Check Your Progress I**

**Note:** Use the space provided for your answer.

1) What is your own understanding of disasters?

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...............................................................................................................
...............................................................................................................
...............................................................................................................
...............................................................................................................

2) What are some the different types of disasters?

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...............................................................................................................
...............................................................................................................
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...............................................................................................................


4.3 IMPACTS OF DISASTERS

The increasing nature, volume, intensity of disasters all over the world has established the fact that disasters are recurrent phenomenon and their impacts are massive. Due to its geographical position, climate and geological setting, India is among the top ten countries in terms of life loss due to natural disasters every year. As per the World Disaster Report 2002, during the last two decades (1982-2001), around 1,07,813 people were killed due to disasters in the country. This number measures up to 5,340 people per year on an average. During the same period, more than 110 crore population of the country was affected by these disasters. The death toll rose more than double in the last two decades. During the decade (1992-2001), the heavy loss of life has been due to large scale disasters i.e. Orissa cyclone of 1999 and Gujarat earthquake in the year 2001.

Tsunami that stuck South and East Asia on 26th December 2004 is seen as one of the unprecedented natural calamities of this era. Over 230,000 people died of tsunami and many more millions were affected by the tsunami that hit the Indian Ocean. India, with almost 3 million people affected, over 12,000 dead and hundreds of thousands of people left homeless, was among the countries that bore the brunt of tsunami. There are families which lost either their relatives or resources who have not been able to recover from this tragedy.

India has been traditionally vulnerable to natural disasters on account of its unique geo-climatic conditions. Floods, droughts, cyclones, earthquakes and landslides have been recurrent phenomena. About 60% of the landmass is prone to earthquakes of various intensities; over 40 million hectares is prone to floods; about 8% of the total area is prone to cyclones and 68% of the area is susceptible to drought. In the decade 1990-2000, an average of about 4344 people lost their lives and about 30 million people were affected by disasters every year. The loss in terms of private, community and public assets has been astronomical.

The country is highly vulnerable to droughts, floods, cyclones, avalanches, forest fire, and landslides. From the year 2004 it has become absolutely clear that the country is very much vulnerable to tsunami too. Out of 35 states/union territories in the country, 27 are disaster-prone. This sub-continent is amongst the world’s most disaster-prone areas with:

- 55 per cent of the total land of the country is vulnerable to earthquake,
- 8 per cent area prone to cyclones,
- 5 per cent vulnerable to floods,
- 50 per cent forest cover is fire prone,
- 12 per cent of the population of India is draught prone.

It is significant to note that there could be different disasters in the country at the same. In the year 1998, while Rajasthan was affected by draught, Uttar Pradesh was hit by floods and landslide. Moreover, out of 27 disaster-phone states/union territories, one states (West Bengal) of the country is phone to four common disaster — flood, drought, cyclone and earthquakes, six face three types of disasters, thirteen face two types of disasters and seven states face one type of disasters. Thus in brief, almost each and every part of the country is phone to one or the other type of disasters. Further, there are regions which witness different types of disasters at the same time.
The data in Table 4.2 tries to capture the picture of different types and impacts of disasters in India. In the recent past the frequency of natural disasters in India has increased drastically. Earthquakes of Gujarat, Chamoli, Jabalpur, and Latur; landslides in Garhwal and Kumaon; cyclones of Gujarat, Andhra Pradesh and Orissa; tornadoes of Balasore and Midnapore, etc., are some of the examples of recent catastrophes in India. Natural disasters in the country are resulting into colossal loss to life and property. If a particular region is affected by different disasters recurrently or at the same time, the impact it has on the people, resources, living condition, education, economy etc are unimaginable.

Table 4.2: India’s Disaster Vulnerability

<table>
<thead>
<tr>
<th>State/Union Territory (UT)</th>
<th>Drought</th>
<th>Flood</th>
<th>Cyclone</th>
<th>Earthquake</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Arunachal Pradesh</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Assam</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Bihar</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Chhatishgarh</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Gujarat</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Haryana</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Karnataka</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Manipur</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Meghalaya</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Mizoram</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Nagaland</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Orissa</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Punjab</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Sikkim</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Tripura</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Uttarakhand</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>West Bengal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>Andaman &amp; Nicobar (UT)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>14</td>
<td>18</td>
<td>5</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

Based on the above discussion one can highlight the impacts of disasters as follows:

- Extensive damage to life
- Extensive damage to property
- Extensive damage to crops and cattle
- Disruption of communication channels
- Lack of water, food and essential items
- Lack of life saving medicines
- Outbreak of epidemics
- Lack of space for relief camps, relief works etc
- Panic and disruption
- Social unrest

It is also important to highlight this fact that though disasters have immediate impact on the lives of people, yet they have long term impact too. For example, due to the Kosi Floods in 2008, few thousands of families of that area moved out of their place and migrated to unknown places. This is because people saw that their agricultural land was covered with sand and they can not cultivate the land anymore. This forced them to migrate to some other place where they would be able to find livelihood.

### Check Your Progress II

**Note:** Use the space provided for your answer.

1) What are some of the impacts of disasters in India?

| ........................................................................................................................................ |
| ........................................................................................................................................ |
| ........................................................................................................................................ |
| ........................................................................................................................................ |
| ........................................................................................................................................ |
| ........................................................................................................................................ |
| ........................................................................................................................................ |

### 4.4 RESPONSE TO DISASTERS

All these facts and figures reiterate the fact that disasters have become integral part of human beings. Hence, at the global level, there has been considerable concern over natural disasters. Even as substantial scientific and material progress is made, the loss of lives and property due to disasters has not decreased. In fact, the human toll and economic losses have mounted. It was in this background that the United Nations General Assembly, in 1989, declared the decade 1990-2000 as the International Decade for Natural Disaster Reduction. The objective
behind this declaration was to reduce loss of lives and property and restrict socio-economic damage through concerted international action, especially in developing countries.

Most of the disasters are not completely unavoidable and hence they are to be faced. The best approach to minimise the impacts of these disasters is to search for response to disasters. Some of the best ways through which disasters are controlled are managed as follows:

- **Disaster Preparedness:** This refers to those actions which are designed to minimize loss of life and danger, the effects of disasters and to organize timely and effective rescue and relief operations. In the long run being ready with rehabilitation packages and operational guidelines. It is progressively becoming clear that the damage from natural hazards can be minimised by introducing appropriate preparedness measures.

- **Disaster Prevention:** This may be described as measures designed to prevent natural phenomenon from causing or resulting in disasters or other related emergency situations. Preparedness is not limited only to the short-term measures which are taken during a warning period before the impact of a disaster event; it must be supported by legislation and be concerned with operational planning; education and training of the population at large, and the technical training of those who will be required to help in a relief operation; stockpiling of supplies; and emergency funding arrangements.

- **Disaster Management:** Along with preparedness and prevention, disaster management is an important part of response to disasters. After preparing to face disasters and after making all the efforts to prevent disasters if disasters occur one has to manage them. This can be presented in disaster management cycle.

**The Disaster Management Cycle:** Disaster management in general comprises of three main stages pre-disaster, emergency and post-disaster.

1) **Pre-disaster:** The stage refers to preparedness and mitigation aspects mainly with the objectives to reduce the potential risks for human, material, or environmental losses caused by hazards and to ensure that these losses are minimised when the disaster actually strikes.

2) **Emergency:** The stage covering the relief, rescue, check on epidemic spread, and loss assessments basically aims to ensure that the needs and provisions of victims are met to alleviate and minimise suffering.

3) **Post-disaster:** This important stage of disaster management starts immediately after the actual phase of disaster is over. With the sole objective of rehabilitation of disaster affected people this stage is geared to achieve rapid and durable recovery, which does not reproduce the original vulnerable conditions.

A successful disaster management planning encompasses the complete realm of activities and situations that occur before, during and after the disasters. All these stages of disaster management, i.e., preparedness and mitigation, disaster, emergency, rehabilitation and reconstruction are in fact cyclical and overlap, referring to disaster management cycle, shown in the Fig. 4.1
Keeping in view the new developments and initiatives, the disaster management setup in India is trying to orient itself towards a strong focus on preventive approaches, mainly through administrative reforms and participatory methods. Preparedness measures such as training of role players including the community, development of advanced forecasting systems, effective communications, and above all a sound and well networked institutional structure involving the government organisations, academic and research institutions, the armed forces and the non-governmental organisations have greatly contributed to the overall disaster management in the country.

Some of the efforts made by the Government of India in terms of disaster response are as follows:

1) The National Centre for Disaster Management (NCDM) was constituted in 1995 to oversee the disaster management programmes.

2) A High Powered Committee on Disaster Management (HPC) was constituted by the Government of India in 2000 to propose measures for disaster management. This HPC advocated a new culture of “Preparedness, Quick Response and Strategic Thinking”.

3) After the Gujarat Earthquake the Government of India, established a National Committee on Disaster Management (NCDM), to provide a forum to political parties of all shades to share and discuss the issues related to disaster management and mitigation.

4) Understanding the importance of disaster management, the Planning commission of India, in its Tenth Plan has added a chapter titled “Disaster
Management: The Development Perspective”. In this an effort was made to address the community-based disaster preparedness and management by way of strengthening and capacity building of Panchayati Raj Institutions (PRIs) and Urban Local Bodies (ULBs).

5) The Government of India in 2004 set up The National Institute of Disaster Management (NIDM). The NIDM is supposed to gear up the national, state and district level administration to tackle natural calamities and also to coordinate research projects, training programmes and build a database on natural disasters with case studies.

6) In 2005, the Government of India established a National Disaster Management Authority. This authority is supposed to draw up and implement disaster management plans for preventing and mitigating disasters.

Check Your Progress II

Note: Use the space provided for your answer.

1) What are some of the responses made with regard to disaster?
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4.5 THE NATIONAL DISASTER MANAGEMENT AUTHORITY

As stated above, the Government of India in the year 2005 established a National Disaster Management Authority. According to this authority, the term “Disaster” would mean a catastrophe, mishap, calamity or grave occurrence affecting any area, arising from natural or man made causes, or by accident negligence, which results in substantial loss of life or human suffering or damage to and destruction of property or damage to, or degradation of environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area.

1) The composition of the National Disaster Management Authority will be as under:
   a) The Prime Minister of India shall be the Chairperson, ex-officio
   b) Members not exceeding nine to be nominated by the Prime Minister
   c) One of the Members may be designated as Vice-Chairperson of the Authority by the Prime Minister
2) The National Disaster Management Authority shall have the responsibility for laying down the plan and policies for disaster management. The Authority may:

a) lay down policies on disaster management;

b) approve the National Disaster Management Plan;

c) approve plan prepared by the Ministries and Department of the Government in accordance with the National Disaster Management Plan,

d) lay down guidelines to be followed by a State Authority in drawing up the State Plan,

e) lay down guidelines to be followed by different Ministries and Departments of the Government of India for the purpose of integrating the measures for prevention of disaster of the mitigation of its effects in their development plans and projects;

f) coordinate the enforcement and implementation of the policies and plan for disaster management;

g) arrange for, and oversee, the provision of funds for mitigation measures, preparedness and response;

h) provide such support to other countries affected by a major disaster as may be determined by the Central Government;

3) The Authority may lay down guidelines for the minimum standards of relief to be provided to persons affected by disaster, which shall include-

a) the minimum requirements to be provided in the relief campus in relation to shelter, food, drinking water, medical cover and sanitation,

b) the special provision to be made for widows and orphans;

c) ex-gratia assistance on account of loss of life as also assistance on account of damage to houses and for restoring of means of livelihood; and

d) such other relief as may be necessary

j) give direction regarding relief in loan repayment or of grant of fresh loans on such confessional terms as may be appropriate in the judgment of the Authority;

k) take such others measures for the prevention of disaster, of the mitigation of its effects, or for preparedness and capacity building for dealing with the threatening disaster situation or disaster as it may consider necessary.

Thus the National Disaster Management Authority (NDMA), headed by the Prime Minister of India, is the Apex Body for Disaster Management in India. The setting up of the NDMA and the creation of an enabling environment for institutional mechanisms at the State and District levels is mandated by the Disaster Management Act, 2005.

India envisions the development of an ethos of Prevention, Mitigation and Preparedness and will strive to promote a National resolve to mitigate the damage and destruction caused by natural and man-made disasters, through sustained and collective efforts of all Government agencies, Non-Governmental Organisations and People’s participation, by adopting a Technology-Driven, Pro-Active, Multi-Hazard and Multi-Sectoral Strategy for building a Safer, Disaster Resilient and Dynamic India.
Based on the provisions of the Disaster Management Act 2005, this National Disaster Management Authority was constituted. From 2005, the National Disaster Management Authority has been in operation.

But this is also a fact that the setting up of this highest national body to ensure disaster risk reduction, disaster management, disaster mitigation etc came into existence only as late as 2005, many of the early disasters did not receive the attention they deserved.

### Check Your Progress III

**Note:** Use the space provided for your answer.

1) What are some of the responsibilities of the National Disaster Management Authority of India?

### 4.6 THE DISASTER MANAGEMENT ACT, 2005

Since, the Disaster Management Act is the legislation which addresses all the issues of disaster management in the country, let us briefly examine its salient features. According to this act, disaster management means a continuous and integrated process of planning, organizing, coordinating and implementing measures which are necessary or expedient for:

i) prevention of danger or threat of any disaster;

ii) mitigation or reduction of risk of any disaster or its severity or consequences;

iii) capacity-building;

iv) preparedness to deal with any disaster;

v) prompt response to any threatening disaster situation or disaster;

vi) assessing the severity of magnitude of effects of any disaster;

vii) evacuation, rescue and relief;

viii) rehabilitation and reconstruction.

The act directs the National Executive Committee to draw up a national plan in consultation with the State Governments and expert bodies or organizations in the field of disaster management to be approved by National Authority. The National Plan shall include:

a) measures to be taken for prevention of disasters, or the mitigation of their effects;
b) measures to be taken for the integration of mitigation measures in the development plans;

c) measures to be taken for preparedness and capacity building to effectively respond to any threatening disaster situations or disaster;

d) roles and responsibilities of different Ministries or Departments of the Government of India in respect of measures specified in clauses (a), (b) and (c).

In the same manner, every state is supposed to constitute a State Disaster Management Authority and similarly, every district is supposed to constitute a District Disaster Management Authority. Like the National Plan, the states are supposed to draw up State Disaster Management Plan in the line of National Plan. Going down further, every district is supposed to have District Management Plan. Through all these efforts, the government wants to address disasters in a serious manner and provide security to its citizens.

The provisions of this act are in conformity with the International Strategy for Disaster Reduction, the Rio Declaration, the Millennium Development Goals and the Hyogo Framework 2005-2015. The themes underpinning this policy are:

- Community-based disaster management, including last mile integration of the policy, plans and execution.
- Capacity development in all related areas.
- Consolidation of past initiatives and best practices.
- Cooperation with agencies at national, regional and international levels.
- Compliance and coordination to generate a multi-sectoral synergy.

Thus, the National Disaster Management Act and Authority are in line with the international efforts to ensure a disaster free world for all or at least that disaster risk reduction, disaster management and mitigation is ensured. This is all the more the need of the hour since every one of us are affected by disasters. But the poor and the vulnerable get affected disaster in a serious manner.

Check Your Progress IV

Note: Use the space provided for your answer.

1) What are some of the measures proposed in the National Disaster Management Act of India?

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4.7 LET US SUM UP

In this chapter, an attempt was made to present to you the meaning of disaster, the various understandings of disasters, the different types of disasters and the impact of disaster on the people. Along with this a brief presentation of the types of disasters that India is affected is given for your understanding. Moreover, an attempt was made to spell out the various responses made by the Government of India. The government’s efforts are geared towards preparedness, preempting, mitigating and managing. Going further when the disasters strike the government is engaged in rescue, relief and rehabilitation.

Let us conclude by looking at the vision of the Government of India on disaster reduction and mitigation. According to the Government of India, “Our vision 2020 is to build a safer and secure India through sustained collective effort, synergy of national capacities and people’s participation. What looks a dream today will be transformed into reality in the next two decades. This is our goal and we shall strive to achieve this goal with a missionary zeal. The path ahead, which looks difficult today, will become a lot easier as we move along together”.

Along with the government if all the citizens of the country work together for a disaster risk reduced country, there is every possibility of success. The call of the hour is to collaborate with the various agents of the government to understand the disasters that affect the different geographical regions of India, to work towards community based disaster preparedness, to identify preventive measures in particular situations, to respond when disaster finally strikes. We may not be able to stop disasters but we can surely reduce the risks of disasters.

4.8 FURTHER READINGS AND REFERENCES


