Domestic violence and disability in India explored in relation to the Sustainable Development Goals

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Introduction

Our purpose in this chapter is to expand the current body of knowledge in relation to how domestic violence and abuse (DVA) and disability intersect, and we do this in the context of India. We have chosen India because it is the home country of one of the authors (Deshmukh) and it has been the site of research projects that deal with DVA conducted by one of the other authors (Bradbury-Jones). The third author identifies as a disabled woman and second generation Indian, or British Indian. She has published research on disability and DVA over the life-course (Shah, Tsitsou, & Woodin, 2016a, 2016b; Shah & Bradbury-Jones, 2018), primarily in the Global North.

We endorse the view of Crenshaw (1994) who argues that, when writing about DVA of disabled women in India, it is inadequate to focus on one identity (be it gender, disability or ethnicity) as each triggers unique experiences of discrimination and disadvantage. Rather, an intersectional analysis is necessary to understand how the combination of self-identities shapes the social, cultural and political structures that perpetrate violence against disabled women in general and in the context of our chapter, India specifically. Adopting such a framework allows us to understand the unique meanings of DVA, how people with different identities experience and respond to violence and abuse, how they construct particular consequences of DVA and what safety means to them. For instance, although disabled women may experience similar types of DVA to non-disabled women, they are also likely to experience disablist violence or impairment-specific violence, which will not be experienced by non-disabled women. Such acts of abuse include those which simultaneously increase the powerfulness of the perpetrators and the powerlessness of the disabled women. An example of disablist violence would include the misuse of medication, isolating individuals from family and friends, and removing the battery from the woman’s power wheelchair (Shah et al., 2016a; Curry, Hassouneh-Phillips, & Johnston-Silverberg, 2001). With an intersectional lens, this chapter can also offer an understanding of how an individual’s positionality and interaction with social structures...
influences their different levels of vulnerability to DVA and also access to support services and the responses received when disclosing DVA or seeking help.

In the first part of the chapter we visit some of the wider literature about DVA and disability for contextualisation and then explore these in the context of India. Nearer the end of the chapter we continue with the focus on India but use the United Nations Sustainable Development Goals (SDGs) as a framework to explore how DVA and disability are being addressed. This adds a fresh perspective to some of the current discussions and debates about DVA and disability in India. As we will explore, the SDGs are relevant to resource rich and resource poor countries, but the most pressing needs are in low- and middle-income countries (LMICs), such as India. We hope that the chapter will illuminate some of the important aspects of DVA and disability in India and provide insights into the SDGs for readers who are less familiar with them. Crucially, we want to provide insights into their place in tackling DVA and disability, not only in India, but globally.

**Thinking about disability**

The concept of disability is culturally constructed and socially produced. It has evolved over time and space, shaped and assigned value by various cultural and social structures of a given society. In Indian society for instance, disability has not been seen as positive, and thus not been given equal value to class or gender (Daruwalla et al., 2013).

Traditionally, research in relation to people with impairments, health issues and illnesses drew largely on the powerful discourse of biological determinism which focused on a bodily or cognitive imperfection that needed curative and rehabilitative medical intervention (Barnes & Mercer, 2010; Shah & Priestley, 2011; Kudlick, 2003, 2018). This view has long governed the definition of disability and it was termed the medical or individual model of disability (Oliver, 2013). If rehabilitation fails or is not accessible, the ‘disability problem’ remains within the person. Focusing only on the bodily deficiency, studies based on medical models neglected the role of societal structures in shaping the choices and experiences for people with impairments.

However, disability is not just a pathological condition located within the individual. It is also influenced by environmental factors that create barriers of physical as well as attitudinal kinds that hinder people’s choices and participation in society. Environmental factors and attitudes can differ depending on the time and space, and thus influence the construction of disabling behaviours or attitudes. This interpretation of disability, coined the ‘social model of disability’ (Oliver, 1990) was prompted by disabled people’s activism, encouraging scholars to view it as a human rights issue, and find out how and why surrounding barriers are created, deconstructed or persist, and how they impact people with and without impairments. Such knowledge is useful so strategies can be put in place for their removal to enable a more equal society for all. However, the assumption that ‘society’ is the sole determinant of disabled people’s experiences is also unhelpful. The authors of this chapter believe disability is an interplay of the individual and the social, as recognised by the United Nations Convention for the Rights of Persons with Disabilities (UNCRPD) (United Nations, 2006). We draw on the definition used in the World Report of Disability (WHO, 2011, p. 4):

Disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.
With 50 binding articles, the UNCRPD (United Nations, 2006) is the first international treaty to afford disabled people full civil rights and fundamental freedoms in all aspects of life. Three of these articles are particularly relevant to this chapter: Article 6 which pays particular attention to the situation of disabled women and girls and calls for actions to ensure they are able to exercise and enjoy their human rights; Article 15 which seeks to protect disabled persons from abuse, violence, torture or scientific experimentation by taking appropriate measures (administrative, legal and judicial); and Article 16 which also aims to protect disabled people from abuse, exploitation and violence, including gender-based violence – inside and outside the home.

There is a great deal of conceptual and definitional content in this book as regards the differences between the many forms of violence which sit under the broad term DVA. They do not need repeating here, so we move straight into a discussion about disability. When thinking and talking about disability, it is important to use language that reflects a social model of disability, as a purposeful move away from other pervasive (and in our view unhelpful) orientations, such as the medical model (Mays, 2006). Using the term ‘disabled people’ and ‘disabled women’ as opposed to ‘people with disabilities’ and ‘women with disabilities’ is consistent with this approach.

An estimated 15% of the world’s population live with some form of impairment (WHO, 2018) and the percentage is increasing due to many factors, but principally an increase in chronic health conditions and ageing populations. Like DVA though, an accurate picture is difficult due to variable reporting and recording across countries. According to the Department of Economic and Social Affairs (DESA) (2018), disabled people and especially women and girls, experience disproportionate levels of poverty; lack of access to education, health services and employment; and underrepresentation in decision-making and political participation. Moreover, the report goes on to say that access to health-care services remains a challenge for many disabled people, who are more than three times as likely to be unable to get health care when they need it. Importantly, DESA do not merely problematise the issue: they lay out a number of ways to address such inequalities. Table 20.1 is adapted from the DESA report and shows what needs to be done to achieve gender equality for disabled women and girls.

| 1. Address the needs and perspectives of disabled women and girls in national strategies or action plans on disability and on gender. |
| 2. Develop policies and programmes focused on disabled women and girls aiming at their full and equal participation in society. |
| 3. Support the empowerment of disabled women and girls by investing in their education and work. |
| 4. Raise awareness on the needs of disabled women and girls and eliminate stigma and discrimination against them. |
| 5. Identify and eliminate obstacles and barriers to accessibility in health-care facilities for disabled women and girls. |
| 6. Train health-care personnel on disability inclusion and improving service delivery for disabled women and girls. |
| 7. Empower disabled women and girls to take control over their own health-care decisions. |
| 8. Make sexual and reproductive health-care facilities and information accessible for disabled women and girls. |

Source: Adapted from DESA (2018)
The intersection of disability and DVA

A growing body of evidence suggests that disabled women are at a higher risk of DVA than non-disabled women, with an estimated 50% of disabled women having experienced DVA in some form across their lives (Shah et al., 2016a; Nosek, Hughes, Taylor, & Taylor, 2006; Hague, Thiara, & Magowan, 2007; Barranti & Yuen, 2008; Martin et al., 2008; Nixon, 2009; Slayter, 2009; Hague, Thiara, & Mullender, 2011). They are likely to experience prolonged periods of violence by multiple perpetrators including paid and unpaid carers. There is evidence that they are at risk of severe physical violence (Brownridge, 2006) and sexual violence. Though several forms of violence (i.e. physical, psychological and sexual violence) are not unique to disabled women and girls, this population is considered at increased risk of exposure to such violence due to their dependency on others, reduced physical and emotional defences, experience of communication barriers, stigma and discrimination (Hughes et al., 2012). Further they may be restricted in their ability to leave an abusive situation/relationship due to, for example, reliance on families and caregivers (Nixon, 2009; Human Rights Watch, 2018).

The dependent status of some disabled women can suggest, to the outside eye, that they are incompetent and powerless to resist perpetrators’ advances or report them, making them an ‘easy’ victim. Perceptions that disabled women are powerless, lack agency to report or disclose, and are unlikely to retaliate are created by structural inequalities in different societies which exclude them from certain social processes and impede their access to support and resources to facilitate life choices and opportunities on par to non-disabled women. Galtung (1969) refers to this as structural violence, and argues how it has the potential to underpin acts of DVA. This is particularly pervasive in countries such as India where disabled women are seen as ‘flawed’ and their inequalities to structures and processes is seen as a social norm (Daruwalla et al., 2013).

Several authors report on the particular forms of impairment-related abuse that can take place. For example, withholding assistive devices is a common mechanism of control and abuse (Nosek et al., 2006; Radford, Harne, & Trotter, 2006; Hague et al., 2011). Impairment-specific violence was also evidenced in a four European country comparative study involving the UK, Austria, Germany and Iceland. The study was conducted between 2013–2015 (Mandl et al., 2014) and Shah led the UK team. The study evidenced the different types of violence experienced by disabled women across the life-course, sometimes motivated by specific aspects of their identity. The study showed how, often, impairment-specific violence is not recognised as violence, but as a normal part of the disabled person’s life, and the perpetrator was often someone who the women was reliant on, who exploited their position (Shah, Woodin, & Tsitou, 2014, 2016). This is exemplified by the following quote from a participant named Adele (self-selected pseudonym) who recounts how she experienced abuse for a good part of a decade starting when she was a young teenager. The perpetrator, who was in their 20s at the time, was Adele’s carer and sexual partner who, she believes, exploited his role as her carer to control and isolate her:

They would purposefully give me the strongest painkillers when my friends were coming, and they couldn’t come then obviously because I was asleep. [They] would cancel care shifts, they would then say that I’d cancelled them, because again when you’ve had them tablets you’re not good at remembering anything – even what your name is.

Similarly, the refusal to provide basic care has been reported (Kroll, Jones, Kehn, & Neri, 2006; Lightfoot & Williams, 2009; Public Health England, 2015). Bowen and Swift (2019) suggest
that individuals with intellectual disabilities are at heightened risk of DVA due to a number of reasons; for example, not always being able to identify and read social cues and misinterpreting inappropriate/abusive behaviour as friendship or love.

As regards disabled women and girls, abuse that violates their reproductive and sexual rights is a considerable problem and really brings to the fore the gendered aspects of abuse. Disabled women have been victims of involuntary sterilisation in a number of countries (DESA, 2018). There is a pervasive and inaccurate discourse that disabled women are a-sexual and hence their disclosures of sexual violence against them may not be taken seriously. It is why point 8 in Table 20.1 is so important: making sexual and reproductive health-care facilities and information accessible for disabled women and girls.

Pregnancy is a high-risk time for DVA, and many women experience DVA for the first time during pregnancy, or existing abuse escalates in terms of frequency and severity. There is some evidence that for disabled women, the risks are even higher. Almost 10% of women giving the birth in the UK each year have one or more long-term impairment (Redshaw, Malouf, Gao, & Gray, 2013) and approximately half of these women will experience DVA (Šumilo, Kurinczuk, Redshaw, & Gray, 2012). In 2012, one of the authors (Bradbury-Jones) led on a UK study that investigated how disabled women with experiences of DVA are able to navigate maternity services. The study highlighted multiple barriers to access and utilisation of services. Some barriers were identified as physical/environmental, but a significant obstacle to accessing much-needed maternity care was found to be women’s previous experiences of treatment by health-care staff (Bradbury-Jones et al., 2015a, 2015b; Breckenridge et al., 2014). In Table 20.2, we have presented one of the quotes from a disabled woman who took part in the study. It illustrates well the multiple discrimination that we referred to earlier in the chapter.

Disability and DVA in India

In this next section, we move the discussion to thinking about DVA and disability in India and as we have done earlier in the chapter, we explore their intersection. In India, the lifetime prevalence of DVA in general is reported by 40% of all women (Kalokhe et al., 2015). Although global estimates do vary from somewhere between 15% and 71% (WHO, 2009), this is relatively high. Moreover, it is important to recognise its distinct manifestations, attributable to prominent religious and cultural aspects of much of life in India. For example, the ‘traditional’ Indian family is a joint family where abuse can extend to perpetration by in-laws in addition to that perpetrated by a spouse. Daruwalla and colleagues (2013, p. 8) reported that disabled women face ‘violence in the form of neglect, control, restricted mobility, forced marriages, and lack of autonomy’. Sexual abuse and forced sterilisation by family members are also risks (Mohapatra & Mohanty, 2005). Moreover, its perpetration is from multiple potential sources such as partners.

Table 20.2 Disabled woman’s perception of discrimination

<table>
<thead>
<tr>
<th>It’s really easy to put a stereotype on someone, like “Oh, well, this person cannot make good decisions for themselves because a) they’re disabled or b) they made such horrible decisions to put themselves in an abusive situation”, which the two don’t have anything to do with each other a lot of times. I think it’s understood in society that if a woman is in an abusive situation, she can’t make good decisions for herself.</th>
</tr>
</thead>
</table>

Source: Taken from Bradbury-Jones et al. (2015b)
family members and paid carers. Drawing on the work of Ahmed-Ghosh (2004) and Kalokhe et al. (2018) it is possible to identify some prominent forms of DVA in India:

1. Eviction from the house if a woman does not agree to a demand of dowry or other material.
2. Preference for a male child and abuse if a woman gives birth to a female child by physical violence and passing scathing comments.
3. Burning or beating the woman with kitchen utensils, misuse of religion and making her change her dietary preferences.

The fact that many women and girls are not literate and have not experienced the same benefits of education as many boys and men (UN (India) 2020), is another pervasive challenge around their understandings of DVA as a human rights issue. This has been a hurdle for many years in India. Within this societal and contextual environment, often girls and women do not realise that they are experiencing abuse because the acts of dominance and oppression in the household and broader society become normalised.

In India, normative judgements as regards meaningful contribution to society are based on factors such as productivity, property ownership, family as a social unit, marriage, religion and patriarchy (Daruwalla et al., 2013). Having explored the double impacts of DVA and disability on women generally it could be argued that the context of India adds yet another discriminatory layer. Ghai’s (2001) book titled Marginalisation and Disability: Experiences from the Third World explores how even though disability is a global issue, in India its implications differ as regards contexts and cultures. For example, in the Hindu religion, it is widely believed that disabled people are suffering from the wrath of God: punished from misdeeds of either them or their family members. Another notion is that of disability perceived as an eternal childhood where survival depends on constant care and protection. These conceptualisations focus on disability as a negative cultural identity. Difficulty in access to education for disabled girls and women can also lead to increased susceptibility to divorce, DVA and sexual violation (Buckingham, 2011).

Financial dependence often worsens the situation (Dutta, 2015) and as Ghai points out, when families are living in extreme poverty, the birth of a disabled girl can add a significant additional financial stress on the family. Salian (2018) reported the case of a young woman with cerebral palsy who was raped by three neighbours in an Indian village in 2014. Rather than express outrage at the plight of this young woman, the villagers were reported to be angry at the decision to sentence the men to imprisonment on the grounds that it wasted their productivity as young, healthy men. This shocking account highlights well the misplaced societal responses and the shame and stigma faced by disabled women in India.

Moreover, taking the viewpoints of Padte (2013) and Deepak et al. (2014), there are a number of problems in the specific context of India. Violence towards those who are perceived as being weak in some way is part of society and is often seen in family and community relationships. Sexual violence is a taboo topic in much of society and hence not discussed widely by many people. Additionally, sometimes the authorities and police who are supposed to help victims exploit them in the form of sexual favours or bribes, making the risk even greater for disabled women. There is also the pervasive problem of normalisation, with many women believing that domestic violence/beating is okay because they deserve it, owing to the low self-esteem caused by the disability and societal misconceptions (SNEHA, 2020).

Although the issue of DVA is a major concern in Indian society, there are certain barriers that hamper disclosure of sexual assault amongst disabled women (Dawn, 2014). Whilst fear of
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disclosure applies to most women, disabled women experiencing DVA face the fear of double disclosure; they not only worry about the stigma surrounding DVA, but also about how health professionals’ misconceptions about disability may affect their care (Bradbury-Jones et al., 2015a, 2015b). Referring back to Table 20.2, we can see how the disabled woman would be anxious to talk about either of these aspects of her life. In the context of India there may be additional complexities. Barriers to disclosure of DVA among disabled women and girls act at multiple levels including societal, organisational and personal. In a society, if sexual violence is regarded as acceptable and justifiable, as it may be in some Indian contexts, then disabled women may be disinclined to report. At an organisational level, there may be barriers in communicating the violence due to ineffective or limited aids required for a disabled woman. As we explored earlier, there are physical barriers to access and utilisation of services for disabled women generally, but the development and accessibility of services in India means that the situation is more problematic. Points 4–8 in Table 20.1 point to some of the important strategies to overcome this problem. On a personal level, often violence of any type might be considered as a shameful act and an act of stigma and hence may not be disclosed and reported. Women with physical impairments may find it more difficult to escape from violent situations due to limited mobility. Because of the lack of accessible information, disabled women and girls, particularly those with intellectual disabilities, may not know that non-consensual sexual acts are a crime and should be reported.

Another factor in relation to barriers to disclosure lies in the perceptions of how a complaint will be managed and this is illustrative of the simultaneous oppression that we have already discussed. Police and court officials have a poor level of understanding about issues related to DVA and issues related to disability and when these are combined, they are likely to be even less prepared to respond appropriately. Access to justice, access to health care and dealing with the issue in the court systems are all problematic (Barriga, 2016; Salian, 2018). Salian (2018) details how the police and other officials do not have enough training in dealing with such situations. Police may not know how to speak properly and to handle the issue sensitively. So, it is important to train police officials, health-care workers and other personnel dealing with such cases about handling the issues sensitively and communicating with different forms of disabled persons effectively. The same can be said of the need to train health personnel and other workers and professionals in the context of health and social care.

Addressing DVA and disability in India

When the women’s rights movement gained momentum in India, there was a focus on poverty, education, caste discrimination, employment, dowry, population control, female feticide and domestic violence. The issue of disability was not even highlighted.

In 2007, the United Nations Convention on the Rights of People with Disabilities was signed and acknowledged by India. It recognised that disabled women and girls may be exposed to increased risk of DVA, requiring gender perspectives to be incorporated into discourses and policies about human rights; and thus, provisions were made from that point (Badjena, 2014). In 1983, DVA was recognised as a criminal act and punishable offence in India. In recent years, the government of India has taken measures to develop and improve the situation by making laws for the protection of women and girls. In 2005, the government of India passed the 2005 Protection of Women from Domestic Violence Act (PWDVA) which included experts from different committees coming together to develop policy and action. With the traditional structure of Indian families based on patriarchy, it is difficult to expect a major change in Indian
society in a short span of time. However, several measures have been taken and continue to be taken by the Indian government and various non-governmental organisations (NGOs) to work towards awareness about DVA and women empowerment.

An important framework for implementing such measures is the United Nations Sustainable Development Goals (SDGs). Before exploring how these link specifically to DVA and disability in India, we will say a few words about the SDGs generally. They were adopted in 2015 by all United Nations Member States as a blueprint for ensuring wellbeing, peace and security for people all over the world. The blueprint is focused on 17 SDGs for all countries – resource rich and resource poor – to pull together as a global partnership to tackle the 17 most pressing challenges faced by the world now and in the future.

As Abu Al-Ghaib and Wilm (2020) point out, the SDGs differ in many ways from their predecessor, the Millennium Development Goals (MDGs). One crucial difference in the context of this chapter is that the MDGs were silent on the issue of disability. This is important because as we have already discussed, the issue of disability was not part of prominent policy within India until relatively recently. As a consequence, disabled people have been excluded from development initiatives and funding streams (Abu Al-Ghaib & Wilm, 2020). The SDGs on the other hand, do take account of disability. But, according to DESA (2020), disabled people are at a disadvantage regarding most SDGs. DESA’s viewpoint is that it is critical to ensure the full and equal participation of disabled persons in all spheres of society and create enabling environments in line with the Convention on the Rights of Persons with Disabilities (DESA, 2020). Abu Al-Ghaib and Wilm (2020) make the point that it is important to bear in mind that the commitment to ‘leave no one behind’ means that the SDGs cannot be considered a success unless they are met for everyone – including disabled women and girls.

Unlike disability, gender equality did feature in the MDGs. Out of the eight MDGs, Goal 3 was to ‘Promote Gender Equality and Empower Women’. The SDGs have a number of related goals as regards gender and violence, most directly Goal 5 (Gender Equality) and Goal 16 (Peace and Justice). Butchart (2020) provides a clear presentation of how the SDGs and violence intersect that makes an extremely useful resource for exploring the issue in greater depth. He suggests that there are two goals that have direct relevance to tackling violence (Goals 5 and 16) and a further six goals that help to address the risk factors for violence. These are shown in Table 20.3. It is important to remember that all the goals are inter-linked and with this in mind,

### Table 20.3 Linking the SDGs to gender and violence

<table>
<thead>
<tr>
<th>Achieving Gender Equality (Goal 5)</th>
<th>Achieving Peace and Justice (Goal 16)</th>
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</thead>
<tbody>
<tr>
<td>Eliminate all forms of violence against women and girls.</td>
<td>Significantly reduce all forms of violence and related death rates everywhere.</td>
</tr>
<tr>
<td>Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.</td>
<td>End abuse, exploitation, trafficking, and all forms of violence against children.</td>
</tr>
</tbody>
</table>

**Addressing the risk factors for violence**

- No Poverty (Goal 1)
- Good Health (Goal 3)
- Good Education (Goal 4)
- Reduced Inequalities (Goal 10)
- Sustainable Cities and Communities (Goal 11)
- Partnerships for the Goals (Goal 17)
there are also several goals that can be regarded as being relevant to addressing some of the risk factors for violence as shown in Table 20.3.

One critical element of the SDGs was highlighted by DESA (2018), who made the point that many countries still address gender and disability issues separately, without focusing on the intersection between the two (DESA, 2018). Hence the relevance of this chapter where we have attempted to draw the issues together. In order to achieve Goal 5, United Nations India has a comprehensive programme to map their progress and development (Table 20.4).

Although there are several laws in India to address the intersection of DVA and disability, often women are not aware of such laws. Lack of awareness among disabled women can be due to the socialisation which truncates and limits formal and informal learning, opportunities including peer group exposure owing to their impairments. As Badjena (2014, p. 55) observed: ‘The social role or absence of the role attributed to women with disabilities, in conjunction with the stereotypes that exist, contribute to their vulnerability, and lead to violation of their rights’. Thus, it is imperative for governments and relevant institutions to enact the law and to provide a mechanism for justice. An important step would be to consult with the relevant communities, particularly girls and disabled women about these laws and ways of implementation, and training of relevant officials (Barriga, 2016). This could be achieved by spreading awareness about these laws amongst the community and affected individuals in the form of advertisements on TV, newspapers, schools, primary health centres and other places of community gatherings.

Returning to Ghai’s (2019) writings on the re-thinking of disability, some interesting reflections arise as regards where India has been and where it is heading in terms of addressing inequalities pertaining to gender and disability. In exploring the marginalisation of disabled people’s lives and their right to a full life, Ghai talks of how India is going through rapid economic expansion and social change, which creates significant opportunities (and of course, some challenges). For example, several multinational companies across India have developed policies and practices that include disabled people, including women, proactively tackling the barriers that

Table 20.4 UN targets for achieving gender equality and empowerment of women in India

- End all forms of discrimination against all women and girls everywhere.
- Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
- Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.
- Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life.
- Ensure universal access to sexual and reproductive health and reproductive rights. Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws.
- Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women.
- Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

Source: Adapted from https://in.one.un.org/page/sustainable-development-goals/sdg-5/
might otherwise exclude them. Given time, such initiatives can have significant impacts on the lives of many disabled women in India, lifting them out of poverty and moving them forward with an empowering agenda. For those disabled women whose lives are marred by an abusive relationship, the ability to be empowered to recognise, disclose and seek help for the abuse are far more likely to be realised.

Education and empowerment of girls increases the chances of improvement in the economy, thereby reducing poverty and population burden, achieving SD Goals 1, 3, 4, 10 and 16. Ending violence against women is a key national priority as identified by the Government of India, which aligns with SDG 5 on gender equity. As discussed, for years women in India have seen degradation and deprivation of basic human rights in their family and society. Measures taken to achieve the SDGs have raised hopes for women’s empowerment and equality. That is for all women and girls. There is further to go for disabled women and girls where DVA exists, but in this chapter, we have provided insights into some of the policies and frameworks that may assist with this endeavour.

**Conclusions**

Disabled women and girls across the world are at heightened risk of violence and abuse in myriad forms in comparison to their non-disabled counterparts. In addition to the types of violence that can be perpetrated against all women and girls, they can experience impairment-targeted abuse and/or their impairment is used as a mechanism to enhance their vulnerability in some way. India is one of the poorest countries in the world. Its poverty creates opportunities for structural violence against disabled women to be embedded within its community, which underpins other forms of DVA.

In India, both DVA and disability rates are high, yet there is a great deal being done to tackle DVA and to better support disabled women and girls. Discrimination and oppression experienced by individual disabled women will not lessen purely through interventions aimed at the individual – it requires structural change to enact attitudinal and societal change. We have explored how the SDGs come together as potential levers for change, and how an intersectional lens is critical to understand and address experiences of DVA for disabled women in India. This gives hope that in India, the enduring challenges of multiple discrimination experienced by disabled women and girls can be reduced, if not (ideally) eradicated. We have focused on India, but many of the issues discussed are transferable to other jurisdictions, particularly low- and middle-income countries.

**Critical findings**

- Cultural and religious barriers, patriarchal dominance amongst Indian society act as major contributing factors for the prevalence of violence and discrimination against disabled women and girls.
- Sexuality of disabled women and girls is often not recognised and hence abuse takes place and goes unreported.
- Raising societal awareness about gender and disability rights is imperative.
- Proper training to tackle the issue of DVA with disabled women effectively amongst police personnel, health-care workers and other related officials is necessary.
- In India progress has been made to tackle many human rights issues, including saving girl children, educating women and overall women empowerment.
- The SDGs provide a framework to drive change, to tackle both DVA and disability.
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Keys implications for policy, practice and research

**Practice**

- Public education and proper interventions are required to increase awareness among disabled women and girls regarding their rights to live free of violence.
- Health Care Practitioners (HCPs) and workers of the criminal justice system need to be trained to work with DVA related issues and disabled victims with sensitivity, care and consideration.
- Governmental organisations, various agencies, and donors are to work together to make prevention possible and provide protection services for the affected.

**Policy**

- Under-reporting of violence is a significant problem and it is imperative for the police and lawmakers to address the issue and to enact their legal duties to protect disabled women and girls.

**Research**

- Published literature on DVA and disability in India are primarily focused on urban populations as opposed to rural areas. Studies that include both urban and rural populations would provide useful comparisons and would ensure that a broader range of perspectives and needs are captured.
- While several policies are in place in India for women empowerment, it will be useful to know whether or not these are working and the degree to which the targets for achieving the SDGs in relation to both violence and disability are likely to be met.

**References**


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