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Women's Initiatives

Editorial Borad

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Editorial

I have long known the yawning gulf between theory and praxis. This became even more evident when Samyukta Research Foundation (SRF) launched the 'Reflexive Humanities' project in 2021. Envisaged with the motto 'Invest in Future', our aim was to explore the emerging field of Humanities within the academia and outside. The key idea was to "underscore the reflexive and self-evaluative nature of Humanities that continuously revises and reforms its own basic premises".

As our work on Reflexive Humanities progressed, the one thought that surfaced repeatedly was the erasure of the past, of memory, the very corner stones of our life. The implication of this was mind-blowing. To come to terms with the free-flowing nature of time, events and history was tough. It proved to be near impossible to know why the patterns of encoding, storage and retrieval deeply embedded in our brain undergo continuous churning. We felt we have to study the domains of both Health and Humanities to comprehend what can generally be called the human life processes and how it impacts life.

This enquiry, interdisciplinary in nature, became the focus of the Foundation since the launch of the Reflexive Humanities project. We invited hitherto untold stories and refreshing ideas from health professionals, academicians, caregivers and patients. Step by step we put together a network of scholars with diverse research interests to explore the rationale of the conjoining of health and humanities. We encouraged them to transcend nomenclatures and glean information from various sources, direct and indirect. We agreed to leave the choice of research methods fluid. However, we nudged them to defy dualisms that may arise from the exercise.

To supplement these out-of-the box enquiries, we conducted a series of talks by established scholars in Health Humanities across the world. These talks gave clarity and direction to our research project. As work progressed, we were excited at the synergistic effects the combination of Health and Humanities produced. To test the waters, we put out a call for papers in Health Humanities for a special number of Samyukta. The response was overwhelming.

This double-number of Samyukta carries representative papers from the steady stream of submissions we received. Cutting across multiple domains of human life, they are diverse in tone and content, conveying the present status of the discourse on health and its intersection with humanities. We have papers ranging from patient-caregiver-provider dynamics within Indian healthcare systems to period tracking apps and data privacy in India, examining its risks, awareness and gaps in empowerment exercises.

At Samyukta, we are acutely aware of the social disruption any derangement in the health system can lead to. Women are condemned to bear the brunt of the breakdown of social, political or economic order, as we saw recently during COVID 19 pandemic. Therefore, Engendering Health is the first problematic the Foundation identified to analyse, and simultaneously implement corrective measures to ensure gender justice. We are cognisant of the challenges these ambitious measures involve. The twin-issue of Samyukta on Health Humanities is meant to test the waters, before we launch a multi-pronged campaign towards engendering health. It also signals the rise of a new order in the academia, with a set of brilliant young minds who see study as play and play as study.

In them, we place our trust.

G. S. Jayasree
Editor
Samyukta: A Journal of Gender and Culture

Table of Contents

Samyukta 2025 July

Sl.No.	Title	Author
	Indian Health Care System: Policy Frame Work	
1.	Strategic Health Communication in Kerala: Evaluating Governmental Approaches and Structural Challenges	Amrutha G. Pradeep M. S Harikumar
2.	Insights into evolving patient-caregiver-provider dynamics within Indian healthcare: A critical perspective	Shraddha Namjoshi Hiba Siddiqui Yuvraj Singh
3.	The Evolution of the Transgender Welfare Board in Tamil Nadu: A Historical Study	M. Pramod
	Indian Health Care System: Challenges	
4.	Human Trafficking in India: Policy Gaps and Grassroots Solutions for Change	Prerna Pawar
5.	Reclaiming Digital Safety: Feminist Strategies Against Online Harassment	Shreya Sharma
6.	What Will They Think: A Choreography of Feminine Surveillance	Preethi Kethavath
	Socio-Cultural Reading of Health	
7.	A Cultural Reading of Sports Narratives through Health Humanities	Divya S R
8.	Staged Strength: Intergender Kushti in North India as Spectacle and Sociocultural Commentary	Joseph Viruthiyel

9.	Kaavu theendal and Bharanipattu: A Sacred Manifestation of Drama Therapy	Haritha H. Venkitesh Soumya Murukesh
	Mental Health	
10.	Redefining Mental Health Care: A Human-Centred, Ethical Approach to Reducing Stigma	C S Prabha
11.	Role of Narrative-Memory Synergy in Memoirs Discussing Mental Illness	Krishna Priya S
	Disability	
12.	Embodied Otherness and the Semiotics of Disability in the Ramayana	Ankush Mishra
13.	The Effectiveness of RPwD Act, 2016 in Providing Inclusive Education for Women with Disabilities in Mizoram	Lawmsangpuia Ralte

Samyukta: A Journal of Gender and Culture
Vol.10, No. 2, July 2025

Strategic Health Communication in Kerala: Evaluating Governmental Approaches and Structural Challenges

Amrutha G. Pradeep, **Dr. M.S. Harikumar**

Abstract: In the contemporary world, health communication has assumed greater significance than ever before. It integrated both interdisciplinary and multidisciplinary efforts to widen its scope, applicability and dynamic nature (Rashid, 2012). Kerala, a state in India, has a unique paradox in the health communication landscape. Due to its strong public infrastructure and high literacy rates, the state employs various communication strategies, including trans-media storytelling and multilingual outreach, to disseminate health information effectively. Kerala also faces significant challenges in providing accurate and timely health information to the needy. This study analyses the prospects and challenges of health communication in Kerala, employing qualitative content analysis to examine the role, limitations, and efficacy of government strategies aimed at improving health communication for its populace.

Keywords: *Media literacy, E-Health, E-Governance, Disease Surveillance*

Introduction

Communication represents the indisputable connection in the global knowledge production, acquisition, and distribution of knowledge across the globe (Airhihenbuwa et al., 2000). Ultimately, it is through communication that knowledge is signified globally, and the values attached to it are disseminated in the realms of emerging policies and interventions addressing global health problems (Dutta and de Souza, 2008). Health has become a significant factor in how we judge the life and certainly the vitality of a community, as well as the intervention of the people who live in it (Airhihenbuwa et al., 2000). Now, health is

emerging as the foundation for the development of global interventions, bringing forth economic, political, social, and cultural initiatives that are also designed to address health issues.

The evolution of health communication has also brought a shifting, yet richer, terrain in which matters of culture, politics, identity, and meaning assume a central role in defining and deploying public health (Zoller and Dutta, 2008). Health communication is the study and practice of communicating health information, such as in public health campaigns, health education, and between doctors and patients. It can also create proper awareness regarding health issues and diseases, promote health literacy and influence personal health choices. Health communication serves as a guide for both individuals and society to lead healthy lives. Better healthcare is essential for a developed nation; therefore, health communication plays a crucial role in a nation's overall well-being.

In India, health communication efforts were initially concentrated on health and family planning in the early 1950s. With the launch of the National Family Planning Program, the use of formal communication started using electronic media. Community radio, community television and other advanced technologies were also employed at these times. In 1966, health communication got a boost with the central government’s family planning program. The government created a separate Department of Family Planning, which later became the Department of Health and Family Welfare. The department started to provide information, services and health commodities. One of the major achievements has been the rise in awareness about one or more methods of contraception and the knowledge of female sterilisation as the safest and most popular method of planning the family. Mass media also played a major role in achieving this goal. A lot of thought went into articulating health communication programs, and they have often attempted to meet the barriers of bridging the gap between the health program and the people; the health providers and the people; and between the health and the people. Despite all these efforts over eight decades since independence, India is still facing certain barriers in covering the last mile (Sinha, 2016).

Different states in the country adopt various strategies to promote health communication programmes. Kerala has the highest literacy rate in India and ranks at the top position in the NITI Aayog report with a score of 74.01. The medical accessibility and coverage of medical care facilities are significantly better in Kerala when compared to other states in the country.

The state also has excellent health care facilities and can boost of a large number of dispensaries, hospitals and nursing homes spread across the different districts (SDG, 2019).

The Kerala model of health is often described as "good health based on social justice and equity" (Ekbal, 2017).This strategy is also a model for other states in India. The high literacy rates, mainly among females, also played a major role in enlightening the health scenario (Eldhose, 2021). The state has implemented various strategies to disseminate health-related information, including using colloquial languages through television channels, radio, print and digital media platforms, and direct announcements. It also takes care of the health of interstate migrant workers by providing health camps in their working areas, distributing posters and notices in multiple languages, such as Hindi, Bengali, etc. This is very effective in reaching migrant-dominated areas. The concept of trans-media storytelling has been utilised, creating engaging content that permeates people's daily lives. For example, in a film created by the Kerala Police Media Centre, a police officer was seen washing his hands properly while dancing to a well-known song. Kerala has also started a "Break the Chain" widespread hand-washing campaign to raise awareness of the importance of personal and public hygiene.

Kerala's health landscape is a fascinating paradox, having impressive health indicators comparable to developed nations, but the state has been grappling with a surge in non-communicable diseases (NCDs), misinformation, digital divide, unhealthy lifestyles, increasing road accidents, etc. However, with changing disease patterns, digital transformations, and social dynamics, both new opportunities and challenges have emerged in the state.

The study is going to analyse the prospects and challenges of health communication in Kerala. The researcher employs a qualitative methodology for the study, which uses secondary data analysis.

Review of Literature

In India, successful public health initiatives hinge on effective healthcare communication. Effective healthcare communication must transcend traditional methods, incorporating digital advancements to address the diverse needs of its population. To increase the effectiveness of healthcare communication campaigns, public health officials and policymakers should adopt science-driven strategies to assess campaign success. Techniques such as digital analytics,

sentiment analysis, and geospatial mapping can track message reception across various communities and demographics. Additionally, audience reactions can be assessed through surveys, focus groups, and social media engagement data, all of which can be used to ensure the effectiveness and success of health communication strategies. Integrating IEC (Information, Education and Communication) and SBCC (Social and Behavioural Change Communication) strategies can also empower public health campaigns to foster meaningful and lasting behavioural changes among the people (Joshi, 2024).

The article "Health Communication in India: Prospects and Challenges" (2021) by Kavitha Koli highlights significant opportunities and challenges within India's health communication landscape. The study emphasises the vast potential of leveraging India's rapidly growing digital infrastructure. This enables innovative channels, such as mobile health apps, telemedicine, and social media outreach, allowing for more personalised and scalable information dissemination. The Koli also identifies certain substantial hurdles that obstruct effective health communication in the country. The study highlights the various socio-economic, linguistic, and digital divides among lower socio-economic groups, women, and elderly people, as well as their inconsistent access to reliable information and digital literacy, hindering their effective use

Koji Nabae (2003) depicts Kerala's health care system for its notable past accomplishments in achieving health indicators such as high life expectancy and low infant mortality rates comparable to developed nations. The success of the healthcare system is highly attributed to high literacy rates, strong political commitment to public health and primary and secondary health infrastructure. Effective decentralised planning empowering the local government (panchayat raj institutions), ensuring broad accessibility and equity in the healthcare system, is also considered a reason for a better healthcare sector. However, the burgeoning private sector in the state increases health care expenditures and makes health a commodity to purchase. Many public facilities remain underused, and the lack of regulations over the private sector does not guarantee the quality of care.

Shamshad Khan's Manufacturing Consent? Media Messages in the Mobilisation Against HIV/AIDS in India and Lessons for Health Communication (2013) critically examined the media messages in the mobilisation against HIV/AIDS in India. In contrast to encouraging educated, rights-based public health communication, the study examines how media narratives, both news and entertainment, create discourses surrounding HIV/AIDS,

frequently promoting stigma, moralistic assessments, and governmental goals. Drawing from Herman and Chomsky's Manufacturing Consent, Khan makes the case that Indian media usually supports elite and state interests by framing HIV/AIDS in ways that put political and economic concerns ahead of marginalised voices like those of sex workers, LGBTQ+ communities, and HIV- positive individuals. The media's framing of these concerns is frequently dominated by sensationalism and moral panic, which reinforce stereotypes rather than conveying messages supported by facts. The study criticises how media representations of HIV/AIDS often link it to "deviant" habits like drug use, sex work, or homosexuality, which exacerbates the stigma in society. Khan compares this with grassroots initiatives and alternative media that prioritise damage reduction, human rights, and community-led campaigning. The paper also highlights the intersections of class, gender, and sexuality in media portrayals, contradicting popular public health narratives by combining discourse analysis of media content with interviews of journalists, activists, and officials.

Raman Kutty (2000) stated that the dynamic role of the state government has been a key factor in the expansion of healthcare facilities. The public sector conquered the early period of rapid growth in health facilities. Still, in the mid-1980s, due to economic and other problems, there was a slowdown in the growth of health institutions. By this time, the private sector was poised for growth, and it took the lead in the growth of health care facilities in Kerala. One of the major developments in Kerala that may ease a more active role for the government is the transfer of more powers to the local councils at the panchayat and district levels, with the recognition that health is one area where such local control can work most effectively (Kutty, 2000).

Study Method

The paper is the result of an exploratory investigation. For the current examination, auxiliary information sources were utilized to assemble data. The required and appropriate information was assembled from public sources, books, papers, and other sources. This study adopts an exploratory research design to investigate the underlying dynamics of health communication practices in the state of Kerala in India. To assemble the necessary data, a wide range of auxiliary information sources was utilized. These include publicly accessible materials and specialised literature, such as academic journal articles, books, government reports, media publications, and other relevant sources. A comprehensive review of these published

materials provides the foundation for analysing the health communication strategies employed by the government and their subsequent impact on the health sector.

Study Objectives

1. To analyse the strategies implemented by the Government of Kerala to enhance the effectiveness of health communication.
2. To examine the role of health communication in shaping public health outcomes within Kerala.
3. To identify the key limitations and challenges in health communication practices across the state.

Health sector in Kerala

Kerala, the southernmost state of India, is well known nationally and internationally for its health care at a low-cost model. Kerala has gathered world-wide recognition for its notable developments in health indicators and excellence of life, as evidenced in the human development index (.84) (Making the SDG a reality, 2021). Regardless of their political stance, all elected administrations in Kerala have consistently invested in health and education facilities. The tradition of government support for health development has been a catalyst for the progression of health care in the state. The number of private health services has increased significantly in recent years, surpassing that of government facilities. This is due to the changes in social and economic factors such as increasing per capita income and the spread of literacy (Kutty, 2000).

Primary health care services in Kerala are organised thoroughly with a network covering to the village level. There are 230 community health centres and 84 primary health centres (approximately one per 30,000 population) in the state. There are 5320 female and 4728 male multi–purpose health workers (MPHW), serving every 5000 population. Accredited Social Health Activists (ASHA), who are community health volunteers, approximately one for every 1000-15000 population (Making the SDG a reality, 2021). The state has a strong

network of health workers and volunteers who are involved in ensuring the provision of comprehensive health care to all. The state's strong network of health workers and volunteers is involved in ensuring the provision of comprehensive health care to all. Managing public health emergencies like floods, landslides, and outbreaks like the Nipah and coronavirus has been further strengthened.

Kerala has a large health sector compared to other states in the country. The healthcare infrastructure has flourished under the three systems of medicine, namely Allopathy, Ayurveda and Homoeopathy. The healthcare institutions are evenly distributed in the state. The public and private sector participation in the health care infrastructure is a major strength of the state. People are very much conscious about their health, and they use the medical treatment facilities available in the private and public sector, irrespective of their income, status, place of residence, community, religion and occupational disparities

Government initiatives for better health care

Kerala's healthcare system is widely regarded as a model in India, built on strong public health infrastructure and inventive government initiatives. The state of Kerala pioneered the concept of Universal Health Coverage (UHC) in 2012 through a pilot study in collaboration with the WHO to strengthen the primary health care services and to address the most important cause of morbidity and mortality in Kerala. According to the project, major activities were carried out were introduction of software for electronic patient records, development of evidences- based protocols, task shifting among nurse and paramedics at the facilities to register patient and to conduct pre assessments such as measuring weight, height, body mass index, blood pressure and the blood sugar levels and implementations pf mental health protocols at the primary care centres. The UHC plays a crucial role in achieving the goals and sub-goals of the 3rd SDG (Making the SDG a reality, 2021).

Measures to Ensure UHC

AArdram

The government of Kerala has launched the AARDRAM mission in the backdrop of SDGs to provide comprehensive health care, including preventive, Curative, and Rehabilitative and Palliative services. The mission empowers a patient-friendly approach and ensures good

treatment at a low cost in government hospitals. The scheme implemented many new services in the government hospitals, such as adequate outpatient registration counters, patient waiting area, and ample seating facilities, a token system along with other facilities like drinking water, toilets, public address systems, information, education and communication systems and signage system. Thus, the mission led to a whole revolution of the public healthcare system in the state.

The government adopted an umbrella program approach and started the Navakerala Karma Paddhati. As part of that 'Aardram Mission' was launched in the Health Department to make it a people's campaign for the betterment of health. The main components are improving quality infrastructure at PHC, CHC, Taluk hospitals and District General hospitals as well as medical colleges. One of the main elements is the transformation of Primary Health Centres into Family Health Centres. By assuring public participation, the Aadram Mission has brought about a paradigm shift in patient care throughout the state.

Karunay Arogya Suraksha Padhathi (KASP)

Karunay Arogya Suraksha Padhathi (KASP) was launched in 2019 to integrate all existing health schemes through a government order to bring in standardisation in operations and better management by convergence. KASP aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalisation to over 42 lakhs poor and vulnerable families (approximately 64 lakhs beneficiaries) that form the bottom 40% of the Kerala population. State of Kerala decided to converge all the Government sponsored health care schemes namely RSBY (Central and State Government combined scheme, where the premium is shared in the ratio 60:40), Comprehensive Health Insurance Scheme-CHIS (Kerala government fully sponsored scheme i.e. full premium paid by the State), Senior Citizen Health Insurance Scheme-SCHIS (all the senior beneficiaries aged 60 years and above in the RSBY/CHIS families were provided additional coverage of Rs 30,000 per beneficiary) and Karunya Benevolent Fund-KBF (Trust model implemented through Lottery department) along with Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY) and formulated Karunya Arogya Suraksha Padhathi (KASP).

Other Major Government Initiatives for Health

Care E-Health

E-governance or electronic governance is the application of ICT for providing government services to citizens. Through the standards of e-governance, government services are made accessible to the citizens in a transparent, suitable, and systematic way. E-Health Kerala is a pioneer project funded by the government of India and the Department of Health and Family Welfare, Government of Kerala. The government launched E-Health Kerala to provide residents with a convenient and centralised healthcare system. Other than that, through this service, provided unique identification and unified health record were provided to the citizens, which is based on Aadhar. The main objective of e-health Kerala is to provide better health care facilities to their citizens and improve the quality of health care. The main services of this scheme are that citizens can take online appointments in any government hospital, smooth and continuous op clinics, telemedicine consultations, excellent health care at the doorstep, one citizen one health record, etc. Through this scheme, all health-related services can be accessed through a single new system. One of the main peculiarities of this project is that patients can visit and make appointments with the doctor at their convenience. The rapid development of e- health services has reduced the time and cost of medical treatment and provides efficient and economical benefits.

Arogya Keralam Palliative Care Project

The Arogya Keralam Palliative Care project is India's first and the only government initiative in the entire Asia (Prasad, 2016). The main aim of this policy is to cover every bedridden citizen in the state. A huge increase in the number of outpatients has been described from general hospitals in different districts after the launch of the free generic medicine scheme.

Arogyakiranam program

The Arogyakiranam program is a state-initiated entitlement scheme in Kerala for 0 to 18-year-olds (excluding dependents of government servants and income taxpayers), which provides free investigation and treatment for health conditions other than the 30 conditions covered under Rashtriya Bal Swasthya Karyakram (RBSK). This initiative is indicative of the State Government's assurance to moving towards Universal Health Coverage for reaching sustainable development goals with an emphasis on equity (Madhavan, 2021).

Healthcare and Role of Communication

Communication plays a crucial role in promoting public health and healthcare services. Communication is the overarching component of any program, ensuring its efficiency and success. It should provide immediate and sustained desired outcomes to be considered effective. Renata Schivao (2014), in her book, 'Health Communication: From Theory to Practice', has explained that one of the key objectives of Health communication is to engage, empower and influence individuals and communities. The goal is admirable because health communication aims to enhance health outcomes by sharing relevant health information. A comprehensive health communication strategy should effectively address the needs and challenges in the health sector of the state. Proper health communication focuses on building awareness, improving health-seeking behaviours and enabling behaviour change.

Kerala should have a well-structured communication needs assessment (CNA) in the beginning. The contents and strategies should be periodically reviewed with the help of subsequent Communication impact assessments. The Revised National Tuberculosis Control Programme (RNTCP) in Kerala, known as the National Tuberculosis Elimination Programme (NTEP), utilises Communication Needs Assessment (CAN) as part of its broader communication strategy to ensure effective TB Control. The National AIDS Control Programme (NACP), Immunisation programmes are also a crucial part of the strategy.

Communication strategies during Nipah and COVID-19 outbreak

In a functional democracy, the government provides its citizens with timely and reliable information to keep them updated on the government’s latest policies and activities. Effective public communication ensures improved acceptance of the government's initiatives, strategies, and actions. However, due to the difficulty of its organisational setup, the government is not considered a great communicator, especially in times of crisis or pandemic. However, the Kerala government has used public health communication as an essential part of the overall crisis and pandemic management (M. A. et al, 2021).

During the time of the Nipah Virus, Kerala activated different emergency protocols led by the

Health Department of the state, which mainly include real-time information flow. Press conferences by the Chief Minister and the health minister provide a transparent update on cases, advisories and containment zones in the time of Covid-19. Frontline workers such as ASHA, JPHNs conducted door-to-door surveillance, distributing notices, posters, and pamphlets on symptoms and precautions. Mass media, especially social media platforms, were widely used by the government to provide awareness, and also the same time used to control unwanted panic among them. Furthermore, real-time updates of the government via digital dashboards such as health.kerala.gov.in are also very effective.

In the time of COVID-19, Kerala focused on cultivating and empowering every citizen to follow the advisory. Healthy volunteers and ASHA workers were utilised maximally for screening of passengers, addressing the needs of houses under quarantine, including community kitchens, medicine delivery and the care of elderly/palliative care patients. Kudumbasree members visited all households with adequate precautions, educated elderly people, provided psychological support and ensured continuity of care for them. Village-wise lists of people above the age of 60 with morbidity were prepared. Women self-help group members, volunteers and palliative care teams contacted all individuals and their families based on the line list education on special precautions. ASHAs, with the support of health system front-line workers, did regular surveillance of the elderly and people with morbidity to address their medical needs. The state has been successful to date in containing the infection among the healthy and controlling transmission to the vulnerable. This again is one of the important reasons for low case fatality despite high general morbidity of cardiovascular risk factors in the community (Making the SDG reality, 2021).

The Break the Chain campaign is an initiative by the Government of Kerala for behaviour change communication, focusing on physical distancing, hand washing and using face masks were put in place. Social media and other mass media campaigns, community education by ASHA, women self-help groups and panchayat leaders, etc., are focused on the different measures for prevention.

Involvement of Local self-governments (LSGs)

Kerala's LSG consists of 941 grama panchayats, 152 block panchayats, 14 district panchayats, 87 municipalities, and 6 corporations (LSGD, 2025). Every panchayat in Kerala has a PHC and an AYUSH (indigenous system of Medicine) hospital, and these are evenly distributed

compared with other parts of the country. Each PHC has various peripheral outreach centres known as sub-centres managed with a Junior Health Inspector and a Junior Public Health Nurse (JPHN). Along with the government facilities, there is a wide network of private hospitals in Kerala that cater to a major proportion of the state's healthcare needs.

Each LSG operates a dedicated Health Standing Committee that collaborates with the health department to provide awareness and information about various community-specific risks. They also disseminate information through community meetings, local events, posters, notices, etc. As a part of this, ASHA worker networks and anganwadi workers effectively provide health information and awareness about various diseases through door-to-door messaging, especially in marginalised communities and rural areas. The well-qualified and trained healthcare staff with a good unity of command resulting from the experience in managing several communicable diseases over the years is the backbone of Kerala's healthcare system.

Local self-government (panchayat) bodies used loudspeakers, audio rickshaws with public announcement systems and most importantly, wall posters for hyper-local alerts and instructions. Awareness programs were also held at the ward level by community health clinics. This multifaceted strategy, which combined the reach of mass media, the interactivity of digital platforms, and the penetration of grassroots networks, guaranteed consistent, believable, and culturally relevant messaging across all demographics, significantly enhancing compliance with health measures and saving lives. So**,** Kerala integrated grassroots networks and localised communication to ensure no one was left behind.

Enhanced Media Relations

State government uses different types of media for the effective dissemination of health information. Health reports, leaflets, public service advertisements, documentaries, short films, informative presentations, web portals and online campaigns are some of them.

These information campaigns are implemented through the Primary Health Centres (PHC) and NGOs. Digital media is also utilised for health communication recently.

The government of Kerala used the media for the effective dissemination of health information. Health reports, public service advertisements, documentaries, short films, web portals, online campaigns, etc. were reached people through various media platforms. These

information campaigns are also implemented through the primary health centres (PHC) and NGOs. Traditional media platforms such as TV, radio, and print emerged as the backbone of the distribution of health information, ensuring broad accessibility. All India Radio and community radio stations disseminated crucial information in local dialects, reaching remote and elderly populations.

Social media platforms are considered critical tools to address public health issues and transform the information to the right audience with lucidity and accuracy (Kumar et al, 2018). The increase in digital platforms and social media usage paved the way for rapid digital surveillance, disease mapping, and information sharing and addressing health sector issues (Dash et al, 2024). The health department of Kerala actively used Facebook, Twitter (X), Instagram and YouTube to share info graphics, explainer videos and live updates and making complex information digestible.

In Kerala, the media plays a critical role in disseminating information about HIV/AIDS, Polio, Immunisation programmes, etc. The government used media as a powerful tool for education and reducing stigma, but it can contribute to misconceptions if not handled properly. In the time of COVID-19, the state government disseminated the most pertinent public information daily through the CMs 6 pm press meet. For Keralites across the globe, the press meet has become a staple media diet. Since it started on March 24, 2020, the press meet has grown to be the event with the highest TRP and is shown live on all networks. The video is streamed via YouTube, shared on Twitter Live and the official Facebook page, and has received almost half a million views on Facebook. The CM's official website and other pertinent state government websites cross-post the news conference's content as a press release. Using a variety of media to disseminate information allowed the message to reach all demographics more quickly and widely (M. A. et al, 2021). The public relations department (PRD) of the state has developed a strict protocol when it comes to communication with the media during this time. Apart from the chief minister and health minister, only the respective district collectors of various districts are authorised to speak to the media; no other personnel, even cabinet ministers, are allowed to address the media on the issue.

The Kerala Start-Up mission and public relations department launched a multi-lingual app called Gok Direct, which enabled its users to get all the information related to COVID. Government announcements, the precautions to be taken, important telephone numbers, etc.,

are available in the app.

The government put their best foot forward to maintain a good relationship with the media during the current crisis. The shift has been seen in the relationship between the media and government machinery.

'Bhayam Venda, Jagartha Mathi' is a powerful phrase that became the central slogan of the Kerala government's public health communication strategy, especially during the COVID-19 pandemic. The phrase is dominated by TV channels, newspapers, and radio during the press briefings of the Chief Minister and other experts. In social media platforms, it was the hashtag featured in countless infographics and motivational posts shared by health departments and government handles.

Communication with Stakeholders

Kerala's success in health communication stems significantly from its structured, multi-level engagement with stakeholders. The state has a three-tier decentralised governance for direct stakeholder communication.

During the COVID-19 crisis, state or district war rooms hosted daily virtual meetings with LSG representatives, health officers, police and NGOs. The control rooms also had multi-lingual support to cater to the migrant labourers, a critical mass in the state (Directorate of Health Services, 2020). Online dashboards such as 'COVID-19 Jagratha' gave LSGs direct access to local case data, quarantine lists and resource inventories. DISHA (Directorate of Intervention for Health Service Awareness, comprising trained social workers and counsellors) answers questions about COVID-19 from across Kerala and other Indian states and abroad (DISHA, 2021). Also, medical officers' conduct regular ASHA meetings to disseminate guidelines and collect ground reports to address challenges. ASHA report real–time data on symptoms, contacts and stigma incidents via mobile apps such as WhatsApp, triggering rapid state response.

The role of various branches such as LSGDs, public distribution system, police, disaster management, education, information technology, media and fire force has played a pivotal role in addressing the medical and non-medical needs of the people. The police force played a pivotal role in enforcing the preventative measures at the community level, including the use

of face masks and preventative social gatherings and also ensured food and shelter to the vulnerable, including the poor and migrants.

The CM is also directly interested in constituents through his official Twitter account and clarifies their doubts, providing a speedy resolution. So, the direct communication efforts provided adequate adjusting information, ensuring that the highly vulnerable stakeholders could cope with the crisis (M. A. et al, 2021). Kerala considered stakeholders as active participants. They provided real-time feedback loops, ensured precision, accountability and inclusivity in their jobs.

Disease Surveillance System

The Integrated Disease Surveillance Project, initiated in 2005 with daily and weekly reporting of communicable diseases through paramedical field staff, clinical surveillance throughout hospitals, and laboratory surveillance, represents a robust surveillance network at the grassroots level. Anganwadi workers and a well-motivated group of accredited social health activists recruited through the National Health Mission form a network to capture potential health issues that can appear in the community. COVID-19 pandemic control also became a part of their routine activities.

Challenges in Health Communication in Kerala

The relevance of non-communicable diseases (NCD) is ever-increasing along with the growing incidence of emerging infectious diseases across the state, often referred to as the twin burden or double burden of disease (Hussein,2014; Mathew et al,2022). Kerala faces a severe epidemic of NCDs like diabetes, hypertension, cardiovascular diseases and cancers (Revu et al, 2023). Three-fourths of the total disease burden in the state is being contributed by NCDs (Mathew et al, 2022). Cardiovascular diseases, diabetes mellitus, cancer and stroke contribute to the bulk of the morbidity and mortality in the state and due to the high incidence of type 2 diabetes mellitus, making the state the diabetic capital of India (Diabetes in Kerala, 2022). Communication here struggles with promoting sustained behavioural change. Messages about diet modification, regular exercise, alcohol cessation and medication adherence often compete with sedentary lifestyles and cultural (e.g., taking high-carb food)

preferences.

The zoonotic diseases such as rabies, leptospirosis, salmonellosis, avian influenza, and swine fever show a rising trend in Kerala in recent years. The health system in Kerala was also faced with the consequences of monsoon-related natural disasters of floods and landslides, along with the sweeping rise of the pandemic (Mathew, 2022).

Socio-cultural beliefs and practices are one of the main barriers to health communication in each and every part of the world. Deep-rooted traditional beliefs, superstitions and cultural practices can lead to distrust of modern medical advice. Preferring traditional healers (Vaiders, Manthravadis) over modern medicine can delay critical treatment. Malappuram, a district in Kerala, which resisted vaccination camps, is an example of how religious orthodoxy, lack of information, superstitions, and acceptance of quacks contributed to the abysmally low rate of immunisation in the district. However, the situation has changed from the 57% reach of immunisation in 2017; the district has soared to 92.5% (Naha, 2019).

Kerala has the highest literacy rate in India, but health literacy may not be. Gaps in health literacy affect the coverage and utilisation of health services in both public and private sectors (Surendran et al, 2024).The ability to find, understand, evaluate and apply health information to make informed decisions. This affects navigating the health system and understanding medical instructions. The state has also made significant developments in digital health initiatives, such as esanjeevani, e-health services for people's needs, but challenges persist in rural and marginalised communities due to limited internet connectivity and the digital divide.

Marginalised groups, especially the poor, face many disadvantages in accessing public health services for their needs. Due to the financial disadvantages, these groups have been restricted to quality healthcare services. Variations in Malayalam dialects and the presence of migrant labourers speaking other languages also create barriers in communication.

The spread of fake news and misinformation poses a significant challenge in health communication, particularly during public health crises. Social media platforms have been widely used to disseminate false or unverified claims about vaccines, cures for various diseases, home remedies, disease transmission, vaccine hesitancy and panic among the public. We can access a variety of health information topics, their tips, etc. on the internet, but the credibility of this information is questionable. (Koli, 2021) This type of fake news

can mislead patients into abandoning scientifically proven treatment.

Conclusion

Kerala represents a unique and successful model for health communication in India, characterised by high literacy, well-developed public infrastructure, and other innovative strategies, including multilingual outreach, various communication campaigns, and digital initiatives. The state's response to public health crises such as the Nipah outbreak and the COVID-19 pandemic has been widely acclaimed, particularly for its emphasis on transparent and decentralized communication. Despite these achievements, Kerala faces a complex set of contemporary challenges, including a surge in non-communicable diseases, widespread misinformation, digital divide, lack of health literacy, and the growing need for tailored health messages for marginalized and elderly populations.

While government initiatives like Aardram, KASP, and other community health networks demonstrate a strong commitment to accessible and effective health communication, future success depends on overcoming these hurdles through more integrated, adaptive, and equitable communication approaches that bridge the gap between Kerala's advanced infrastructure and its evolving needs. Emphasis must now be placed on participatory communication models that empower local communities, especially in rural and tribal areas, to become active stakeholders in their health narratives. Health communication strategies must also prioritise media literacy, counter-narratives to misinformation, and stronger public-private collaborations to ensure consistency and credibility. As Kerala continues to set national benchmarks, its ability to evolve in response to demographic, epidemiological, and technological shifts will determine how well it sustains and enhances its reputation as a health communication pioneer in India.

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Insights into evolving patient-caregiver-provider dynamics within Indian healthcare: A critical perspective

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Abstract: In the Indian healthcare context, the triadic relationship between patient, caregiver, and physician is evolving amid diverse and ever-changing socio-cultural dynamics. Patients rely heavily on their caregivers to navigate complex healthcare systems. However, illnesses can profoundly impact these relationships, frequently shifting away from an egalitarian bond to one where caregiving responsibilities can strain emotional and physical resources. Additionally, the changing structure of families is altering how patients receive support and how the patient-caregiver dyad interacts with physicians and other healthcare professionals.

In the past decade, there has been growing recognition of the need to incorporate supportive care that addresses the emotional, social, and practical aspects of healthcare management. As the healthcare landscape continues to evolve, fostering trust, effective communication, and mutual respect among all parties remains essential for improving patient outcomes and overall healthcare delivery in India, especially in formulating culturally sensitive policies. This progress, however, requires evidence-based assessments of needs and the participation of allied healthcare professionals.

This critical perspective study explores the present dynamics of the patient-caregiver-healthcare provider relationship through existing literature and attempts to outline potential gaps in supportive care provision, examining Indian healthcare research through a socio-cultural lens. It also aims to highlight the possible interventions that can bridge these gaps, integrating tools and professionals to elevate the standards of care.

Keywords: *Indian healthcare, communication, healthcare professionals, patient-caregiver, supportive care, unmet needs*

Introduction

Healthcare is deeply relational, shaped by the ongoing interactions between patients, caregivers, and healthcare providers. This triadic relationship becomes especially crucial in the context of chronic and life-altering illnesses like cancer, diabetes and cardiovascular disease, where care is not just clinical, but profoundly emotional, logistical, and social. Chronic illnesses often need long-term care, including regular hospital visits, tough treatment choices, and a lot of physical and emotional effort—making caregiving a long and challenging job. This distress is largely influenced by factors such as caregiving burden, perceived lack of support, and the emotional toll of witnessing a loved one's illness (Northouse 236).

In India, the interaction between patient, caregiver, and healthcare provider is deeply influenced by intricate kinship structures, cultural norms, and varying socio-economic factors. At the centre of this dynamic lies the culturally embedded ethic of caregiving, seen across religious traditions. These traditions reflect a broader moral fabric/imperative that underscores intergenerational responsibility and positions caregiving as both a familial and a spiritual act (Dhar 242).

Caregiving in a country like India is traditionally assumed to be a familial responsibility, rooted in cultural expectations of kinship and duty. However, changes in family structures—such as nuclearization, migration, and shifts in gender roles—are challenging these long-standing assumptions/conventions. With fewer available family members and less informal support, patients often find themselves reliant on a single caregiver, typically a spouse or adult child, who may be untrained and under-resourced (Ranganathan 420). These caregivers not only navigate logistical burdens but also face significant emotional fatigue, often without adequate psychosocial support. Many times, the relationship between patients and caregivers is interdependent. Research further indicates that the distress of one party can influence the other,

highlighting the need for interventions that support both patients and their caregivers simultaneously (Koschorke 66).

The illness itself can transform relational dynamics requiring meticulous coordination between all stakeholders of/in care. Carers play a crucial role in managing appointments, communicating with healthcare providers, and ensuring compliance to ongoing treatment and care. Simultaneously, the healthcare provider, in most scenarios the oncologist or primary physician—becomes a central figure in this triad. However, communication between providers, patients, and caregivers can be limited, hierarchical, and medically focused (with use of medical jargon or terminology that the patients and caregivers may be unfamiliar with), often overlooking the psychosocial dimensions of care, particularly in overburdened Indian healthcare settings.

Traditionally, eldercare in India has been anchored in the joint family system, where multiple generations live under one roof and caregiving duties are distributed among family members. In this arrangement, elderly parents usually live with their adult children, most often sons—whose wives are commonly expected to take on the day-to-day responsibilities of care. This setup not only provides practical support but also reflects deep-rooted cultural values of filial duty and interdependence within extended families. This arrangement is not solely pragmatic or about convenience; but also reflective of cultural values that emphasize respect and reverence for elders (Shaji & Reddy 303). However, the traditional caregiving model is undergoing significant transformation due to urbanization, the rise of nuclear families, and increased out-migration for employment. These shifts have led to a reconfiguration of caregiving roles, often resulting in the assumption of filial duties by daughters-in-law and other extended kin. This phenomenon reflects a quiet but important shift within assumed filial roles, where caregiving responsibilities transcend biological relationships and are shaped by marital alliances/ties, societal expectations, and emotional interdependence (Jaji 227; Srivastava 1).

The National Center for Biotechnology Information (NCBI) hosts several studies that delve into caregiving patterns in India. One such study, *"Care Needs and Caregivers: Associations and Effects of Living Arrangements on Caregiving to Older Adults in India"*, discusses how demographic shifts, including increased migration and the rise of nuclear families, are reducing the availability of familial support for older adults (Ugargol 196). Understanding this dynamic

through a socio-cultural lens is essential. In India, stigma surrounding chronic illnesses, deference to medical authority, and emotional restraint in communication often inhibit open dialogue and limit expressions of need—both from patients and caregivers. This cultural backdrop complicates the recognition of support gaps, particularly when needs extend beyond the clinical to include emotional, spiritual, or practical assistance (Kumar 973).

Being diagnosed with a serious illness can profoundly affect a person's physical health, emotional state, and social life (Ronksley 48). Individuals often encounter major obstacles such as managing the physical symptoms and emotional distress, accessing appropriate and affordable medical care, bearing the financial burden of treatment, coping with potential declines in physical or cognitive function, handling changes in personal relationships, and facing the possibility of end-of-life decisions (Barata 285). These difficulties frequently also impact caregivers, who are usually close family members such as parents, partners or children of the patient and experience a set of physical, logistical, emotional and financial challenges themselves alongside the patient (Faruqui 4). In summary, the caregiving experience in chronic health conditions is a complex interplay of emotional, logistical, and social factors. Recognizing and addressing these dimensions through comprehensive support systems is essential for the well-being of both patients and caregivers.

This paper critically explores the evolving dynamics of the patient-caregiver-healthcare provider relationship in Indian healthcare settings, drawing from existing literature to map the social and cultural contours of caregiving. It also examines models of intervention that promote coordinated, patient- and caregiver-centred support systems—emphasizing trust, communication, and the strategic inclusion of allied health professionals to elevate standards of supportive care in India.

Healthcare professionals: The knot that ties the triadic bond

Healthcare providers play a pivotal but often complex role in the triadic dynamic between patients and informal caregivers—especially in the management of chronic illnesses in India. Their role intersects not only with medical authority but also with deeply ingrained cultural expectations, family hierarchies, and emotional interdependencies. Despite this, the research on

experiential aspects of HCPs while dealing with patients and caregivers is underexplored.

In chronic illness care, particularly for conditions like diabetes, cardiovascular disease, cancer, or dementia—healthcare providers act as intermediaries between biomedical paradigms and the lived realities of patients and caregivers. In India, where medical advice is often filtered through family consensus, providers must navigate not just individual patient autonomy but also collective familial decision-making. Families may defer or override patient preferences, particularly for elders or the terminally ill, based on perceived moral obligations. (Das 135). Healthcare providers like doctors and nurses are sometimes seen as part of the family, expected to offer guidance, emotional reassurance, and even help families think through what is morally or spiritually right. This can blur the lines between their professional responsibilities and personal involvement, especially when medical decisions also involve medico-legal, ethical or emotional concerns (Pinto 153).

Because public healthcare in India is stretched thin and primary care is not well organized, doctors and nurses often rely on family members to handle daily care tasks, make sure treatments are followed, and to encourage provision of emotional support. Shifting this care to the home is not just practical—it has become an essential part of managing long-term illnesses (Qadeer 51). In public hospitals, doctors and other healthcare workers often face heavy workloads and have very limited time with each patient. This makes it difficult for them to fully understand or respond to the emotional and relational aspects of family caregiving. However, chronic illnesses usually need ongoing, trust-based relationships—something that can be hard to build in the fast-paced, one-time interactions common in many Indian healthcare settings (Bajpai 22).

Healthcare providers across public or private/tertiary healthcare setups respond differently to caregiving situations. Some are highly empathetic and aware of the challenges faced by women caregivers, especially daughters-in-law. Others, however, may unintentionally support gender stereotypes by assuming that women will take on caregiving roles as a given, without offering recognition or support (Ghosh 5).

Supportive care needs: A standard of care in the triadic relationship

With the involvement of both caregivers and physicians in patient-care a commonality of chronic disease management, there also has to be acknowledgement that basic medical or surgical care is often not adequate and supportive care provision is fast becoming a standard of care worldwide. Supportive care is the provision of crucial logistic, information, emotional, spiritual, social and physical needs of those affected by an illness, during and after they received their diagnosis and treatment. It is usually also expected to include resources and frameworks that support individuals through processes like palliation and pain management (McElduff).

For example, the Multinational Association of Supportive Care in Cancer (MASCC) defines supportive care in the cancer diagnosis and treatment journey as 'the prevention of and management of the adverse effects of cancer and its treatment.' (MASCC) Research consistently shows that when patient needs are unmet, the resulting outcomes are more likely to be adversely affected (Maguire 449; Sanson-Fisher 228). Addressing patients' supportive care needs is critical to improving not only health outcomes but also the overall healthcare experience and wellbeing of the patient as well as their caregivers (Evans Webb 901). Supportive care holds great value in the patient-caregiver-provider relationship and supportive care provision is more complex than would appear at face value. It is not only patients who have supportive care needs, but also their caregivers who are often engaged completely in their care. This further concerns healthcare providers who must tackle challenges such as treatment abandonment, non-adherence, coping with patient distress as well as working in a fragmented healthcare system (Murthy 15).

Unmet supportive care needs are a pressing concern within modern healthcare systems, particularly for patients facing chronic or life-threatening illnesses and their caregivers (Barata 285). The needs come from a number of domains, from physical symptom management and the logistics of care and treatment, to emotional support and information pertaining to the disease and wellbeing of the patient (Patterson 37). When supportive care needs are not fully and appropriately addressed, the consequences are profound—not only for the individuals affected but also on a deeply systemic level for healthcare provision (Ronksley 48). For instance, patients with advanced cancer frequently report significant unmet needs related to emotional support,

symptom management, and clear communication about their illness and treatment options (Carlson 1165).

Furthermore, unmet supportive care needs can strain healthcare resources. Studies showed that cancer patients with significant unmet needs had higher rates of emergency department visits and hospital admissions. These individuals were more likely to experience poor physical functioning, heightened anxiety and depression, and diminished quality of life—all of which correlate with greater healthcare utilization (Cilli 20). These findings underscore the systemic costs of ignoring supportive care needs.

Unmet needs and challenges in Indian healthcare

Unmet supportive care needs are a matter of significant concern in Indian healthcare, particularly for patients with chronic illnesses and their caregivers. These needs encompass physical, psychological, informational, and practical aspects of care that are often inadequately addressed due to systemic challenges, cultural factors, and resource limitations (Chittem 218) Immanuel et al. found that in the case of older adults in India, around 12.5% have major supportive care and palliative care needs with the highest for West Bengal (17%), Madhya Pradesh (16.9%), and Bihar (16.3%) while lowest in Arunachal Pradesh (2.2%), Nagaland (2.4%), and Mizoram (3%) (274). Further, patients with higher levels of education and the availability of health insurance reported lower needs, highlighting the impact of socioeconomic factors in determining the meeting of supportive care needs. Caregivers of patients with chronic illnesses also face unmet supportive care needs, frequently facing a deficit of adequate support in managing the care of the patient. Frequent hospital visits, treatment and transport costs, having to care for other family members, domestic labor and day-to-day caregiving responsibilities can burden caregivers (Murthy 253).

Indian patients, caregivers and physicians further face a number of challenges with unmet needs. Studies show that a large number of patients newly diagnosed with cancer report experiencing significant distress, fatigue and emotional upheaval; often including anxiety and depression. However, these symptoms may go under-reported by the treating physicians, creating a gap in recognizing, assessing and addressing supportive care needs. (Ghoshal 326)

The unique socio-cultural scape underlying the triadic relationship in Indian healthcare

Socio-cultural factors have a profound impact on the delivery of supportive care in India, with its influence both on the patient and their caregiver as well as on the attitudes and practices of physicians and other healthcare practitioners. These are embedded in the role the families play in care provision, gendered norms, health literacy and beliefs as well as other identities such as sexuality, caste, class and language barriers (Baru et al. 52; Dysart-Gale 26).

While, as previously mentioned, filial ties and a sense of duty are a major driving force in the involvement of close family caregivers, the shift to a more urban nuclear setup or due to work related migrations, patients may face isolation or be wholly dependent upon a single primary caregiver. (Ugargol et al. 196) Further, caregiving is very commonly gendered, with male and female caregivers expected to undertake diverse responsibilities. Studies indicate that women caregivers often receive little to no support in nursing the sick patient (parent, child or spouse) and simultaneously caring for their own children and carrying the burden of domestic labor. Whereas male caregivers, pigeonholed in the 'breadwinner' role are expected to take the lead in seeking information, making treatment-related decisions and ensuring logistical and financial provisions (Evans et al.; Mahapatro et al.).

Health literacy, poverty and geographical distance from treating hospitals are greatly predominant and deeply interconnected in India. Patients and their families frequently have to travel extensively to reach treating hospitals in order to avail tertiary care (Ambroggi 1381). This is further exacerbated by the economic burden of the disease in addition to existing poverty. Particularly when the patients or caregivers are daily-wage laborers, farmers or small-business owners, the time spent in travel, treatment and recovery time and follow-up appointments can cause loss of wages or income and further push the family deeper into poverty (Baru et al. 52). Finally, the lack of health literacy poses a multitude of obstacles in both approaching healthcare centers for preventative and curative care (precursors to supportive care) as well as in adhering to the treatment plans (Johri 852)..

Caste-based disparities continue to affect access to healthcare in India, with stigma and discrimination often leading to mistrust and underutilization of services. Often, communities that

face caste-based marginalization also face economic difficulties, further exacerbating their vulnerability and leaving their supportive care needs unmet (Mahapatro et al.). Stigma and illness beliefs go hand-in-hand and the cultural perceptions to illness, pain and their management can strongly influence the communication and solution-seeking of patients and their families. In a culture rife with gendered perceptions of illness and the tendency to underreport pain, help-seeking becomes further complicated. Adding to this, superstition and misinformation can cause further delay or avoidance. (Taher et al. 1328) Spirituality, cultural identity and religious belief may also play a significant role in influencing decisions about treatment and caregiving (Kashyap and Gielen 31).

Indian healthcare systems can also be deeply hierarchical where physicians hold significant authority and are simultaneously given an exalted position; where patients or caregivers may be reluctant to ask questions or express concern over medical decisions, and also therefore held directly responsible for patient outcomes, both positive and negative. Such dynamics lead to a lack of shared decision making, the patients and caregivers deferring to the healthcare provider's expertise without fully understanding the implications of medical decisions as well as unfairly placing blame on the physician for unfavorable outcomes (Rao 781).

India's linguistic diversity poses significant hurdles in triadic communication. With over 22 official languages and numerous dialects (Pandey 741), language barriers can hinder effective communication between patients, caregivers, and healthcare providers. Studies have shown that language discordance between patients and providers often leads to misunderstandings, misdiagnoses, and patient dissatisfaction. Even when the same language is spoken, differences in dialects and medical terminology can create communication gaps (Ali and Watson 5; Narayan 237).

Lastly, the fragmented healthcare systems combined with the availability of alternative care systems can cause disruption in the triadic relationship. While alternative medicine can provide a wide variety of options for patients and caregivers on how to best approach their care, it may lead to conflicts with healthcare providers. Dismissal of these systems by healthcare providers may discourage patients and caregivers from engaging in open communication (Kumar et al. 0010).

All of these unique socio-cultural challenges in India, alongside the new and rapidly growing concern of misinformation or incomplete health information availability online (Patil), are significant challenges patients, caregivers and healthcare providers face. A number of studies, models and strategies are developed or are being developed to explore possible solutions to these concerns.

Models for improving healthcare management: The global and the Indian picture

Due to impending staffing shortages in the healthcare sector and a growing number of patients seeking primary care, patient volumes are rising quickly, making it challenging for a single primary care provider to manage all patient care needs efficiently and effectively (Norful 254). In these circumstances it is essential to identify models of care delivery to address the primary care demands. Norful et al. propose the concept of 'co-management' as two primary caregiving professionals, a nurse and a physician, collectively manage responsibilities related to care of the patient (254). These tasks include, but are not limited to, patient visits for acute or chronic disease management, pharmacological management, such as diagnostic testing and patient education on prevention of disease or risk reduction. By incorporating administrative tasks, such as attending to patient and caregiver phone calls and paperwork, also fall within the ambit of co-management, the definition is expanded beyond the scope of primary care. The authors delineate the definition of co-management from team-based care and collaborative care, by suggesting that the latter usually involves a vertical hierarchy with various team members organised in an organisational structure depending on their role or profession. Co-management involves a horizontal organizational structure, with clinicians comanaging across teams, such as a patient being monitored by a cardiologist and a primary care physician (Norful 255). While both these physicians work within their own teams, they overlap horizontally to comanage a patient. Based on the urgency or need a nurse within the same team may address the care needs of the patient. Needless to mention, in order for effective nurse practitioner-physician comanagement there needs to be willingness on the part of the practitioner to comanage and for there to be sufficient organisational resources. The authors segue into nurse practitioner-physician co-management, incorporating the attributes of effective communication,

mutual respect and trust, and shared philosophy of care. It is essential to mention that these attributes can exist only with the availability of legal and organizational policies, acknowledging nurse practitioners as autonomous primary care clinicians. This model aims to create organisational policies which can ensure that nurse practitioner-physician management is successful. By having two primary care professionals for a patient there is an increase to access to and continuity of care.

Exploring the barriers and facilitators of heart failure care in Kerala, Jose et al.studied the perspectives of healthcare providers, patients and caregivers. They found that heart failure patients appreciated the role of caregivers and considered it to be critical to adherence to the heart failure treatment (250). There is suboptimal heart failure care due to a large patient caseload during consultations and an absence of self-management care plans. From the perspectives of patients and their caregivers, gender roles undergo a shift within families, in addition to loss of productivity and caregivers stress which end up being barriers to heart failure care. Healthcare providers, patients and caregivers underscored the significant role played by the availability of experienced nurses in enhancing quality of care. Noting the challenges physicians face with respect to administering Guideline Based Medical Therapy (GDMT), the authors mentioned that the lack of awareness and high patient load are a few potential factors why physician consultants do not prescribe GDMT. The authors recommended that task sharing with non-physician health workers may potentially improve prescription and adherence to GDMT thus assisting patients achieve the required dose for the drugs. In order to adequately utilise optimal heart failure care the availability of experienced nursing staff was recognised as a critical necessity. With respect to patients and caregivers, emotional distress symptoms sharing similarities with anxiety and depression were found to be significant challenges when seeking optimal care. For caregivers, a change in roles, challenges related to finances and the family were potentially related with distress. Since heart failure patients reported depressive symptoms owing to a variety of factors such as the heart condition, inability to work and financial challenges, the authors suggest that intervention in heart failure should incorporate screening and management of depressive and anxiety symptoms as well. They suggested that since there is an absence of a structured care-plan for patients and caregivers, the transfer of information is incomplete from healthcare providers to heart failure patients and their caregivers, therefore leading to inadequate

adherence to self care activities, and errors in medication. They highlighted the significance of self-management skills and the importance of proper clinical handover of information. They mentioned that a proper clinical handover empowers the heart failure patient and the caregiver by identifying warning signs of worsening of the condition and initiating timely management.

Rao highlighted the unmet needs faced by primary caregivers of children with cancer. They mentioned that the needs of the caregiver become an important factor especially in India where the primary challenge faced by caregivers is financial burden (1469). It was found that parents and families find themselves inadequately skilled to manage the various challenges that arise as a result of caregiving such as medication, symptoms and investigations. They reported that emotional challenges, issues with logistics and informational support were the primary concerns of caregivers. Despite caregivers reporting fear, anxiety and uncertainty most refused to seek professional help. The authors attributed this to a potential stigma associated with seeking psychological assistance. Further, they reported that during treatment academics and school related activities are not prioritised due to apprehensions around infection, stigma around the disease and absence from school due to side-effects. The caregivers also reported concerns associated with informational needs.

In a separate study exploring the perceived needs and barriers of patients with schizophrenia, caregivers and clinicians from Madhya Pradesh, India, in using digital mental health applications it was found that clinicians acknowledged that mental health applications could be a new means of communicating with patients and caregivers (Bondre). The clinicians added that mental health applications could facilitate supporting remote care and enabling oversight of patients' symptoms or mental distress. Among patients and caregivers, mental health applications promoted mental health knowledge especially in rural users apart from alleviating symptoms or distress. This is essential especially to counter superstitions and misinformation surrounding mental illnesses.

Exploring the oncologists' experiences surrounding barriers and facilitators of prognostic discussions with cancer patients and their caregivers, Maya found that system-level, patient-level and physician-level barriers served as impediments to open and honest interactions with patients around prognosis and care plans (1896). Additionally, the authors also found factors involving

family involvement in cancer care and supportive and empathic communication which enables honest and open communication with regards to prognosis and plan of care with cancer patients and their caregivers. The absence of communication skills training for healthcare providers along with difficulties establishing a suitable proxy who would take decisions on behalf of patients potentially leads to conflicts later. In order to facilitate effective prognostic discussions, the authors suggested the following strategies: Plan and set agenda, Review understanding of cancer state and prognosis, Offer information in a manner that is sensitive to the patient's needs and promotes hopefulness, Give empathy, and Summarise and close the consultation (PROGS) (Maya 1901). The authors highlighted that each strategy stresses on a series of communication skills such as stand alone and/or discrete utterances and process tasks involving non-verbal behaviours that enable a conducive environment for effective communication in order to achieve the communication goal. This is a practical strategy within an Indian oncology context and allows for providing information that targets the patients' needs, and ensures hope and reassurance to patients and their families. This structure allows for an exchange of views between physician and patients and families along with an opportunity to understand the condition and also correct any misunderstandings. The strategies also allow for customized delivery of prognostic information to patients and the families whilst providing hope and reassurance. The applicability of the strategies within the Indian context is especially suitable because of the important role the caregiver plays in care delivery and an inclusive response to patient and their caregiver's information cues while also engaging them in the decision-making process.

Studying the role of the family caregiver in the provision of palliative care for cancer patients in India, Fereydooni mentioned that in order to include the caregivers in the care team, respecting and addressing their emotional, informational and financial needs is important. Healthcare providers highlighted the lack of preparedness on the part of the families to take on palliative care roles. Despite volunteers fulfilling a part of the need for training, there are multiple gaps that the authors found to be present. Stigma around cancer and palliative care was another hindering factor while taking up caregiving roles. Healthcare providers underscored the importance of individualised and community interventions. Healthcare providers acknowledged that for families, balancing the cultural preference to provide informal care to their family members, the

restricted alternative institutional facilities and financial exchange that is associated with caregiving put them in a quandary. The authors mentioned that strategies including training caregivers in distinct income-generating skills can assist in generating income. The study also addressed the family's choice for disclosing the prognosis to the patient. Since caregivers were a critical component of the care team, providers acknowledged that their needs had to be respected. The providers tried fulfilling the preferences of the caregivers through each step of the care process unless there was a necessity of disclosure to the patient. Even when disclosure of diagnosis was needed, a trained social worker would counsel the family, underscoring the rationale behind the disclosure.

Dijkxhoorn et al. proposed a multiphase model for experiences of family members of persons with mental illnesses which considers both positive and negative aspects. The authors mentioned that the experience of caregiving is a complex phenomenon particularly when assessing the negative and positive aspects of caregiving (65). The authors noted that while various other frameworks focus on personal transformation of the caregiver, this was not a significant aspect which was detailed by the caregivers in this study. They hypothesized that the low-income status of caregivers could be a probable reason why personal growth and self-discovery aren't priorities. While the Banyan Model proposed by the authors included 'finding new meaning' as an important phase, making ends meet and curing the illness were prime focuses of the caregivers. The caregivers were caught between aspiring to avail long-term facilities in order to reduce burden, which was financially impractical, and abandonment which was untenable. The caregivers sought middle ground by coping with the situation instead of distancing themselves from the relative. Noting the loss and worries of a caregiver is essential since their lives undergo significant changes due to being a caregiver for a family member. The authors noted that the Banyan Framework acknowledges that the experiences of caregivers undergo changes over time due to various factors such as the psychiatric status of the person being cared for, availability of facilities and the quality of treatments. The role played by gender was also worth noting, since most patients were women, and women aren't usually the primary breadwinners, a loss of income was significantly lesser for the participants in this study.

The involvement of AHPs

Allied healthcare professionals (AHPs)—including nurses, physiotherapists, psychologists, social workers, dietitians, and occupational therapists—play a critical yet under-recognized role in chronic disease management. In many global healthcare systems, these professionals act as essential links between physicians, patients, and caregivers, delivering continuous support, health education, rehabilitation, and psychosocial care. Their involvement is particularly important in the context of non-communicable diseases (NCDs), which require ongoing lifestyle interventions and adherence to long-term treatment regimens.

Murthy noted that psycho-oncology in India was in its nascent stage for a variety of reasons. They mentioned that psycho-oncology is restricted to consultations even in places where organised psychosocial care is practiced; often there is an absence of integration of the psychosocial care of all patients. In India, there is also a variation in the perception of one's personal life, differences in family settings, variations in the how social groups function and the pressign challenge of finances of medical care (171). The author proposed that there needs to be interventions at three levels: (i) collating personal experiences of patients and their families, along with their psychosocial needs, (ii) provide the patients and their families with self-care measures during the phases of the illness and (iii) to make psychosocial care an integral part of care for cancer patients and their families. This underscores the importance of psychosocial care for patients and their caregivers and highlights the necessity to integrate psychosocial care within the treatment protocol.

Mehra has studied the significance of upgrading skills and knowledge to address the increased burden of diabetes in India. While there are education programs and capacity building initiatives to educate primary care providers, there is a compromise in terms of the quality of these programs (842). It becomes important to develop and design customised programs tailor made to the needs of the community and the physicians' clinical settings, with the objective of bridging the gap of trained healthcare providers. This can be extrapolated to different low- and middle-income countries which are increasingly being challenged by the burden of noncommunicable diseases.

There are clear deficits in supportive care provision. Despite policy efforts to integrate palliative

and psychosocial care, implementation remains fragmented, particularly in rural and lower-income urban settings. These deficits highlight the urgent need for systemic interventions that move beyond physician-centric models. Allied healthcare professionals—such as psycho-oncologists, social workers, palliative care nurses, physiotherapists, and nutritionists—can play a vital role in bridging these gaps. Their involvement supports a more holistic, interdisciplinary model of care that recognizes the multidimensional nature of cancer and caregiving.

In India, however, the integration of AHPs into mainstream care remains limited. The healthcare system continues to be heavily physician-centric, with a disproportionate emphasis on curative services over preventive or rehabilitative care (Patel 2425). Despite policy frameworks like the National Health Policy 2017, which advocate for task-shifting and the involvement of a broader care team, implementation on the ground remains inconsistent (Ministry of Statistics and Programme Implementation, GoI 2017).

Evidence shows that including AHPs in patient care teams improves clinical outcomes, enhances patient satisfaction, and reduces caregiver burden (Shrivastava 4). For example, psychologists and counselors help manage depression, anxiety, and caregiver stress, which are prevalent among chronic disease populations (Vadakkiniath 7).

Moreover, social workers and community health workers (e.g., ASHAs) often act as cultural mediators, bridging the gap between biomedical care and local beliefs or practices. This role is especially critical in rural and semi-urban India, where access and trust are major barriers to sustained care (Saprii et al. 8).

To harness the potential of AHPs, systemic changes are needed—starting with policy-level recognition, standardized training programs, and clear protocols for interdisciplinary collaboration. Expanding the role of AHPs not only addresses current healthcare workforce shortages but also promotes a more holistic, patient- and caregiver-centred model of care.

The social dynamics within the caregiving triad are pivotal. Effective communication and mutual understanding between patients, caregivers, and healthcare providers can enhance the quality of care and support. Studies emphasize the importance of emotional bonding and the establishment

of a supportive relationship to address the multifaceted needs of cancer patients (Aghaei et al. 86).

Telemedicine: The way forward?

When exploring the triadic relationship among the healthcare provider, patient and caregiver, it is essential to mention the aspect of telemedicine. Telemedicine is utilized to promote various components of healthcare such as health education, to acquire laboratory results especially within the context of rural India (Ghia). Telemedicine by itself can be quite advantageous, providing cost effective and delivering results with relatively lesser errors, however among healthcare providers and healthcare staff a lack of technical expertise and apprehensions regarding the legal ramifications serve as potential barriers to its untapped potential. Among rural women in India, beliefs on telemedicine influence its application in the future. (Bhardwaj & Paul) The control exerted by immediate family members and challenges with digital literacy also influenced the usage of telemedicine. It was also found that views or advice from friends played a role in influencing the utilization of telemedicine. Social-cultural surroundings and one's peers and family members, who often serve as primary caregivers, play a significant role in shaping one's views on and adoption of telemedicine as a substitute for conventional healthcare. there was a positive change in perception around primary health care services and their utilization after the implementation of an integrated health information system. (Faujdar et al.) The authors noted a significant improvement on following advice on quitting tobacco, managing salt consumption and intake of processed food. As compared to primary healthcare delivery, an integrated health information system was found to be more effective in improving health seeking. In the Indian telemedicine context, budget allocation and an absence of infrastructure have a significant impact on the implementation of telemedicine. Further it also impacts patient awareness around telemedicine thus being a challenge in the course of the implementation. (Patnaik & Patnaik, 635) While telemedicine has its strengths, its limitations can't be overlooked. The lack of access to telemedicine platforms and the discomfort with internet-based technologies are some challenges posed by it (Daggubati 859). It is imperative to observe and study the impact of improved connectivity and smartphone ownership on patient outcome and patient provider

satisfaction. The hesitation around privacy, patient and physician association and successful physical examinations persist as pressing challenges.

Recommendations and conclusions

Healthcare providers in India operate not just as clinical experts, but as actors within a culturally layered ecosystem of care—mediating values, managing expectations, and sometimes reinforcing or challenging the norms that shape how chronic illness is understood and handled. Meanwhile, patients and caregivers navigate these complexities on both personal and systemic levels to access healthcare.

Through a socio-cultural lens, this paper examines the evolving dynamics of patient-caregiver-provider interactions in the Indian healthcare context. It explores how traditional kinship obligations, gender roles, language and cultural barriers and geographical difficulties intersect with modern healthcare practices, highlighting the complexities and negotiations caregivers face as they reconcile cultural expectations with institutional realities. By critically analyzing these dynamics, the paper aims to contribute to a more culturally responsive understanding of caregiving and healthcare delivery in contemporary India.

This article further explores and examines models and strategies such as co-management, the involvement of allied healthcare professionals and the use of telemedicine or digital medicine initiatives can help bridge some of the gaps in triadic communication and the resulting issues with supportive care. Alongside improving these modalities and enhancing their efficacy, a few other recommendations can be made.

For effective triadic communication in healthcare, caregiver involvement is crucial and a gap in communication between physicians and caregivers is further widened. Caregivers often manage medication, emotional support, and daily tasks for patients, yet their own needs—burnout, mental health support, respite care—go unrecognized if they are not included in communication loops. Without a structured framework for addressing caregiver wellbeing, healthcare systems risk compromising the entire care ecosystem. (Keelin 352) These can further be enhanced by

developing communication skills training for healthcare providers which endorse caregiver role assignment (formally assigning caregiver/s to be a points of contact and manage specific supportive care needs for the patient) in order to further streamline communication, reduce chances of caregiver burnout and improve supportive care provision for patients. (Keller 763)

Alongside models of intervention and the involvement of allied healthcare professionals such as psychologists and social workers, there is also need for culture-sensitization and communications-skills trainings that focus on provider-led empowerment of the patients and caregivers and the provision of resources, from language-specific aids, medical interpreters and educators to training on communicating during through challenging scenarios such as relapse, non-adherence and bereavement.

Lastly, patient and caregiver empowerment through information and supportive care needs is necessary through tools such as ‘question prompt lists’; which enable patients and caregivers to ask for and receive necessary information, guidelines for navigating hospital procedures and accessing financial aid and awareness campaigns to increase overall health literacy can be beneficial. (Chawak) The future strides of the Indian healthcare system must be towards systemic changes for holistic care provision rather than simply focusing on medical intervention through strategically improving triadic communication encouraging shared decision making and addressing supportive care needs as a standard of care within the system.

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The Evolution of the Transgender Welfare Board in Tamil Nadu - a Historical Study

M. Pramod

Abstract: This paper explains the history and development of the Tamil Nadu Transgender Welfare Board, which was started in 2008 by Dr. M. Karunanidhi. It was the first board in India created for the welfare and rights of transgender people. The paper shows how the board helped the community gain legal identity, education, jobs, housing, and healthcare. It also highlights many government orders and schemes such as pension, self-employment support, and free travel that improved their lives. Success stories like K. Prithika Yashini, the first transgender Sub-Inspector, and others show the progress made through these efforts. The paper concludes that the Tamil Nadu government's continuous support, beginning with Dr. Karunanidhi's vision, has changed public attitudes and given transgender persons dignity, respect, and equal opportunities in society.

Keywords: Transgender Welfare Board, Tamil Nadu, Dr. M. Karunanidhi, Social Empowerment, Legal Recognition, Inclusive Governance

Introduction

A transgender person is a person whose gender identity does not correspond with the sex they are born with at birth. They may identify themselves as male, female, or belong to another gender category beyond the traditional identity during the time of birth. Across societies, transgender individuals have experienced discrimination, exclusion, and lack of access to basic rights and opportunities. Social stigma has often limited their education, employment, and healthcare, leaving them among the most marginalised groups in the world.[i] According to Cambridge dictionary, the word 'transgender' is used to describe someone whose gender does

not match the body they were born with.[ii] In India, a major development took place with the 2011 Census, which officially recognised the "third gender" category for the first time. According to census data, about 4.9 lakh (490,000) persons identified under this category, although the actual number is estimated to be higher due to underreporting.[iii] This recognition marked a progressive step toward inclusion and acknowledgement of gender diversity in the country.

At the global level, several initiatives have been launched to promote the rights and dignity of transgender people. The United Nations and its agencies, including UNDP (United Nations Development Programme) and UNICEF (United Nations Children's Emergency Fund), have advocated for equality and protection of gender-diverse communities through policy programmes and awareness campaigns. The UNAIDS "Unbox Me" campaign (2022), for instance, aimed to create understanding about the struggles of transgender children and promote acceptance and inclusivity.[iv] Many countries have also enacted legal reforms that recognise self-identified gender and safeguard the civil rights of transgender persons.

In India, Tamil Nadu emerged as a pioneer in advancing its scheme for the welfare of transgenders. In 2008, the Government of Tamil Nadu established the Transgender Welfare Board, the first of its kind in the country.[v] The board was created to address the social, economic, and legal challenges faced by transgender individuals and to ensure their access to education, housing, healthcare, and employment opportunities. This initiative was a symbol for a significant commitment to social justice and human rights for the transgender community.

The present study aims to trace the historical evolution of the Transgender Welfare Board in Tamil Nadu and to analyse its significance on the empowerment and inclusion of transgender persons in society. It highlights Tamil Nadu's progressive approach to promoting equality and dignity for all citizens.

Objectives of the Study

The main objectives of the study are to

- study the history of the Transgender Welfare Board in Tamil Nadu.
- understand the aims and functions of the Board.

- find out how the Board has helped the transgender community.
- identify the importance of the Board in the empowerment of the community.

Meaning and Identity of Transgender People

The term transgender refers to individuals whose gender identity or expression differs from the sex they are born at birth. Transgender persons may identify as male, female, both, neither, or outside their traditional gender identity.[vi] Their understanding of self may not align with societal expectations, leading to a unique sense of identity that is distinct from cisgender norms. Gender identity is a deeply personal and psychological experience. Many transgender individuals undergo social, medical, or legal steps to express their gender authentically. Globally, the recognition of transgender identity has evolved over time, with increasing legal and social acknowledgement in many countries, including India.[vii]

Early References about Trangender community

The history of the transgender community in Tamil Nadu can be understood by looking at different time periods, beginning from the early Sangam Age. During the Sangam Age, which was around 300 BCE to 300 CE, Tamil society already knew that some people did not fit fully into the idea of "man" or "woman." Important Sangam books such as *Purananuru* and *Agananuru* use words like "Pedi" and "Ali" to describe such persons. These simple words in the poems show that people with different gender identities lived openly in Tamil society more than two thousand years ago. These early literary references prove that the community was not new, but had long been part of Tamil life.[viii]

In the period after the Sangam Age, from 300 CE to 800 CE, Tamil scholars continued to write about gender in a clear and organised way. The commentaries of the classical grammar text *Tolkappiyam* explain three kinds of gender: Aan (male), Pen (female), and Ali (third gender). This shows that Tamil thinkers understood that gender was not only two types. These writings show that the idea of a third gender was well known and accepted in Tamil thought.[ix]

In the early medieval period, from about 800 CE to 1300 CE, many records from the Chola and Pandya kingdoms show that transgender persons continued to live and work in society. Temple

records and old Tamil writings mention performers and helpers who did not follow common gender roles. In the Chola period, the Rajarajesvara Temple inscription (No. 66, north enclosure) lists several women by names connected to famous shrine sites, including one called Ali (Tiruvali), indicating the use of such community names in temple records.[x]

In the later medieval and pre-colonial period, from 1300 CE to 1800 CE, Tamil society saw changes in rule and culture, but the transgender community still remained visible. Old notes from the Nayak and Maratha periods mention people who took part in folk arts and local events. Even though the writings from this time are fewer, they still show that people with different gender identities lived in villages and towns and were part of daily life. During the British period, from 1800 CE to 1947 CE, the situation became more difficult for the community. The British Government brought strict laws such as the Criminal Tribes Act of 1871, which wrongly listed many groups, including transgender persons, as "criminals." British reports also used the word "eunuchs" in a negative way.[xi] These laws pushed the community away from their earlier social roles and caused great hardship.

After India became independent in 1947, change started slowly. In Tamil Nadu, transgender persons began to receive more attention from social groups and the government. From the 1990s onward, activists and officials worked to support the Thirunangai community. Understanding transgender identity is essential for formulating inclusive policies and welfare programmes. Recognition of gender plurality at both societal and governmental levels is the first step toward reducing discrimination and ensuring equality for transgender persons.

In Tamil Nadu, transgender people are known as Thirunangai (திருநங்கை) referring to transgender women and Thirunambi (திருநம்பி) referring to transgender men.[xii] In 2008, a 25-year-old transgender woman named Pooja from Salem, Tamil Nadu, faced many difficulties because she did not have any proof of her identity in government documents. She was not willing to identify herself as either male or female since all official forms only had two options: 'M' for male and 'F' for female. This made it hard for her to get basic facilities and recognition. Understanding this problem, the Tamil Nadu Government took an important step by officially recognising transgender

persons as individuals. Pooja was given a civic ration card that had the letter 'T' in the gender column instead of 'M' or 'F', marking her as transgender. The Tamil Nadu Consumer Goods Corporation also recognised the 'T' category in their records. This was the first time in India that the government officially recognised a third gender in its documents. This step became a model for the whole country and helped transgender persons get admission in schools, colleges, hospitals, and other institutions by using 'T' in the gender column. It was a major move towards giving identity and respect to the transgender community in Tamil Nadu.[xiii]

Understanding transgender identity is essential for formulating inclusive policies and welfare programmes. Recognition of gender plurality at both societal and governmental levels is the first step toward reducing discrimination and ensuring equality for transgender persons.

Social Status and Problems of the Transgender Community

Transgender persons have historically faced marginalisation and social exclusion in many societies. In India, they were often denied access to education, employment, healthcare, and housing, which limited their social and economic development. Many transgender individuals experience stigma, harassment, and discrimination in both public and private spaces, which affects their mental and physical well-being.[xiv] The lack of official recognition and legal protection further increased their chances for their discrimination. According to the 2011 Census, while 4.9 lakh people identified as transgender in India, many more remain uncounted due to fear of social stigma. Social beliefs also influenced family acceptance, community participation, and access to public services, making it difficult for transgender persons to live with dignity.[xv]

Addressing these social challenges requires awareness, legal protection, and targeted welfare measures. Understanding the social status and problems of transgender persons is important for planning effective policies.

Formation of the Transgender Welfare Board in Tamil Nadu (15 April 2008)

The Tamil Nadu Aravanigal Welfare Board was established on 15 April 2008 which functions under the Department of Social Welfare, becoming the first government initiative of its kind in India. The main objective for the creation of this board was to ensure safety and welfare to

the transgender people in the state. The Board was created to address the social, economic, and legal challenges faced by transgender persons and to provide them with access to education, healthcare, employment, and housing. The Transgender Welfare Board in Tamil Nadu was started by the then chief minister, Dr. M. Karunanidhi. The Board worked to support the needs of the transgender community.[xvi] The government also arranged for gender reconstruction surgeries to be done safely in government hospitals. This helped prevent infections that could happen when the surgeries were done as rituals. The Board also made it possible for transgender people to get family ration cards, identity cards, and voter ID cards, helping them become part of society more fully.[xvii]

In a case filed for the welfare of the Aravanis, the Supreme Court gave a judgment on 15 April 2014. In this judgment, the Court declared the Aravanis community as the "third gender." The order stated that, apart from men and women, transgender people should be officially recognised as the third gender. The Court also explained that the term "transgender" usually refers to people who have changed from male to female. However, the third gender includes people with many different gender identities. Since the word "transgender" does not cover all of them, the Supreme Court decided that the term "third gender" is more suitable. Following this judgment, in 2017, the Government of Tamil Nadu ordered that the name of the "Aravani Welfare Board" be changed to the "Tamil Nadu Third Gender Welfare Board."[xviii]

Functions of the Board

- To implement the schemes decided by the Tamil Nadu Aravanis Welfare Board in all the districts of the state through the District Social Welfare officers.[xix]
- To issue transgender identity cards**,** ration cards, and other documents.
- To provide training for self-employment and create self-help groups**.**
- To support transgender hostels and housing needs.
- To raise awareness about transgender rights and social equality.
- To promote social inclusion and participation in public life.[xx]

By institutionalizing transgender welfare, Tamil Nadu became a precedent for other states in India. The Board represents a significant step towards recognising the rights of transgender persons and ensuring their empowerment through structured state support.

Organization of the Board

The Tamil Nadu Transgender Welfare Board functions under the Chairmanship of the Minister for Social Welfare. It has both official and non-official members, including representatives from the transgender community. The State level committee includes Commissioner of Social Welfare as the Chair person and Director of Institute of Obstetrics and Gynaecology or a representative nominated by him/her, Director of Institute of Mental Health or a representative nominated by him/her and Transgender representative nominated by Chairperson as members of the committee.[xxi] At the district level, District Collectors act as heads of the committees to identify and support beneficiaries. The Board ensures that every district has local transgender representatives so that help can reach everyone.[xxii] The Tamil Nadu Transgender Welfare Board is headed by the Hon'ble Minister for Social Welfare and Nutritious Meal Programme as Chairperson. The Board includes 11 official members and 12 transgender persons as non-official members, ensuring equal participation of government representatives and community members in decision-making.

Welfare Schemes (2008–2011)

In its early years, the Board introduced many useful schemes to improve the lives of transgender people. Training was given in Fine Arts free of cost to make transgender persons financially independent.[xxiii].The Board also helped with money to start small businesses. Many people received sewing machines and training to make fashion jewellery with a subsidy of Rs. 1,68,360 to improve the livelihood of the Aravanis and to enhance their dignity. The amount was to be provided to the 'Sister Foundation' for setting up production centers for making modern beauty ornaments using Aravanis.[xxiv]

Transgender Self Help Groups

In the fifth conference of the Tamil Nadu Transgender Welfare Board held on 15.10.2009, it was decided to form transgender self-help groups. Each group would have 7 to 8 members. The main aim was to improve their livelihood by helping them earn a better income.[xxv] The government introduced a 25% subsidy for Transgender Self-Help Groups (SHGs) that are ready to start income-generating activities. Business project proposals from these SHGs were received through the Tamil Nadu Transgender Welfare Board. Support was also given for training, formation costs, and funds to create new groups under the Mahalir Thittam scheme of the Rural Development Department. In each district, a District Level Committee was formed with the District Collector as Chairperson to evaluate these project proposals. The scheme was implemented to provide training, marketing tie-ups, and field-level monitoring for transgender SHGs through registered Non-Governmental Organisations (NGOs).[xxvi] For example, Rs. 20,000 was given to Ms. V. Kausalya (Aravani) to start an idly shop in 2010[xxvii].

By 2009–2010, the Board had issued 2,411 identity cards, 1,211 ration cards, 335 free land pattas, distributed 111 free sewing machines, provided self-employment grant of Rs. 20,000 to 320 persons, done free sex-reassignment surgery (SRS) to 49 transgenders, provided education grants to 2 persons[xxviii] and issued medical insurance card under Kalaignar Kaapittu thittam to 585 transgender people.[xxix]

Transgender Day (April 15)

In 2011, the Government of Tamil Nadu declared 15th April to be celebrated every year as Transgender Day in recognition of the struggles and achievements of the transgender community. This day serves to promote awareness, equality, and respect for transgender persons across the state.[xxx] The Government of Tamil Nadu instituted an award to honour third-gender individuals who have risen in life through their own determination and hard work, without any external support, and who serve as an inspiration to others in the community. This award is presented every year on 15th April, observed as Third Gender Day, by the Hon'ble Chief Minister of Tamil Nadu.[xxxi] In 2024, the award was presented to Ms. Sandiya from Kanyakumari District in recognition of her remarkable achievements and service to society.[xxxii]

Welfare Schemes Since 2012

Community Certificate

Third gender candidates who do not have a community certificate are to be considered under the Most Backward Class (MBC) category. However, those belonging to the Scheduled Caste (SC) or Scheduled Tribe (ST) communities will continue to be treated as per their respective community classifications.

Reservation in Employment

Third gender candidates who hold identity cards and identify themselves as 'female' can be considered under both the 30% reservation for women and the 70% general category (for men and women). Those who identify themselves as *'male'* will be considered under the 70% general category (for men and women).[xxxiii]

Pension Scheme

In 2011 the Government of Tamil Nadu decided to provide a monthly pension of Rs. 1,000 to all destitute transgender persons who are economically weak and above 40 years of age. This welfare measure aims to ensure financial security and social support for elderly transgender individuals who have limited sources of income and livelihood opportunities.[xxxiv]

Introduction of Mobile App

In 2024, the Government of Tamil Nadu launched a mobile application named **"Thirunangaikal"** to help transgender persons improve their livelihood and easily access various government welfare schemes. This app marked an important step toward digital empowerment, making it easier for the transgender community to stay informed about welfare measures and avail themselves of benefits without difficulty.[xxxv]

From 2025 onwards, all transgender persons in Tamil Nadu can travel free of cost in public transportation by showing their identity cards. This scheme is significant because it helps

transgender people move freely, reduces their financial burden, and promotes social inclusion and equality in everyday life.[xxxvi]

These steps show the continuous efforts made by the government to ensure equality, respect, and livelihood opportunities for the transgender community.

Success Stories and Empowerment

The seeds planted by Dr. Karunanidhi have grown into many success stories. In 2020, transgender persons in Chengalpattu opened a grocery shop called "Thiru Stores" with the help of volunteers. This became a model for group efforts and financial independence.

K. Prithika Yashini made history in 2017 by becoming India's first transgender Sub-Inspector of Police through the Tamil Nadu Police Department. Her achievement showed that with opportunity, transgender persons can succeed in any profession.

Many transgender persons today have become successful in media, arts, and business. Padmini, a transgender woman, now works as a news reader, inspiring many others. The Angel Transgender Self-Help Group started a garden project, promoting teamwork and green livelihoods.

In 2025, the Best Transgender Award was given by the Hon'ble Chief Minister to A. Revathi (Namakkal) and K. Ponni (Thoothukudi) for their great work in helping their community. These stories show how the Board's schemes and support have led to real empowerment and respect in society.[xxxvii]

Conclusion

The establishment of the Tamil Nadu Transgender Welfare Board by Dr. M. Karunanidhi stands as a landmark achievement in his steps towards equality and social justice. His visionary step in 2008 laid the foundation for recognizing the transgender community as an integral part of society, deserving of dignity, opportunities, and state support. The Board became a hope for

thousands of transgender persons, giving them access to education, healthcare, employment, and housing rights that had long been denied to them.

Through consistent efforts, the Board helped transgender individuals gain a legal identity by issuing identity cards, ration cards, and voter IDs, ensuring that they were not invisible in the state. Over the years, Tamil Nadu became a pioneer in inclusive governance, recruiting transgender persons as police officers, healthcare workers, and staff in various departments as a milestone that redefined the boundaries of opportunity. The institution of the Best Transgender Award and the celebration of Third Gender Day each year have further strengthened their social standing and self-worth.

Dr. Karunanidhi's initiative was not merely an act of welfare but a transformative vision that acknowledged the transgender community's right to equality and empowerment. His leadership became the basis for social reform that continues to advance even today. The Tamil Nadu Transgender Welfare Board remains a best example of how empathy, inclusion, and political will can change lives, inspire other states, and build a society where every individual regardless of gender identity is respected, valued, and given the chance to live.

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Human Trafficking in India: Policy Gaps and Grassroots Solutions for Change

Prerna Pawar

Abstract: *According to social media, reports and news channels, widespread human trafficking is one of the major issues in today's time. The target group are mainly young girls and women who disappear more than men. One of the reasons for the increase in human trafficking in India is poverty. In addition to trafficking or smuggling for prostitution, ladies and girls also are sold and offered into forced marriages, in girls' deficit areas. Many social activists and NGOs are actively involved in numerous activities in addition to government implementation, in particular for the training and higher education of people at the community level and for the protection of the endangered class of society. The recent legislative amendment to the Indian Penal Code (IPC) to define the term 'human trafficking' also shows a lack of seriousness on the part of the government. It is argued that the recent amendment is not sufficient to combat trafficking and a comprehensive legal reform is required to synergize different legislations and institutional support mechanisms. The paper begins with the definition of human trafficking navigating through the causes of trafficking, legal system, case studies and preventive measures emphasizing particularly on Immoral Traffic Prevention Act (ITPA) and IPC 370.*

Keywords: Human trafficking, prostitution, NGOs, legal, ITPA, IPC 370

Introduction

One of the greatest forms of abuse and exploitation that people have ever experienced or witnessed in the twenty-first century is human trafficking. Trafficking is one of the world's most heinous crimes. The rise in global migration and labor mobility limitations has led to a notable rise in irregular migration, including human trafficking. The issue of human trafficking for the purpose of sexual exploitation is becoming more widespread worldwide. Since trafficking is the fastest-growing criminal organization in the world, it has been diagnosed as a massive organization. This section highlights the concepts of bonded work, baby labor, and sex trafficking that were employed in Indian and international jails at an undefined point in the report's future. Under section 370 of the Indian Penal Code, trafficking of persons for "physical exploitation or any form of sexual exploitation, slavery or practices just like slavery, servitude and the forced removal of organs" is prohibited.

What is Human Trafficking?

Human trafficking is a crime and a human right violation. It involves the recruitment, movement and exploitation of someone for earning. Men, girls and children are trafficked in India for numerous causes. Females are trafficked within the countries for the motives of professional sexual exploitation and forced marriage particularly within the areas where female sex ratio is significantly low. Men are traded for the purpose of work and can be sexually exploited by criminal means to serve gigolos, news experts, escorts. Children under the age of 14 who were forced to work in factories begged as domestic workers and were used as armed soldiers by some terrorist and rebel groups. United Nations' Palermo Protocol defines Human Trafficking as,

"*Trafficking in persons can be defined as the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another*

person, for the purpose of exploitation. Exploitation should include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs".[1]

On the given ground in the Trafficking in Persons Protocol, it is seen that trafficking in persons has three constituent elements: -

- The law (what is done): Recruitment, promotion, transfer, placement or reception of people
- The means (how to do it): threatening or using force, coercion, kidnapping, fraud, deception, abuse of power or vulnerability, or giving payments or benefits to anyone who has control over the victim.
- The purpose (why it is done): Exploitation, including the exploitation of the prostitution of others, sexual exploitation, forced labor, slavery or similar practices, and organ harvesting.

The processes by which human trafficking begins are initially the transport of victims from the main area. This human trafficking process has several stages and stakeholders. The first phase begins with the place of origin, commonly known as the header, where the victim is enlisted or fraudulent and then transported to the place of demand with the help of local human traffickers or professionals. The origin of human trafficking can vary depending on the scope and network of the traffickers. For example, the source may be a small town or village for domestic human trafficking, while it may be a country for international human trafficking. After the initial phase, the next phase is the "transition phase" in which the victim must stay for a limited period of time or for a few days, weeks or months. Transit can also become a starting point for your next transportation. The last phase is the "objective phase", in which the victim of human trafficking is finally handed over to the owner and then asked to provide services to the clients and thus become that victim of this modern-day slavery. The entire system of this transportation process has a series of actors involved in this heinous crime of human trafficking. It is the third largest crime in the world after drug and arms trafficking. This has made this industry one of the most organized crime industries in the world. Furthermore, the activities and participation of thousands of criminals

1 Protocol to prevent, Suppress and Punish Trafficking in Persons. (n.d.-o). https://www.ohchr.org/en/professionalinterest/pages/protocoltraffickinginpersons.aspx

working as organized crime professionals have fuelled various other social discourses and have also become fuel for other criminal activities. It includes human trafficking in relation to prostitution, in relation to migration, as a human rights problem, as a labor problem, as a criminal problem and child trafficking.

The Causes of Human Trafficking

Several factors are responsible for the trafficking of men, women and children in India. The reasons are many, but the main cause of human trafficking is poverty. However, despite 67 years of independence, the benefits of economic development have not filtered down to the marginalized sectors of society. Millions of people in India still live below the poverty line.[2]The problem of poverty and hunger makes children and women fall into the trap of human trafficking. The desire for a better life can easily seduce unhappy women and children who are trafficked without their knowledge. Other factors that many people want to venture into are the desire for better living conditions and the lack of job opportunities in their place of origin. These factors tend to pressure victims that "push" them to move and make them more vulnerable to control by traffickers.[3] In most cases, due to poverty, parents encourage children to move from their place of origin to a place where they can have a better life and more opportunities. This actually makes children easy prey for human traffickers. In a few cases, socio-cultural and religious factors have an impact on child trafficking where religious idols have made use of their position to traffic girls for prostitution. Frequently, trafficking is accomplished through the deception of girls and their families. One of the most important push factors which results in human trafficking is Globalization. According to the International Organization for Migration report, 90 percent of the victims of human trafficking as sex slaves experienced domestic violence before being trafficked. The declining sex ratio and increasing demand for women in women-hungry areas are also considered to contribute to the bridal trade in India. For some workers, it has meant leaving their abusive homes and living in the parts of the world they only dreamed of. The perpetrators took advantage of this and the operators

2 Poverty line is a level of personal or family income below which one is classified as poor according to governmental standards- Merriam Webster Dictionary

3 Push Factors: poor socio-economic conditions of a large number of families, poverty coupled with frequent, almost annual natural disasters like floods leading to virtual destitution of some people, etc

began to give guarantees of better compensation and a more comfortable life, increasing the demand for marriage proposals for girls in different regions. The other set of factors responsible are the pull factors.[4] Child marriage is one of the easiest pull factors for traffickers to send girls from one place to another. In a traditional village community, single women are stigmatized. The failure to arrange a daughter's marriage is a source of shame and embarrassment for parents. After marriage, the girls are sold and resold until it reaches its final destination. Other forms of human trafficking in addition to child marriage are fictitious marriage, false recruitment, kidnapping and kidnapping of children, transporting children with parental consent, adoption of children, exploitation of poor working-class families. and better living conditions in cities.

Legislative Framework on Human Trafficking

a) Constitution Of India

The Constitution of India under Article 23 (1) prohibits trafficking in human beings and forced labor. This right is enforceable against State and private citizens. The Constitution of India puts the responsibility on the State to protect its vulnerable groups, prevent and punish their exploitation and take steps to protect their exploitation and take steps to promote their welfare.

b) Section 366 IPC

In case of trafficking under the guise of marriage there is a misuse of the vulnerability of the victim and their circumstances which does not seem to be included in this section. Sec 366 starts with the word kidnapping and abduction, the section is sufficient where bride trafficking takes place through kidnapping and abduction but as many of these cases start with girls and with parent consent which lately land up to undesired consequences. So this section is severely lacking in this area. Secondly this section covers only the traffickers and not the husband. In practice, documented studies reveal that women are often lured with the prospect of

4 Pull factors: lucrative employment propositions in big cities, easy money, promise of better pay and a comfortable life by the trafficking touts and agents, demand of young girls for marriage in other regions, etc

job / employment in the cities. Therefore, the extant provision in the IPC falls short of the menace of selling women for purposes of marriage.

c) Section 370 IPC

Buying or disposing of any person as a slave. —Whoever imports, exports, removes, buys, sells or disposes of any person as a slave, or accepts, receives or detains against his will any person as a slave, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.[5]

The definition includes illegal acts and means adopted for the purpose of exploitation. The different form of exploitations are as follows: -

- Physical Exploitation
- Sexual Exploitation
- Slavery or Practice similar to slavery
- Practice similar to servitude
- Removal of Organ

d) The Suppression of Immoral Traffic in Women and Girls Act, 1956 (SITA)

This Act was enacted under Article 35 of the Constitution with the object of inhibiting and abolishing trafficking in women and girls. It was also in pursuance of the UN's Trafficking Convention, which India signed on 9 May 1950. The Act aimed to rescue exploited women and girls, to prevent the deterioration of public morals and stamp out the evil of prostitution that was rampant in various parts of the country.[6]

e) Immoral Traffic Prevention Act, 1956

5 Section 370 in the Indian Penal Code. (n.d.-p). https://indiankanoon.org/doc/1153041/

6 The suppression of immoral traffic in women and Girls Act ... (n.d.-s). https://www.wcwonline.org/pdf/lawcompilation/India_SUPPRESSION OF IMMORAL TRAFFIC IN WOMEN AND GIRLS AC.pdf

In 1986 SITA was drastically amended and renamed the Immoral Traffic (Prevention) Act, 1956. It is a special legislation that deals exclusively with trafficking. Offences under the Act are:

- Keeping a brothel or allowing a premises to be used as a brothel (S.3) living on the earnings of prostitution (S.4)
- Procuring, inducing or taking persons for the sale of prostitution (S.5) *detaining a person in a premises where prostitution is carried on (S.6)
- Seducing or soliciting for the purpose of prostitution (S.7)
- Seduction of a person in custody (S.9)
  It also introduced several initiatives including setting-up of Protective Homes to provide protection and services to victims and educational and vocational training to at-risk groups. The Act also provides for the appointment of special Police Officers assisted by women police to investigate trafficking offenses and for setting up of Special Courts.

f) Section 373 IPC

Buying minor for purposes of prostitution, etc.—Whoever buys, hires or otherwise obtains possession of any 1 (person under the age of eighteen years with intent that such person shall at any age be employed or used for the purpose of prostitution or illicit intercourse with any person or for any unlawful and immoral purpose, of knowing it to be likely that such person will at any age be) employed or used for any purpose, shall be pun-ished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.[7]

7 Any prostitute or any person keeping or manag-ing a brothel, who buys, hires or otherwise obtains possession of a female under the age of eighteen years shall, until the con-trary is proved, be presumed to have obtained possession of such female with the intent that she shall be used for the purpose of prostitution.

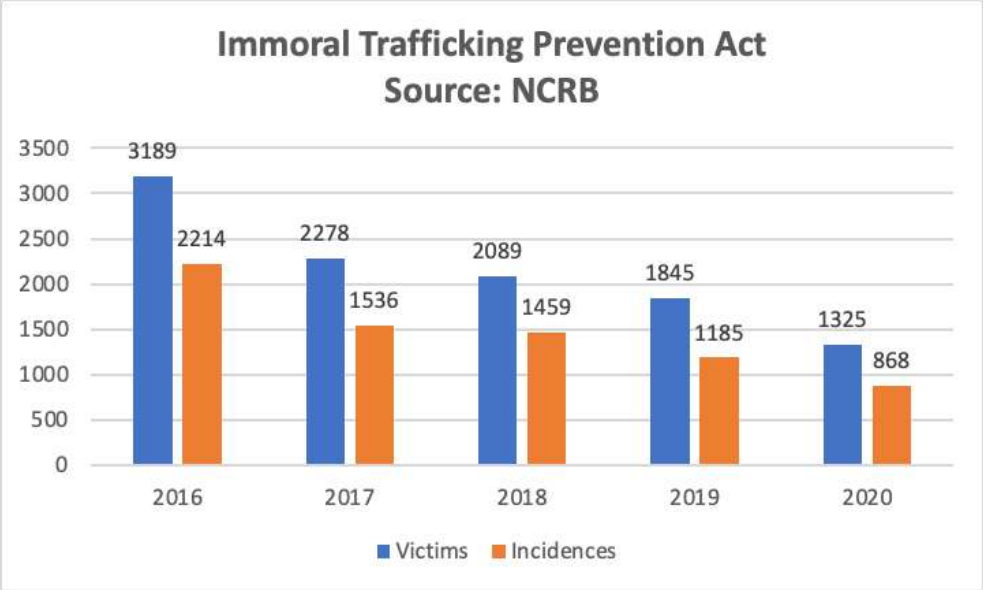
A comparative analysis between the 2 major acts is given below:

Act	ITPA	IPC 370
DEFINITION	The Immoral Traffic (Prevention) Act, 1956 [the ITPA] acts related to prostitution becomes an offence when there is commercial exploitation of a person.	Buying or disposing of any person as a slave. —Whoever imports, exports, removes, buys, sells or disposes of any person as a slave, or accepts, receives or detains against his will any person as a slave.
PUNISHMENT	Punishment for keeping or allowing premises to be used as a brothel is one to three years rigorous imprisonment and a fine of up to Rs 2,000. Subsequent convictions are punishable with two to five years imprisonment and a fine of up to Rs 2,000. Procuring or inducing a person for prostitution would be punishable on conviction with rigorous imprisonment for three to seven years and a fine of up to Rs 2,000. If the offence is committed against a person's will, the penalty would be imprisonment for 7-14 years. The offence of procuring or inducing a child for the sake of prostitution is punishable by rigorous imprisonment for seven years to life. In case of a minor, it would be rigorous imprisonment for 7 to14 years.	Punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

BAIL OR NON-BAILABLE	Bailable	Non- bailable
PURPOSE	Prostitution in brothels specifically.	Sexual exploitation

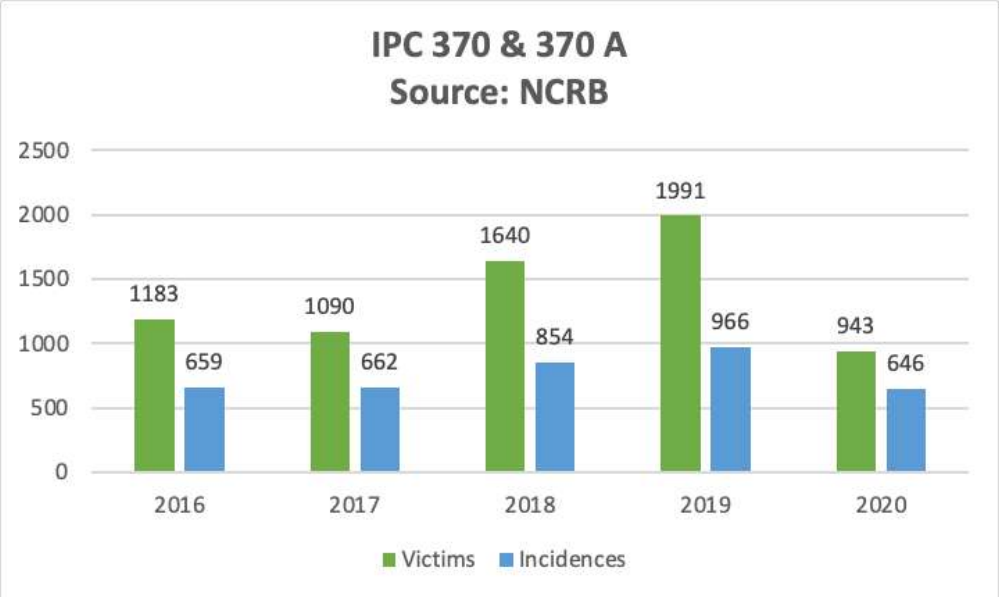
Data Analysis from 2016-2020

Incidents reported vs Persons rescued (Victims) under ITPA



The above graph demonstrates the number of cases reported and number of persons rescued from sexual exploitation. Interestingly, the number of victims rescued are more than the number of cases reported. The above figure also indicates the continuous decline in the cases and the rescued persons. This constant decline in the number of cases under the ITPA is most likely due to a new legislation on the anvil. An impetus to anti-trafficking interventions is visible in the aftermath of India signing the Palermo Protocol, including proposals to amend the ITPA in 2006, establishment of anti-trafficking units in most states, a special chapter on trafficking in the NCRB reports from 2007, and tabling of the Trafficking of Persons (Prevention, Protection and Rehabilitation) Bill, 2018 (that lapsed in 2019).[8]

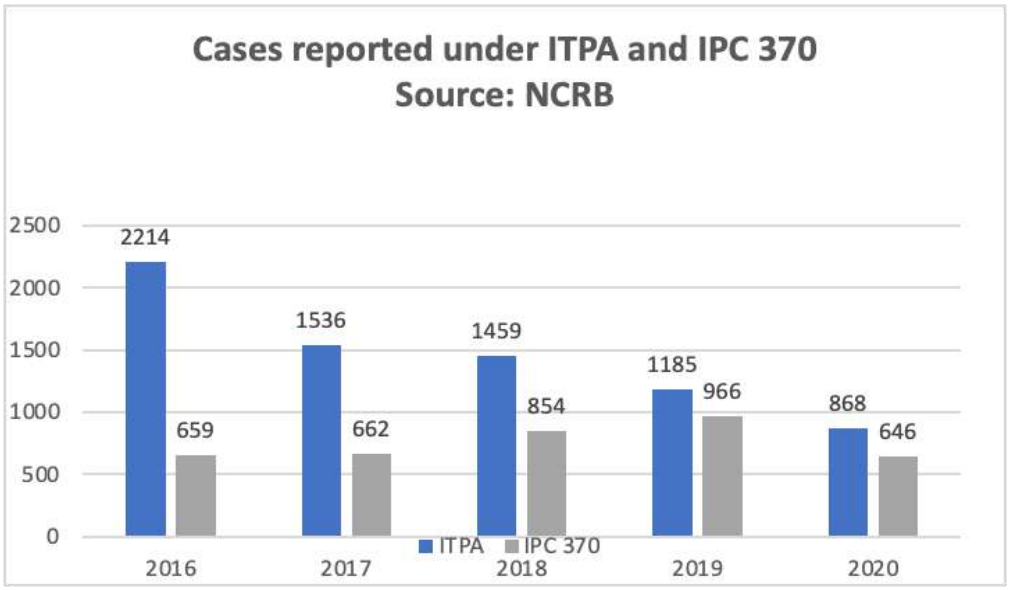
Incidents reported vs persons rescued (Victims) under IPC 37



8 The data for the graphical representation has been taken from the NCRB statistical report from 2016-2020.

The perusal of the above figure reveals that there is constant increase in the cases reported under IPC 370 from 2016 to 2019 and the number of persons rescued are also going up. However, in the year 2020, there is a sudden decline in the number of cases reported and a significant decline in the number of victims rescued as compared to 2019 presumably due to COVID -19 pandemic and national lockdown.

Cases reported under ITPA vs IPC 370



The above figure shows that the number of cases reported under ITPA are much more in the year 2016 but gradually the cases are decreasing under ITPA. Interestingly, the cases reported under IPC 370 are steadily increasing indicating acceptance and awareness about article 370. Though, IPC 370 is much broader which accommodate exhaustive measures to counter the hazard of human trafficking including trafficking of kids for misuse in any frame including physical abuse or any type of sexual abuse, bondage, subjugation, or the constrained expulsion of organs while ITPA is to inhibit or to abolish commercialized vice, namely the traffic in women and girls for the purpose of prostitution, as an organised means of living.

Loopholes in the legal system

India signed the Palermo Protocol in 2002 and ratified it in 2011, but a comprehensive anti-trafficking law has not yet been enacted.[9] The current law specifically dealing with human trafficking is the Immoral Traffic (Prevention) Act of 1986 (ITPA 1986), which covers only one aspect: prostitution or commercial sexual exploitation. However, despite the large number of laws, the problem remains unresolved. One of the reasons for the difficulty is the fact that the law is under different control of the ministry and the state or central government. This leads to a lack of clarity about the capabilities of the territory. However, the law itself is irregular about victims' rights, weak disciplinary action against perpetrators, and inadequate enforcement mechanisms. Therefore, the conviction rate is low.

India ratified the Palermo Protocol in 2011, but it was stated in national law in 2013, through the formation of the Criminal Law (Amendment) Act, which resulted in changes in several sections of the IPC, especially 370 and 370A. The amended sections have brought a quite comprehensive definition of trafficking into the Indian legislation, but despite these changes the framework for trafficking falls short of meeting the Protocol requirements on at least three counts.

- First, it excludes forced labor from its definition, so it does not recognize and punish all forms of trafficking. Given that workers are responsible for most of India's trafficking problems, this is a huge loophole.
- Second, there are not enough safeguards to prevent trafficking. The existing is for commercial sexual exploitation, not trafficking for any other purpose.
- Third, it does not provide an effective system for the safety, recovery and compensation of trafficking victims.

ITPA has not changed without reference to IPC changes. As a result, the two major legal documents on trafficking are still somewhat different. The scope of ITPA is limited to commercial

9 Even though the Constitution specifies prohibition of trafficking in Article 23, which states: “Traffic in human beings and ‘beggars’ and other similar forms of forced labor are prohibited and any contravention of this prohibition shall be an offense punishable in accordance with law”.

sexual exploitation or prostitution and penalizes those who promote and encourage commercial sexual exploitation, including those who live on the income of clients and prostitutes.In fact, even commercial sexual exploitation is not clearly defined by law.

- The fundamental flaw in ITPA is that there is no particular definition of trafficking, even though the title of the law specifically mentions the word trafficking. In fact, even commercial sexual exploitation is not clearly defined by law.[10]
- Sexual exploitation in private premises, other than a brothel, is not covered by the Act. In fact, with the emergence of newer technologies and the changing global scenario, commercial sexual activity has emerged in diverse forms and can take place in residences, hotels, clubs, or involve mobile locations.
- Treating the victim as a perpetrator, as reflected in the placement in the House of Reform, is a contradiction in terms, as the victim cannot be the perpetrator at the same time. This contradiction reflects the confusing attitude towards prostitution inherent in the law. Although prostitution itself is not banned in India (only when using public spaces), all women involved in prostitution are routinely treated as criminals under the ITPA.
- The existing practice of hiring girls for prostitution under the guise of religion, as in the case of Devadasi, is outside the law. Explicit references to socio-religious practices that are not punished by law will put a good end to this form of sexual exploitation.
- Lack of a witness protection programme or the option of in-camera proceedings prevents many victims, especially children from testifying.

Section 370 before the Indian Criminal Code of 1860 was replaced by the 2013 Criminal Code (Amendment). This change introduces certain new terms to increase the level of criminalization. This change was the result of a report submitted by the Justice Verma Committee, which focused primarily on the sexual exploitation of trafficking victims.[11] The insertion of Section 370A of the Indian Criminal Code of 1860 is a restricted provision to prevent the exploitation of trafficking in other sectors of forced labor. Existing legislation is primarily aimed at commercial sexual

10 Prostitution" means the sexual exploitation or abuse of persons for commercial purposes.."

11 On December 23, 2012 a three member Committee headed by Justice J.S. Verma, former Chief Justice of the Supreme Court, was constituted to recommend amendments to the Criminal Law so as to provide for quicker trial and enhanced punishment for criminals accused of committing sexual assault against women.

exploitation and does not cover trafficking for other purposes. In addition, the legal framework is inadequate to provide an effective system for the safety, recovery and compensation of trafficking victims.

Case Studies

1. Case Study 1

In a case it was seen that the wrong accused was charge-sheeted and even though the victim supported the prosecution case on points of proving prostitution and her trafficking, she failed to receive any monetary compensation. This woman had deposed that she was forced into prostitution at the said brothel. The Bangladeshi woman also categorically stated how she was trafficked from Bangladesh and exploited in a brothel in Mumbai. Two women were arrested during this rescue and later charge-sheeted. The trial was also conducted against them. The rescued woman made allegations against another woman. And the charge-sheeted women were two other women and not the manager, nor were the trafficker traced. In fact, the police arrested another woman who was prostituted in the same premises and not the woman who bought her from the trafficker and lived on her earnings. In the end, the place was sealed under section 18 but because of acquittal the woman received no compensation. The police have somewhere failed to understand and internalize the purpose behind passing of the law, i.e., ITPA Act. The acts of the police clearly point to a moralistic implementation of the law with an intention to clean the area of the vice of prostitution with little consideration to rehabilitation of the women being rescued and sometimes falsely accused.

2. Case Study 2

My name is Heena (name changed). I belong to a traditional Muslim family and was born in Muzaffarnagar, Uttar Pradesh. I am 29 years old. I was one of those ill-fated girl children, who were unwanted, while the family was desperate for a boy. I never attended school and never had any friends. When I was 13 years old my family married me to a man who brutally raped me. I started living life as a duty which every girl is forced to perform. After one year of marriage, my

husband died. My in-laws held me responsible for his death, calling me, ―inauspicious for the family. I was pregnant and decided to go back to my parent ‘s home, but my parents just considered me another burden. I questioned my own existence but had another life inside me and I had to take care of it. I gave birth to a boy whom I named Asif, and it was the first time I was happy. Unfortunately, Asif developed a skin infection and when I asked my mother to take him to the doctor, she refused. I decided to leave my family. I went to the nearest railway station, not sure where I would go. A lady named Reena saw me crying and asked me what was wrong. I told her everything. Reena invited me to come and live with her and promised that she would get me a job. After a month, Reena tricked me and sold me into sex slavery. When I refused to do the work, I was locked in a room for 2 days without food or water. My son was then taken from me. I was told that if I ever wanted to see him again, I had to do this work. I cried in protest and was ruthlessly beaten. Eventually, I had no choice, but to give into my destiny. I began drinking, smoking and cutting my veins because I did not wish to be in my senses. While at the beginning I was forced to work from a hotel, eventually I was shifted to G.B. Road to a brothel where I was ―left open to the world of sex trade. I gave up all hopes of getting out of this hell because even the policemen were frequent visitors. One day, during a rescue operation led by STOP India, along with the police, I was taken out of the brothels. I did not give a statement for a long time, because Reena, the woman who trafficked me, sent me a message that she would kill my son if I revealed her name. Eventually, with the encouragement of Roma, the mother of STOP India, I gave my statement. Roma also helped me locate my son, who had been bought by an older couple who did not have children. They refused to give me my son back and said they had taken very good care of him. I know that they have nurtured him and at the end of the day, all I want is a good future for my child, wherever he stays. I stayed at the STOP family home for a long time during which I gained valuable vocational training in a variety of fields such as painting, handicrafts, beauty culture, bakery etc. I am happily married now. My husband is very caring and supportive. I have a two-year-old daughter. STOP gave me a new life and also taught me to live life with dignity and face challenges courageously. I am now living my life on my own terms.

Review of Literature

The Supreme Court and the Supreme Court have issued important instructions to the government on the protection and rehabilitation of trafficking victims in several decisions that make up most of the literature available on this subject.

In *Vishal Jeet vs. Union of India and others* there was a PIL against forced prostitution of girls, devadasis and jogins, and for their rehabilitation. The Supreme Court held that in spite of stringent and rehabilitative provisions under the various acts, results were not as desired and, therefore, called for evaluation of the measures by the central and state governments to ensure their implementation. The court called for severe and speedy legal action against exploiters such as pimps, brokers and brothel owners. Several directives were issued by the court, which, inter alia, included setting up of a separate Zonal Advisory Committee, providing rehabilitative homes, etc.[12]

In *Prerana vs. State of Maharashtra and Others* the Mumbai High Court looked into the issue of violation of rights of trafficked children by various authorities who are supposed to implement the law. The court took serious objection to the judicial authority treating the trafficked minor girls as "confirmed prostitutes". The High Court issued several directions for the proper implementation of the JJ Act and ITPA, keeping in view the human rights of the trafficked persons. The court order addressed several issues concerning child rights, viz. the role of advocates and NGOs in the JJ Act, child friendly procedures in dealing with rescued persons, etc., and has brought out clear guidelines for compliance by all concerned.[13]

In *Bachpan Bachao Andolan vs. Union of India and Others*, issued on 18 April, 2011, the Supreme Court recognized human trafficking as an organized crime and defined human trafficking as per the optional protocol to United Nations Convention on Transnational Organized Crime. The Apex Court banned the employment of children in circuses and directed the establishment of Anti Human - Trafficking Units in all districts. The court also issued guidelines on implementation of the institutional framework for the protection of children. As a result of this decision India ratified

12 (1990, 3 SCC 318)

13 [writ petition No. 788 of 2002]

the "Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children" on 5 May, 2011.[14]

In *Gaurav Jain vs. Union of India*, the Supreme Court passed an order dated 9 July 1997, directing, inter alia, the constitution of a committee to make an in-depth study of the problem of prostitution, child prostitutes and children of prostitutes, and to evolve suitable schemes for their rescue and rehabilitation. Taking note of the fact that "children of prostitutes should not be permitted to live in the inferno and the undesirable surroundings of prostitute homes", the apex court issued directions to ensure the protection of human rights of such persons.[15]

Preventive Measures

- Border Measures

Strict enforcement of cross-border trafficking, safe vigilance against trafficking routes, and appropriate social accountability are required.

- Economic and social policies

    - Take steps to raise the level of social protection and create employment opportunities.
    - Take appropriate measures to eradicate discrimination against women in employment to ensure equal pay for equal work and equal rights in employment opportunities based on gender equality.
    - Develop programs that provide livelihood options, including basic education, literacy, communication, and other skills, and remove barriers to entrepreneurship.
    - Promote gender-specific awareness and education of equal and respectful relationships between men and women to prevent violence against women.
    - Make sure that policies are in place that allow women to have equal access to and control of their economic and financial resources.

14 [writ petition(C) 51 of 2006] [2011, 5 SSC 1]

15 (1997, 8 SCC 114)

- Awareness-raising measures

With the help of NGOs and police officers, there should be several awareness programs conducted through media that are popular among specific locations, villages, local schools, children in poor societies, and the general public. In this way, certain types of ads can warn victims.

- Legislative Measures

Legal, appropriate criminal charges, corrupt officials, educational, social, cultural or other measures and, if necessary, bilateral to counter the demands of promoting the exploitation of all forms of people. Adopting or strengthening criminal law through interpersonal and multilateral cooperation, especially women and children, which leads to trafficking.

- National Plan of Action to Combat Trafficking and Commercial Sexual Exploitation of Women and Children 1998.

It was formulated with the aim of mainstreaming and reintegrating victims of trafficking. The Central Advisory Committee (CAB) was constituted to advise on methods and tactics to address the problem.

- Encouraging business to not use child labour

An ecosystem for child trafficking gets silent approval when demand for child labour is commonly used in businesses like retail, hospitality, etc. NGOs have established a dialogue to sensitize trade organizations to end this social evil that will save them a few rupees. At the same time, locals have been made vigilant to report instances of child labour at businesses, so that it is actively discouraged.

- Scheme by the Government of India – Ujjwala Scheme
    - ❖ To prevent trafficking of women and children for commercial sexual exploitation through social mobilization and involvement of local communities, awareness generation programmes, generate public discourse through workshops/seminars and such events and any other innovative activity.
    - ❖ Facilitating the rescue of victims and placing them in safe custody.

- ❖ Providing rehabilitation services both immediate and long-term to the victims by providing basic amenities/needs such as shelter, food, clothing, medical treatment including counseling, legal aid and guidance and vocational training.
- ❖ To facilitate reintegration of the victims into the family and society at large.

- Anti- trafficking cell

The Home Office has set up a node cell to handle trafficking-related issues. Since the "police" is a national territory, the registration, investigation and prevention of trafficking is primarily the responsibility of the state government. However, the Government of India has taken various steps to combat the threat of trafficking. The Home Office occasionally publishes some advice to states and UTs that provide guidance on how to effectively address trafficking issues.

- Web Portal on Anti-Human Trafficking

A website (stophumantraffickingmha.nic.in) for combating human trafficking was launched in February 2014. It is an important IT tool for exchanging information among stakeholder groups, states / UTs, and civil society organizations to effectively implement measures to combat trafficking.

- Project on *"Strengthening the law enforcement response in India against trafficking in persons through training and capacity building"*

The government, through the Ministry of Home Affairs in collaboration with the United Nations Office on Drugs and Crime, has launched a two-year project to train trafficking law enforcement officers in four states: Maharashtra, Goa, West Bengal, and West Bengal. have started. Andhra Pradesh. A project steering committee was established to manage, control and monitor the project. Through a series of training programs, the project aims to raise awareness of law enforcement officers (police and prosecutors) on trafficking issues and further enhance their ability to better investigate crime and prosecute perpetrators.

- NALSA (Victims of Trafficking and Commercial Sexual Exploitation) Scheme, 2015.

The objective of the Scheme is to provide legal services to address the concerns of victims of trafficking including women of all age groups and at every stage: i.e. prevention, rescue and rehabilitation. Also, to provide economic and social pathways for these marginalized groups so that they are socially included and thus get all social protections available to an ordinary citizen and to ensure the protection of dignity of the victims and their fundamental right to life.

Conclusion and Suggestion

Human trafficking jeopardizes the dignity and security of trafficked individuals, and severely violates their human rights. Constitutions of India guarantee the equal rights of men and women, but they are often merely rhetoric when it comes to the question of practical implementation. In order to combat trafficking and thus to protect the human rights of the vulnerable people, strong political will of the government is vital in implementing their anti-trafficking mandates. The procedures, process, means, methods as well as the rate of involvement is increasing in this crime each day due to lack of resources, highest demand in the market, very few income options and impotent legal watch system. The issue of human trafficking is very sensitive in nature. The need of the hour is a comprehensive strategy to deal with it:

- The government should aim at rehabilitation and integration of the victims into society.
- The laws concerning human trafficking should be more stringent w.r.t to the punishment imposed.
- To create awareness amongst people about human trafficking by different sources like print and visual media and inform people about this heinous crime and mobilize them to stop it.
- Education is most important in pausing the flow of women, children and men into forced bondage. It is through education that we can elicit the most direct influence in the fight against human trafficking.

Further, there is a lack of knowledge and understanding on trafficking among the general public. The need of an hour is to sensitize the general public especially the poor people in the rural areas about trafficking. For this purpose, the government is required to collaborate with the NGOs

working in this field and also the people have to collectively work towards eradicating the evils of Human Trafficking.

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Reclaiming Digital Safety: Feminist Strategies Against Online Harassment

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Abstract: The expansion of digitization of public discourse has heightened both opportunities and challenges for gender justice. As, cyber platforms which provide spaces for feminist activism and resistibility, they have also become sites of pervaded online harassment, which disproportionately target women and weaker section in Global South. This theme critically examines the gendered framework of online harassment that led to fraudulent activities, with exploration of intersection of race, caste, class and sexuality. It also tried to put light on colonial and patriarchal roots of digital violence, demonstration of how historical regulatory frameworks and platforms policies often failed to safe vulnerable agents. By a view of decolonial feminist lens, this paper tried to analyses grassroot strategical ways for digital safety, including community- led initiatives, digital self- defense tools and counter speech movements. It also channelizes the role of tech corporation and government subsidiary in shaping digital world, emphasizing the need for intersectionlaity, feminist policy making. The study argues for the creation of inclusive, community- driven digital safety models that prioritize the voice and experiences of those who are mostly affected. Ultimately, this research paper calls for collective reimagining of digitalized spaces- one that is rooted in feminist social value of care, accountability and gender-based justice. By centering towards resistibility-based strategies from Global South, it contributes to the ongoing discourse on claiming digital safety and ensuring equitable access to online spaces free for harassment and violence.

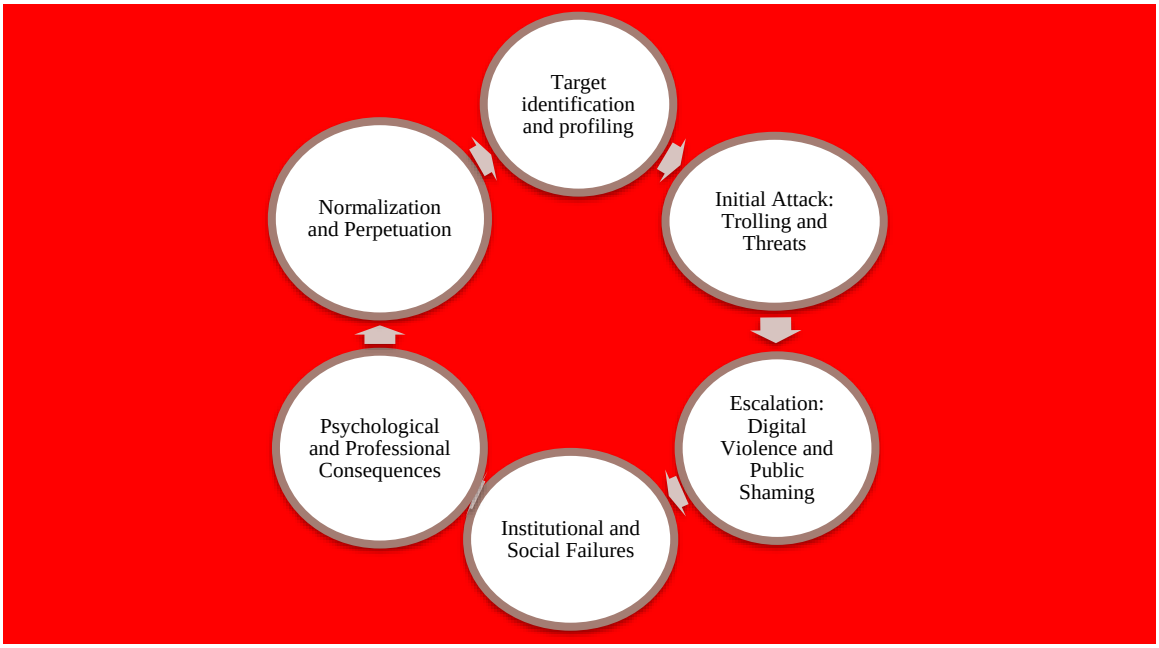
Keywords: Digitization, Race, Caste, Community- Driven.

1. Introduction: The Gendered Nature of Online Harassment

In today's world cyber space, at one end where all community meet for different set of interest but when interest clash for some derogatory cause especially concerning to marginalised section especially women lead to intractable image of women. Cyber Crime refer to illegal activities that normally carried out with intention of flustered look in women taking online resource using internet and digitalized technology encompassing broader range of heinous offences taken from financial fraud to cyberbullying, hacking with intent to online harassment. As a precursor, major consequences aimed at women was to deteriorate mental and physical health. In India, according to National Commission for Women in year 2021 number of registered cases of cyber-crime against women was 863 (N. C. Women). One more study by same department, revealed 54.8% of women have experienced cyber harassment while 26% reported cases of morphed images or videos. In the unforeseen circumstances & commodification for women bodies is evident in way of women shown in media and cyber related world (Sathyan). Cyber fraud not limited to physical fraud rather financial fraud gaining heightened stigma for women, in which women losing their jobs or experience financial fraud through online platform. 47% of urban Indian experienced financial fraud in which 38% were women in past three year, with mainly two methods namely with credit card fraud consisting 43% and UPI transaction Scams consisting 30% (Mumbai).

As far as the definition of the cyber harassment is concerned, according to the United Nations, 'Cyber harassment is a threat via the use of digital technologies. It can take place on social media, messaging platforms and cell phones. It is a repeated behavior, aimed at threatening, scaring, shaming, and silencing those who are targeted.' (Nations). Furthermore, 'The term online harassment refers to the utilization of information and communication technologies by an individual or a group to repeatedly inflict harm upon another person. This may encompass issuing threats, causing embarrassment, or inducing humiliation in a virtual environment' (Press). One of the expressions of online harassment and crime includes cyberbullying which is 'bullying with the use of digital technologies. It can take place on social media, messaging platforms, gaming platforms and mobile phones. It is repeated behavior, aimed at scaring, angering or shaming those who are targeted' (UNICEF).

With explanation of gendered oriented cycle of repeated online harassment that starts from targeted set of population through disproportionately targeted women, girls and marginalised gender group which definitely remain by systemic inequality, digital anonymity and inadequate institutional responses. In comparison to men, women face higher level of severe consequences, sexualised threats and long-term effect. Primarily, it started from targeted identification and profiling means deliberate selection of individual especially women for online abuse based on their identity opinion and public presence e.g., women in public roles, marginalized identities and explore provocative post weaponizing personal information. As of now individual get identified, now harasser start trolling and use threat by sexist, misogynistic and dehumanizing language. If it fails in second attempt, he will use non-consensual sharing of intimate images, coordinating attacks e.g., cyber mobs and victim experience gaslighting situation. With two attempts by perpetrator, now women move for institutional support namely Police and Legal which can slow down effect put by perpetrator if it remains accountable from both ends. But if it remains not accountable, deeper effect on psychological wellbeing and professional lifestyle affect women. The lack of accountability encourage harasser to repeat and escalate behaviour which lead women exclusion from online spaces reinforces gender power imbalances.



Statistics

As per encompassing, global southern continents include Asia, Africa, Latin America and the Middle East women of these regions face unconsolidated challenges on online platform due to patriarchal structure, weak institutional support and digital divide. In India, women politicians received 13.8 times more abusive tweets than male counterpart. It means 113 per women per day. 1 in every 5 were deeply sexist and misogynistic abuse. Muslim Women politician received 94.1% more abusive content then women of other religion (India). In Pakistan, 53.6% of women who uses internet become victim of online abuse include cyberstalking, non- consensual image sharing and gendered hate speech. 86% of 460 blackmailing cases were reported by women. 90% women concerned about their dignity (Basit). In Brazil, from 2016 to 2020 73% women journalist had become victims of online fraud. In every 1 in 4 women experienced threat of physical violence. 1 in 10 women will to go to police station (UNESCO). In Sub Saharan African region, 28% of women experiences cases related digital case violence with black women become victim of higher level of abuse (unwomen).

Case Studies

India: In 2021- 22, apps like "Bulli- Bai" & "Sulli- Deals" raised in which 100 of Muslim Women were online auctioned and misused without consent. Journalist, Social Worker and prominent personalities found their morphed images about new app called Bulli- Bai after six months span one more app Sulli- Deals started. Delhi Police with National Commission for Women made an FIR taking Suo Moto cognizance against culprit. However, Delhi High Court granted bail to the culprit (independent.co.uk).

Pakistan: Journalists like Gul Bukhari and Asma Shirazi have faced massive online trolling and threats for speaking on gender centric issues and political issues. The Digital Rights Foundation reported that online abuse extends to online abuse often extend to offline threats including physical harassment and surveillance (digitalrightsfoundation.pk).

Brazil: Brazilian congresswomen Tabata Amaral faced gender disinformation campaign, including deep pornography and threats of violence, aimed at discrediting her. Women in politics are frequently subjected to sexualised abuse online with discouraging their political participation (Francesca Giannaccini).

South- Africa: Activists like Dr. Sithembele Mbete with feminist movements such as #TotalShutdown have faced targeted online abuse. Black Women in South Africa often face a combination of racist, sexist and misogynistic harassment making digital activism risky (U. Women).

Egypt: Amal Fathy, feminist activist was arrested as she spoke about online harassment. Government in this region, use cyber law to target women activists, more often entitling them as "threats to national security" (Awino Okech)**.**

2. Understanding the Ecosystem of Online Harassment

In the digitalised age, the prevalence of Cyber Crime leading to online harassment of marginalised section of society especially women and girls can take many forms to form ecosystem of mental online harassment happening again and again. Online Harassment includes: cyberstalking, doxxing, trolling, revenge porn, deepfakes, etc. This type of harassment consequences can be psychological and emotional which try to put a woman in condition of fear, anxiety, loss of control on their online presence and depression. When a perpetrator tries to do persistent, unwanted and intrusive online surveillance or communicative actions aiming to intimidate, harass or threaten victim with objective of monitoring social media activities, calls and messages with repeated threats or unwanted messages. Tries to track a person location through digitalised means is called Cyberstalking. Doxxing means an act of publicly sharing someone's personal information without their consent, often to encourage harassment or violence. Especially female politicians of nation can be triggered by perpetrator by leaking personal data on personal forms, publishing private addresses or phone numbers with intent to leak family data. Trolling lead to deliberate disruptive behaviour of perpetrator which tries to harass marginalised women with aim to provoke, humiliate and attack with posting offensive comments or slurs, spreading false information to discredit women and coordinating mass

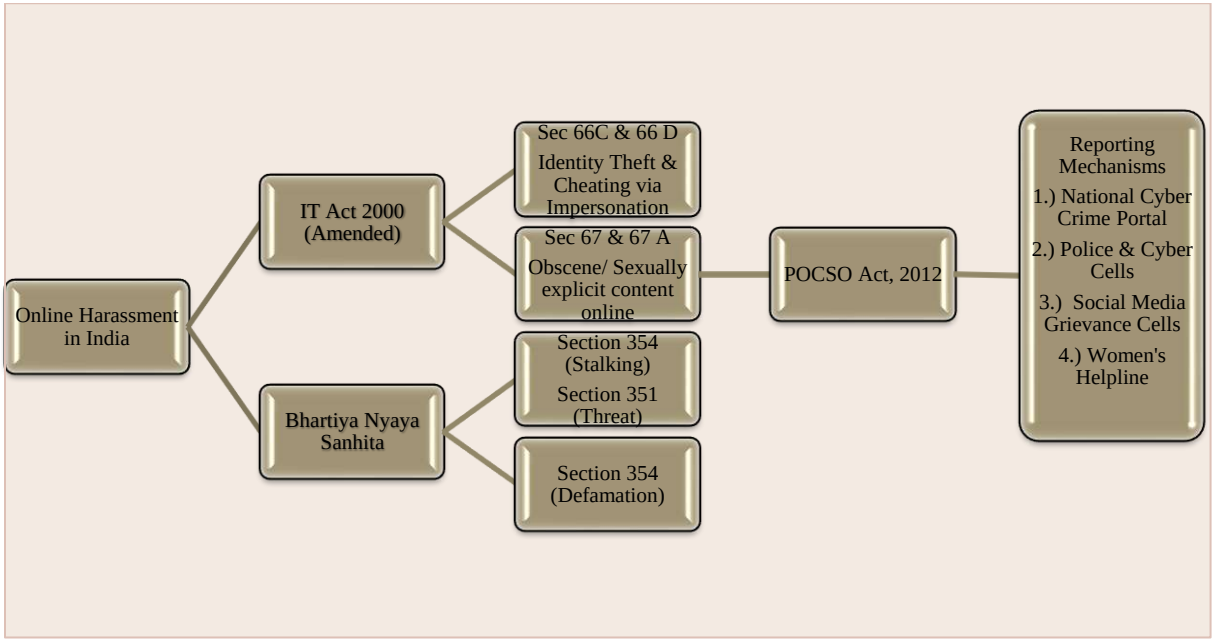
attacks for overwhelm person online presence. Revenge porn is an unauthorised distribution of private intimate images or videos to embarrass, blackmail and punish someone with ex-partner leak intimate images, hacking private accounts and release personal images and circulate sexual content to fuggily victim reputation. Deep Fakes is a form of online harassment in which Artificial intelligence manipulated videos, images or audio falsely depicted women saying or doing things they never did, often used for blackmail, misinformation or political manipulation with superimposing a victim face onto pornographic content, crating fake videos to spread misinformation or defamation and mimicking voices to generate fake statements. Astroturfing means coordinated online behaviour which meant to mislead victim about scale and intensity of public opinion (Mendez).

Now, with time and space coming of different platform like social media, gaming communities, and online forums especially in which female & LGBT are more in targeted position of online harassment for satisfaction from perpetrator end. Social media plays a preconceived negative intent to women. Heinous crime by perpetrator starts with contribution to online harassment with making fake profiles to do cyberbullying, trolling and cyber harassment. Post and comment can lead to gain bountiful filthy comments leading to harassment and doxxing. False rumours and accusation can lead to women defamation. The U.S. National Violence Against Women Survey suggest that 60 percent of cyber stalking victims are women, and the National Centre for Victims of Crimes estimating that the rate is 70 percent.[1] For over a decade, Working to Halt Online Abuse (WHOA) has collected information from cyber harassment victims. Of the 3, 393 individuals reporting cyber harassment to WHOA from 2000 to 2011, 72.5% were female and 22.5% were male[2]. Female gamers often report the experience of harassment and other illegal behaviour while joining the game (Cote; Gray KL; Adrienne Holz Ivory; Griffiths; Vermeulen). Gaming online lead to harassment especially perpetrator try to show toxic behaviour with trash taking, harassment through in game voice chat, doxxing including personalised information leaks or dangerous pranks like swatting and last but least women and marginalised groups face exclusion with proof that they are not allowed in gaming

[1] Vindu Goel, "Fight Back against the Cyberbullies and Trolls," Vindu's Views from the Valley (blog), San Jose Mercury-News, April 1, 2007 (11:00 p.m.).
[2] Steven D, "Kathy Sierra and Online Hate Crimes," Booman Tribune, April 2, 2007, http://www.boomantribune.com/story/2007/4/2/203416 /5935

spaces. (Trepte), tried to suggest that social ties are developed in online gaming by social interaction that occur outside gaming platform and competing and it is precursor to note that the level of involvement female gamers are experiencing in gaming. Many females have reported the experience of receiving disproportionate attention in online interactions, particularly concerning sexual intent, in comparison to males (Herring). In this Online forum, tries to put marginalised women at a blaming position by which forum become breeding grounds of hate groups for spreading harmful ideologies. Some group start cyberbullying, threat and organised harassment pattern against women and girls. With doxxing they tried to put women at pornographic sites to psychological fear of death.

For counterfeiting these criminalised activities in global south countries, various laws and policies were made to revive the status for women. In global south, police and law tries to build nation with sensitive acts and policies for upliftment of marginalised section of society. In India, we are governed by Information Technology (Amendment) Bill 2023, this bill was introduced in response to Information Technology Act 2000 with technological advancement and increased cyber threat. There is a rule in Indian Computer Emergency Response Team (CERT-In) rulebook that fine of Rs 1 lakh increased up to 1 crore fine (Agarwal). Indian Government introduce obligation for intermediaries to work with diligence in content moderation and user data protection (Chin). According to legal system of India, we follow Bhartiya Nyaya Sanhita in which Section 66 C & 66 D (Identity Theft and Cheating via Impersonation), Section 67 & 67 A (Obscene/ sexually explicit content online). Protection of Children from Sexual Offences Act (POCSO), it is also made for to put a barrier against child exploitation at online platform.



In other global south countries, online criminalising activities debar through act as stated like in Pakistan, Prevention of Electronic Crime Act PECA), 2016 criminalises cyberstalking, hate speeches and online harassment. In Indonesia, Electronic Information and Transaction (EIT) Law, 2008 put barrier on defamation and cyberbullying but criticized for vague wording. In Africa, Cybercrime Act, 2020 criminalizes cyber harassment, hate speech and porn activities against women. Protection from Harassment Act, 2011 allow victim women to seek restraining orders against online criminals. In Kenya, Computer Misuse and Cybercrime Act, 2018 criminalises cyber harassment, fake news and hacking. In Brazil, Marco Civil da Internet, 2014 protect digital rights and regulate content takedown request and Lei Carolina Dieckmann, 2012 criminalizes online invasions of privacy and cyber harassment. In Mexico, according to Olimpia Law, 2021 penalizes digital violence including porn and cyber harassment.

3. The Colonial and Patriarchal Roots of Digital Violence

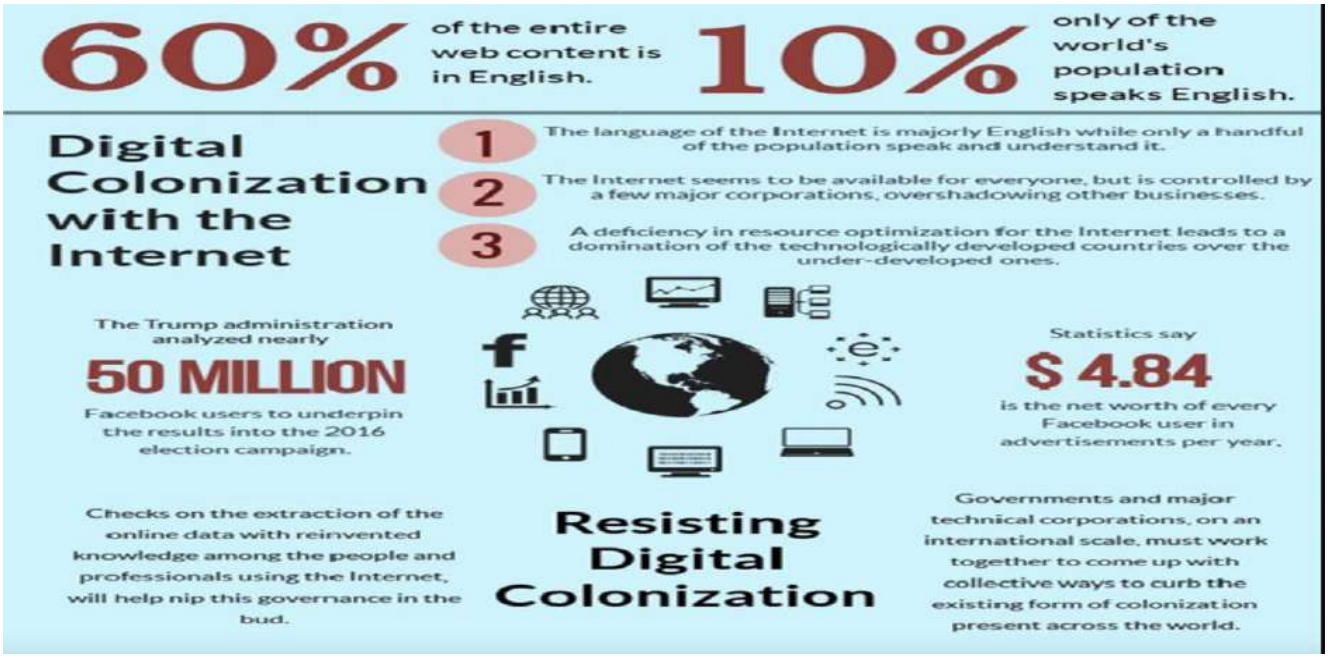
Digital colonialism refers to the dominance of western countries dominates global south over the digital infrastructure, data and platform used worldwide. Digital technologies are supplementing the human capability for information storage, analysis and communication and their relative

ubiquity means that more individuals have opportunity to production, communication and using digital infrastructure than ever before[3]. With, the reachability of digitalised networks allowed individuals to access global networks of other users, granting them the potentiality to connect to people across long distances[4]. This creates a form of neo colonialised control, where, marginalised communities especially from global south were meant for exploitative data practices, algorithm practices and restrict to self-determined data practices. It engulfs existing inequality by reinforcing western cultural, economic, social and political hegemony while limitation of local agency in shaping digital future. As the scholar Dan Schiller warns: for most of the world's people, whether profitable growth for capital may be renewed and by whom, are far less important than the results of digital commodity for employment and led to exploitation and inequality; for the future of democratic self-government; for the ravaged environment; and for the character and quality of cultural services needed to sustain purposeful lives. The terror of digital commodity is writing a new chapter in capitalism's long history of violent misallocation. This makes discussion for strategies for social alternatives essential and urgent[5].

[3] Castells M (2004) Informationalism, networks, and the network society: A theoretical blueprint. In M Castells (ed) *The network society: a cross-cultural perspective*. Northampton, MA: Edward Elgar.

[4] Bennet WL and Segerberg A (2013) *The Logic of Connective Action: Digital Media and the Personalization of Contentious Politics*. Cambridge, UK: Cambridge University Press.

[5] *Dan Schiller, "Geopolitics and Economic Power in Today's Digital Capitalism." Presentation to the Hans Crescent Symposium, December 13, 2015, accessed June 20, 2018, http://informationobservatory.info/2015/12/14/geopolitics-and-economic-power-in-todays-digital-capitalism.*



Data is basic currency for nation rather than wealth, natural resources and advanced weapons. This data may be retrieved or supplied as a product to political system and firm whose win is based on targeted population for promoting political messages and objectives. Eduardo Galeano's book "open veins", author described the economic exploitative practices of Latin America by colonial powers of the Global North, can be viewed as being the "digitalised veins" that traverse the seas, bridging the tech ecosystem owned and controlled by a small number of primarily US Based firms, but with same intention of exploitation of the neo colonialised. Major U.S. based giants like META, Google, X, Microsoft & Amazon dominate content moderation policies. These policies reflect westernised legal cultural norms with leaving perspectives of global south. Decision making ability of global north provide misinformation, hate speech and censorship which is hub at Silicon Valley where moderators and AI system lacks contextual understanding of global south leading to biased enforcement and even political suppression in some region. Global South Feminist now in a position to put a demand for revival of digital governance structure for raising their voices. The dominance ability of westernised corporate culture & policy frameworks means that feminist concerns related to gender-based violence, online harassment, data justice and digital labour exploitation are not addressed equitably. Issues of violence like caste-based discrimination, misogyny and indigenous knowledge capability remain suppressed in global digital policy debates reinforcing epistemic injustices. Now,

demands of nearly 100 feminist activists, academicians from global south, in the charter address key principle and demand for United Nation Global Compact tried to made their view highlighted in a comprehensive document "Charter of Feminist Demands from the Global South", that envisage feminist vision for digital transformation, for need of gender-based equality in evolving digital landscape. Its core principles include Openness for Constructive Pluralism which Advocates for inclusive digital spaces that respect diverse perspectives, ensuring that marginalized voices are heard and valued. Then come Freedom for Equitable and Just Societies which emphasizes the protection of human rights in the digital realm, advocating for freedoms that support equitable societies and lastly, Security for Flourishing Futures which highlights the importance of safety and security in digital environments to promote well-being and development. Its key demands include state and corporate accountability which calls for mechanisms to hold both governments and corporations responsible for protecting women's rights in the digital age, new global social contract which proposes a framework for a socially just digital transition that benefits all, especially marginalized communities and communing the Internet and Data Resources which advocates for treating the internet and data as commons, ensuring equitable access and governance (Chami).

4. Methodology

This paper tries to put base of **qualitative, interpretive, and feminist analytical approach** to research on online gender-based violence. **It is based** on **theoretical and comparative**, grounded in feminist epistemology that tries to value experiential and narrative-based knowledge which draws data from **secondary data** including feminist reports (UN Women, Amnesty International, Internet Freedom Foundation), academic research, and digital media case studies. This analysis tries to integrates **feminist discourse analysis** and **intersectional comparison** to understand how structures of patriarchy, class, race, and coloniality intersect with digital violence narratives. **Sufficing with** illustrative case studies from **India, Pakistan, Brazil, Egypt, and South Africa** which used to highlight regional variations and common structural patterns in gendered online harassment. The study respects survivor anonymity and focuses on publicly available data to avoid re-traumatization or exploitation of vulnerable subjects.

5. Feminist Strategies for Digital Safety and Resistance

In a digitalised stage, feminist movement from early 1970's tried to put a mark in some way getting opportunities and challenges in online spaces. At one end Internet serves as powerful tool for activism, it also tries to expose women & marginalised communities which get convicted for cause of harassment, surveillance and censorship. In the global south countries, challenges are often intensified by social, political and cultural factors, digital divide and surveillance. For combatting threats, feminist strategies for digital safety and resistibility which put emphasis on community led initiatives, digital self-defence and counter speech movements. In Community-Led Initiatives which means grassroot feminist organisation in Global South play role in fostering digital safety through collective action and education. It includes Digital Literacy Programs in which many feminist groups conduct workshops to educate women and marginalized individuals on digital security, data privacy, and safe online engagement, often addressing language barriers and accessibility issues. Also, Mutual Aid Networks means Online feminist communities provide support systems where individuals can report harassment, share resources, and advocate for safer digital spaces, especially in regions with weak legal protections against cyber violence. Lastly, Policy Advocacy means Feminist organizations actively campaign for stronger laws and platform policies against online harassment, misinformation, and gendered violence, often in contexts where legal frameworks are inadequate or poorly enforced. With digital self-defence, means Protecting one's digital identity and data is a critical component of online resistance, particularly in the Global South, where state surveillance and online threats are prevalent. Feminist digital self-defence strategies include Encryption Tools like secure messaging applications like Signal and Proton Mail ensure private communication, reducing risks of surveillance in repressive regimes, Anonymity and Privacy Strategies means using VPNs, pseudonyms, and privacy-focused browsers like Tor enhances online security and protects against doxxing and state monitoring and Cyber Hygiene Practices means regularly updating passwords, enabling two-factor authentication, and controlling social media privacy settings help individuals safeguard their online presence, especially in regions where digital literacy remains low and with Counter-Speech Movements means online advocacy enables feminists to challenge misogyny, reclaim narratives, and create safer spaces. In the Global South, counter-speech movements take on unique forms, including Hashtag Campaigns means Movements like #NiUnaMenos in Latin America and #StopTheBan in Africa amplify

marginalized voices and expose systemic injustices related to gender-based violence and reproductive rights. Content Creation and Digital Storytelling means Blogging, vlogging, and social media storytelling empower individuals to share lived experiences, counter misinformation, and document resistance in environments where traditional media is often censored. Engaging in Online Discourse means feminists actively participate in digital debates, fact-checking misinformation and promoting inclusive discourse to shift cultural norms, often facing greater risks of online backlash and cyber-attacks.

Conclusion

The objective of the paper, was to understand the meaning and context of digital safety through a feminist lens. In this process, the paper attempted a gendered reading and understanding of digital safety along with online harassment of women and adolescent girls. At this point, it is important to note that in the contemporary times of global media and technology as a result of globalisation has opened up new channels of information access and distribution. The misuse of such global digital space against adolescent girls and women results into something understood as cyberviolence and digital violence including online harassment. Ensuring women's digital safety requires a multi-faceted approach that balances regulation, platform accountability, and community-driven solutions. Governments must create policies that protect users without enabling censorship, while tech giants must address algorithmic biases and improve transparency in content moderation. A decolonial feminist vision for digital safety prioritizes ethical, inclusive, and justice-driven online spaces. Bridging digital literacy gaps and strengthening solidarity networks across borders are crucial steps toward reclaiming the internet as a space for empowerment rather than exclusion. By fostering collective resistance, we can build a safer, more equitable digital world for all marginalized voices.

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What Will They Think: A Choreography of Feminine Surveillance

Preethi Kethavath

Abstract: This article theorizes feminine surveillance as a choreography of internalized ideology, where Indian womanhood is regulated not through overt discipline but through emotional scripts, sartorial cues, and social whispers. Drawing on Louis Althusser's Ideological State Apparatuses (ISAs), Judith Butler's gender performativity, and Sara Ahmed's feminist killjoy, the essay maps how everyday acts—dressing, thanking, menstruating, walking at night—become ideological performances. Through cinematic critique (*Mrs.*, 2024), personal anecdotes, and cultural rituals, the article explores how the "bad girl" archetype resists normative femininity by refusing apology, embracing visibility, and disrupting ideological rhythms. It proposes a feminist methodology rooted in emotional resonance, aesthetic resistance, and lived witnessing.

Keywords: Feminist Surveillance; Ideological State Apparatuses (ISAs); Gender Performativity; Domestic Labor; Feminist Killjoy; Cinematic Critique

Objectives

This study theorizes feminine surveillance as an internalized ideological performance shaped by emotion and aesthetics. It examines everyday acts—such as dressing, menstruating, expressing gratitude, and navigating domestic labor—as sites of ideological control and feminist resistance. Drawing on feminist theory and cinematic critique, the article explores how

visibility and refusal disrupt normative femininity. It proposes a methodology rooted in emotional truth, aesthetic defiance, and lived experience.

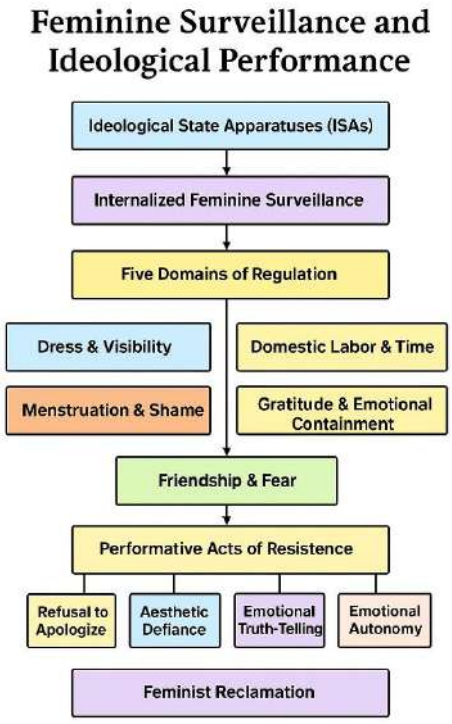
Conceptual Framework Narrative Summary

This framework maps how Indian women navigate emotional regulation and ideological control through everyday aesthetic and social practices. Drawing on Althusser's ISAs, Butler's performativity, and Ahmed's affective politics, it identifies five overlapping domains—Fashion, Family, Media & Ritual, Drama & Fear, and Ornamentation—as sites of ideological discipline.

Within each domain, reflexive acts like styling, symbolic refusal, and emotional rupture become counter-narratives of resistance. Ornamentation, especially, emerges as a layered site of ideological inheritance and emotional truth—worn, feared, and reclaimed.

Conceptual Validation

The framework is conceptually validated through its grounding in feminist theory and its alignment with experiential methodology. Drawing on Althusser, Butler, and Ahmed, it treats everyday acts—dressing, menstruating, labouring—as ideological performances. The episodic structure and use of cinematic critique reinforce its interdisciplinary rigor and emotional resonance.



Conceptual Diagram Flow

Figure 2: Conceptual Flow Diagram of Feminine Surveillance and Ideological Performance in Indian Womanhood This diagram illustrates how ideological structures shape internalized feminine surveillance and regulate everyday behaviour across five domains—Dress & Visibility, Domestic Labor & Time, Menstruation & Shame, Gratitude & Emotional Containment, and Friendship & Fear. These domains lead to performative acts of resistance and culminate in feminist reclamation, where agency and emotional autonomy are affirmed.

Introduction: The Whisper That Shapes Us

They must be thinking I'm such a bad girl.

This sentence, whispered across bedrooms, WhatsApp threads, and bathroom mirrors, is not merely a thought—it is an ideological echo. It is the choreography of restraint, the internalized gaze, the performance of apology. It is the girl rehearsing her shame before anyone speaks it aloud.

Louis Althusser's theory of Ideological State Apparatuses (ISAs) helps us understand how institutions—family, media, religion, education—do not just instruct; they stage. They choreograph femininity as a performance of obedience, silence, and self-erasure. Judith Butler deepens this by reminding us that gender is not a stable identity but a repeated performance. The "good girl" is not born—she is rehearsed. She is taught to smile without speaking, to dress without drawing attention, to bleed without asking.

This essay traces how the "bad girl" script operates as an ISA—regulating desire, dress, speech, and movement through internal surveillance. The girl is not simply watched; she watches herself. She becomes both performer and audience in a moral theatre she did not audition for. Through fragments, scenes, and cinematic critique, I explore how obedience is rewarded, and self-love is punished.

The Dress: Shame in the Seams

I want to wear this dress—so sexy, so mine. But they'll think I'm a slut.

Fashion is not fabric—it is ideology. It is not merely a choice of colour or cut, but a choreography of visibility. The girl's desire to wear something that fits her well is interrupted by the imagined gaze of neighbours, relatives, even strangers. Her body becomes a site of moral panic. Ornamentation, once a form of cultural expression, is now read as provocation. The ISA here is sartorial morality, where shame is stitched into the seams.

Louis Althusser's concept of Ideological State Apparatuses (ISAs) helps us understand how institutions like family, media, and religion do not simply discipline from the outside—they operate through internalized scripts. The girl does not need to be told she looks "too much." She already knows. She has rehearsed the apology before stepping out. Judith Butler's theory of gender performativity reminds us that femininity is not innate—it is enacted. The "good girl" is not born; she is styled into existence.

To be in touch with one's body, to love how a dress fits, is to risk being labelled. The "bad girl" is not the one who dresses provocatively—she is the one who dresses with intention. And that knowing is punished. She is told to cover up, tone down, blend in. Her silhouette becomes a battleground.

Even compliments are coded. "You look nice" becomes "You're asking for it." The girl learns to dress not for herself, but for the comfort of others. She learns to disappear.

I recall an incident—meeting my co-workers before a big day. I wore a black oversized V-neck t-shirt, black trousers, comfortable nude sandals. To complement the look, I added a layered choker and a generous stroke of kajal, leaning into a goth vibe I love. As we walked toward the dosa Bandi, one of them said, "Why did you get ready so much? Your kajal is too much." I turned and said, "Did I ask for your opinion on how I look? I always get ready. I love it. So don't bother to worry."

That moment was not just a retort—it was a refusal. A refusal to be interpellated into the "good girl" script. A refusal to apologize for aesthetic joy. A refusal to shrink.

Sara Ahmed writes that the feminist killjoy is the one who "refuses to smile when expected." In that moment, I refused to smile for his comfort. I chose to wear my kajal not as decoration, but as declaration.

The dress, the choker, the kajal—these are not just accessories. They are acts of resistance. They are ways of saying: I am here. I am visible. I am not sorry.

And yet, the cost of this visibility is high. The girl who dresses with intention is read as dangerous. She is seen as seductive, rebellious, excessive. She is asked, "Who are you dressing for?" The answer— "Myself"—is rarely accepted.

In many households, fashion is policed through subtle cues. A raised eyebrow. A delayed compliment. A suggestion to "change into something simpler." The girl learns to anticipate these cues. She learns to pre-edit her wardrobe. She learns to ask, "Is this, okay?" before she even knows what she wants to wear.

This is not modesty—it is surveillance. It is the internalization of a gaze that never sleeps.

And yet, the bad girl persists. She wears the dress. She applies the kajal. She walks toward the dosa Bandi with her head held high. She knows she will be seen. She chooses to be seen.

Friendship: Surveillance in Motion

They saw me with a guy friend. They'll think I'm loose, reckless, available.

Even platonic companionship becomes suspect. The girl walking beside a male friend is not seen as a student, a thinker, or a peer—she is seen as a symbol. Her presence is interpreted, her proximity politicized. The ISA here is social surveillance, enacted through gossip, silence, and reputation management. The girl learns to walk beside men with caution, apology, and emotional armour.

She is not allowed to be seen with men unless she is claimed by them—sister, wife, daughter. Anything else is risk. Her friendships are policed. Her laughter is monitored. Her proximity is punished.

The gaze is not always external. It becomes internal. She begins to question herself: Was I too close? Did I smile too much? Should I have walked away sooner? She becomes her own censor. Althusser's interpellation is no longer theoretical—it is embodied. The girl hears her name called not by the state, but by the street, the corridor, the family WhatsApp group.

I remember the day my cousin came over, her voice hesitant but urgent. "I heard Nani and others talking," she said. "They're saying you roam around with a guy on a scooty. They're only discussing you lately. They say… such a bad girl." The words weren't hers, but they landed like stones. I felt the weight of a gaze I hadn't seen, a judgment I hadn't invited.

Later, I went to my Nani's house. I sat across from her, the air thick with unspoken things. "Nani," I asked, "what do you think about male friends? About friendships with the opposite gender? When we're studying, going outdoors, it's natural that we'll have friends. How did it come down to gender? Why can't you behave like an actual Nani who loves her grandchildren, instead of starting gossip?"

She didn't answer directly. She smiled, then changed the subject. But the silence was telling. The grandmother who once held me as a child now held me in suspicion.

Judith Butler reminds us that gender is a performance, but it is also a script handed down. The grandmother, once a girl herself, now becomes the enforcer. The woman becomes the means through which other women are disciplined. The gossip is not just talk—it is choreography. It teaches the girl to rehearse her exits, to edit her friendships, to apologize for her joy.

Sara Ahmed writes that "to be a feminist is to be seen as willful." In that moment, I was willful. I asked a question that disrupted the family rhythm. I refused to accept the gossip as care. I named the surveillance. And in doing so, I became the bad girl—not because I had done anything wrong, but because I had refused to be silent.

Friendship, in this context, is not innocent. It is ideological terrain. The girl learns to walk beside men with her head down, her voice low, her smile rationed. She learns to anticipate the whisper before it arrives. She learns to be invisible in motion.

And yet, the bad girl persists. She rides the scooty. She laughs at the dosa Bandi. She asks her Nani questions that aren't meant to be asked. She refuses to rehearse shame. She chooses to be seen.

Gratitude: Language as Risk

Should I say thank you? Ask his name? No—he'll think I'm into him.

Even gratitude becomes a minefield. The simple act of acknowledging help is ideologically loaded. The girl fears misinterpretation, fears being read as flirtatious, as available. Language itself is regulated. The ISA here is gendered communication—where women must speak in codes, soften their tone, and anticipate male misreading.

To be polite is to be provocative. To be warm is to be misleading. She learns to rehearse neutrality, to flatten her voice, to erase her curiosity. She is not allowed to ask, to thank, to

linger. This is not just about speech—it's about presence. The girl learns to shrink herself in conversation. She learns to exit before she's noticed.

I didn't experience this directly, but I witnessed it—and I felt ridiculous just watching it unfold.

We were heading back to our hotels after work, carpooling. The car was full: an anchor, a driver, a few coworkers. The anchor, probably drained from a long shoot, was speaking casually to one of my friends. She said she was exhausted, wanted to change and rest, and mentioned how difficult it was to remove her costume alone. It was a designer outfit—heavy, layered, and elaborate. She was venting, not flirting. Her words were out-loud thinking, not coded invitation.

But later, my coworker twisted it. "She was totally into him," he said. "She was hinting he should come to her room. That comment about not managing alone? She was inviting him to undress her."

I was stunned. A woman expressing fatigue, discomfort, and the physical burden of her costume had been reduced to a sexual proposition. I turned to him and said, "I don't think that was her gist. And please don't assume all women in the world are into you. You're not that handsome."

It was a moment of rupture. A comment turned into a hint, and the hint was dragged all the way to the bedroom. The woman's exhaustion became erotic. Her costume became foreplay. Her words were stripped of context and repurposed for male fantasy.

Judith Butler reminds us that gendered speech is always performed under constraint. The woman must anticipate how she will be read—not just by men, but by society. Even her sighs are suspect. Even her silence is interpreted. She cannot speak freely because her speech is never hers alone.

Sara Ahmed writes that "to speak as a feminist is to be heard as complaining." In this case, the anchor wasn't even speaking as a feminist—she was simply speaking. But her complaint was sexualized. Her fatigue was eroticized. Her body, already burdened by costume, was further burdened by misreading.

This is the violence of gendered communication. The woman cannot express discomfort without being seen as seductive. She cannot say "I'm tired" without being read as "I want you." She cannot say "I need help" without being read as "I want intimacy."

The ISA here is not just the man's assumption—it is the cultural script that teaches him to assume. It is the media that tells him women speak in hints. It is the family that tells him women are coy. It is the society that tells him desire is always hidden, never direct.

And so, the girl learns to rehearse silence. She learns to say less. She learns to exit before she's misunderstood. She learns to flatten her tone, to erase her warmth, to speak in parentheses.

But the bad girl refuses. She thanks without fear. She asks without apology. She speaks without code. She says, "I'm tired," and means it. She says, "I need help," and means it. She refuses to be read through the lens of male desire.

She is not performing seduction. She is performing truth.

Menstruation: Ritual and Apology

Shit—periods started. Papa's home. I start with sorry.

Menstruation, though biological, is ideologically framed as shameful, secretive, and disruptive. The family becomes an Ideological State Apparatus—not through explicit punishment, but through emotional choreography. The girl learns to whisper her needs, to run inside, to start with sorry. The apology is not for the blood—it is for the interruption. She learns that her biology is inconvenient, that her cycles must be hidden, that her pain must be silent.

Even sanitary pads become contraband. She hides them in newspapers, in black bags, in drawers. Her body becomes a secret. The shopkeeper wraps the packet like it's a weapon. The girl carries it like it's a sin.

I remember the ritual well. Every month, I carried an extra black polythene bag—only black. I stored it carefully, reused it, folded it like a sacred cloth. It was my monthly cloak of invisibility. I would walk to the shop, hand over the money without eye contact, and receive the packet wrapped in shame. I never questioned it. It was just how things were.

But something shifted. Slowly, I began to accept periods as part of me—not a flaw, not a disruption, but a rhythm. I stopped asking for the black cover. I began to carry the packet in my hand like any other thing. The first time I did it, I was hesitant. I felt exposed. The uncle at the shop gave me a confused look, as if I had broken a rule he didn't know how to enforce. But I felt liberated. I had stepped out of the choreography.

Judith Butler reminds us that gender is a performance, but it is also a repetition. The girl who hides her pads is not just performing shame—she is repeating it. She is inheriting it. She is rehearsing a script written long before she bled.

In many households, menstruation is not discussed—it is managed. The girl is told not to enter the kitchen, not to touch the pickle jar, not to sit near the altar. She is not punished, but she is excluded. The exclusion is framed as tradition, but it is ideology. It teaches her that her body is impure, that her presence is disruptive, that her cycles must be contained.

Louis Althusser's ISAs operate through such rituals. The family does not need to shout. It only needs to gesture. The girl learns to interpret the silence. She learns to disappear during her own biology.

Sara Ahmed writes that "feminism is homework." In this case, the homework is emotional. It is the work of unlearning shame, of refusing secrecy, of carrying the pad in daylight. It is the work of saying, "I am bleeding, and I am not sorry."

The apology is everywhere. "Sorry Papa, can you get me pads?" "Sorry, I can't come to temple today." "Sorry, I need to lie down." The girl learns to apologize for her existence. She learns to shrink her pain, to soften her discomfort, to smile through cramps.

But the bad girl refuses. She names her cycle. She carries her pad. She walks into the shop without shame. She does not whisper. She does not hide. She bleeds, and she breathes.

Menstruation is not a disruption—it is a declaration. It is the body's rhythm, the body's archive, the body's resistance. The bad girl does not apologize for it. She honours it.

Night: Movement as Transgression

Hey Mumma, I'm going out tonight. You were out the other night too. What will people think? You roam at night. You're that kind of girl.

Movement through public space—especially at night—is ideologically coded. The girl's desire to go out is interrupted by the fear of being labelled "bad." The ISA here is community morality, often enacted through mothers, neighbours, and extended family. The street is not neutral—it is a stage. And the girl, simply by walking, becomes a performance.

To walk at night is to risk being seen. To be seen is to be judged. The girl learns to rehearse her curfews, to justify her outings, to shrink her steps. She is not allowed to roam. Even joy becomes suspect. If she laughs too loudly, dances too freely, stays out too long—she is marked. Her freedom is always conditional.

I remember the long arc of negotiation with my mother. It took months—arguments, examples, emotional appeals, quiet reasoning. Eventually, she softened. She understood that my night outs were not rebellion—they were rhythm. But even then, the permission came with a clause: only on the days Papa wasn't home.

So, the freedom was not full—it was negotiated. It was borrowed. It was conditional. And I, having no choice, accepted it. For a few days, I lived in that compromise. I walked out with my head high, but my steps measured. I knew I was seen. I knew I was tolerated, not accepted.

Louis Althusser's ISAs do not always punish—they regulate. The father's presence becomes a signal. His absence becomes a loophole. The girl learns to read the house like a map of permissions. She learns to time her joy. She learns to schedule her autonomy.

Judith Butler reminds us that gender is not just performed—it is policed. The girl who walks at night is not just visible—she is vulnerable. Her movement is read as desire. Her presence is read as provocation. She is asked, "Where are you going?" but the question is not about destination—it is about intention.

Sara Ahmed writes that "freedom is fragile." For the girl, it is also fragmented. She is free only when the father is away, only when the neighbours are asleep, only when the street is empty. Her freedom is not a right—it is a negotiation.

Even the act of walking becomes ideological. The girl learns to walk quickly, to avoid eye contact, to carry her keys like weapons. She learns to smile less, to speak less, to exist less. Her body becomes a map of caution.

And yet, the bad girl persists. She walks at night. She wears her rhythm. She does not apologize for her presence. She knows she will be seen. She chooses to be seen.

Her movement is not transgression—it is reclamation. It is the act of saying: I am here. I am not waiting for permission. I am not performing shame.

She is not "that kind of girl." She is her own kind.

The Clock: Domestic Violence in Silence

In the film *Mrs.* (2024), the ticking clock becomes a tool of abuse. Coffee at 6. Clothes on the bed by 7. Tiffin packed by 8. Tick. Tock. Tick. Tock.

The protagonist, played by Sanya Malhotra, is not beaten. She is timed. Her body is not bruised—it is scheduled. Her exhaustion is not visible—it is ritualized. The vachan of marriage— *"Parivaar ki zimme dariyon ko nibhaane mein mujhe bhi saanjhedaar banaayein"*—becomes a trap. What is framed as shared responsibility becomes solitary servitude.

The mother-in-law, once a sociologist, is now a silent enforcer of domestic duty. Her own intellectual life is erased, her feminist past buried under layers of household expectation. She becomes the conduit through which patriarchy is passed down. The woman is not allowed rest. She is not allowed delay. She is not allowed to be.

This is not just domestic labor—it is ideological violence. The woman becomes a machine: producing, cooking, cleaning, serving. Her worth is measured in punctuality, not presence. Her husband sees her not as a partner, but as a sensual object. Her father-in-law never praises, only corrects. Her labor is invisible, her fatigue irrelevant, her time not her own.

The ticking becomes a rhythm of erasure. Tick—fold the clothes. Tock—serve the tea. Tick—pack the tiffin. Tock—smile while doing it.

She is always on the clock. She is not allowed to breathe.

Louis Althusser's ISAs are most insidious when they masquerade as routine. The family, in this case, is not violent—it is efficient. The woman is not punished—she is scheduled. The ideology is not shouted—it is whispered through time. The clock becomes the disciplinarian. The calendar becomes the cage.

Judith Butler reminds us that gender is performed through repetition. In *Mrs.*, repetition becomes punishment. The woman repeats the same tasks, the same gestures, the same silences. Her identity dissolves into duty. Her body becomes a timetable.

Sara Ahmed writes that "the ordinary can be a site of violence." In this case, the ordinary is the kitchen, the laundry basket, the dining table. The violence is not in bruises—it is in

breathlessness. The woman is not allowed to pause. She is not allowed to forget. She is not allowed to exist outside the tick-tock.

Even her rest is rationed. She rests only when the house is clean, the food is served, the clothes are folded. Rest becomes reward, not right. And even then, she is watched. Her rest is suspicious. Her stillness is questioned.

The film does not show blood—but it shows breakdown. It shows how time can be weaponized. How routine can be oppressive. How silence can be suffocating.

And yet, the bad girl resists. She misses a chore. She forgets a task. She sits down before the clock allows it. She breathes. She disrupts the rhythm. She refuses to be timed.

Her rebellion is not loud—it is late. It is the act of saying: I am not a schedule. I am not a machine. I am not your clockwork.

She is not lazy. She is alive.

The Binary: Good Girl vs. Bad Girl

The good girl is obedient. She dresses modestly, speaks softly, bleeds invisibly, walks quickly, thanks cautiously, and rests only when allowed. She is rewarded with silence, with survival, with invisibility.

The bad girl is bold. She dresses with intention, speaks with rhythm, bleeds without apology, walks with presence, thanks with warmth, and rests when needed. She is punished with gossip, with suspicion, with surveillance.

But the bad girl is not bad. She is in touch with herself. She is not performing shame. She is not rehearsing apology. She is living.

This binary is not just cultural—it is institutional. It shows up in classrooms, in families, in friendships, and in workplaces. I remember one moment vividly, from the early days of my career. I didn't yet know how much work was mine, how much was shared, how much was being offloaded. My manager handed me a task—her task. "I have a lot on my plate," she said. "Can you do this part? Here's a reference document. Watch the video, make a report."

I did it. I worked late, studied the material, wrote the report. When I shared it, she said, "This is so good. Many people have tried this—you came really close." Later, I found out that the document was crucial for the project to go live. It was praised. It was circulated. But my name was never mentioned. She took the credit.

The next time she tried to pass her workload to me, I declined. I said no. She held a grudge. She became cold. She stopped including me. In that moment, I realized: obedience is rewarded, but autonomy is punished. Nodding silently, absorbing others' burdens, being pliable—that's "good girl" behaviour. That's "good employee" behaviour. But standing up for yourself? That's difficult. That's bold. That's bad.

In university, this might have been manageable. But in the workplace, where managers control your visibility, your finances, your future—it becomes harder to navigate. The ISA here is professional hierarchy, where women are expected to be grateful for exploitation, silent about erasure, and cheerful in the face of injustice.

But I felt good. I felt proud. I stood up for myself. I chose to improve my skills, deepen my knowledge, and move toward a work culture that values competence over compliance. Yes, I am a bad employee—for refusing to be used. Yes, I am a bad girl—for having male friends, for speaking up, for saying no. And I take it as a badge of honour.

If someone calls me difficult, I smile. If someone calls me bold, I nod. If someone calls me a bad girl, I say thank you.

Because the bad girl is not bad. She is awake.

Conclusion: Toward Feminist Reclamation

These fragments are not isolated thoughts. They are ideological performances—rehearsed, repeated, and regulated. The "bad girl" is not bad; she is resisting a script written by ISAs that fear her autonomy, her visibility, her voice.

To reclaim these moments is to rewrite the choreography—to treat emotion, dress, and desire not as threats, but as archives of feminist resistance. Each whisper, each refusal, each unapologetic gesture becomes data. It becomes evidence of a life lived outside the script.

Let us teach girls to wear what fits, to thank without fear, to bleed without apology. Let us teach them that politeness is not submission, that friendship is not transgression, that rest is not reward—it is right.

Let us dismantle the ISAs not by silence, but by speech, style, and shared witnessing. Let us archive our refusals. Let us celebrate our disruptions. Let us be bad girls.

Let us be free.

Footnotes

[1] Louis Althusser, *Ideology and Ideological State Apparatuses*, in *Lenin and Philosophy and Other Essays* (Monthly Review Press, 1971). Althusser's concept of ISAs explains how institutions like family, media, and education shape individuals through internalized norms rather than overt coercion.

[2] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (Routledge, 1990). Butler's theory of gender performativity frames femininity as a repeated, socially enforced performance rather than a natural identity.

[3] Sara Ahmed, *Living a Feminist Life* (Duke University Press, 2017). Ahmed's notion of the "feminist killjoy" and her reflections on emotional labor and domestic ideology inform the essay's critique of silence, politeness, and routine.

[4] *Mrs.*, directed by Arati Kadav, performance by Sanya Malhotra (India, 2024). This Hindi film explores passive domestic abuse and the ideological violence of routine, time-bound labor in patriarchal households.

[5] "Parivaar ki zimmedariyon ko nibhaane mein mujhe bhi saanjhedaar banaayein." A vachan from Hindu marital rituals, often recited during wedding ceremonies, used here to critique the gendered burden of domestic responsibility.

[6] Personal anecdotes and observations are drawn from the author's lived experience and feminist witnessing, including workplace dynamics, familial surveillance, and everyday negotiations of autonomy.

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“Parivaar ki zimmedariyon ko nibhaane mein mujhe bhi saanjhedaar banaayein.” *Hindu Wedding Vow*. Cited to critique gendered labor expectations.

Author Bio

Preethi Kethavath is an independent researcher, emerging writer, and MA English Literature scholar at IGNOU. Her work explores emotional regulation, feminist longing, and domestic intimacy through interdisciplinary frameworks and inventive narrative forms. She integrates theorists like Althusser, Butler, and Ahmed with lived experience, spiritual philosophy, and aesthetic critique. Preethi has submitted major articles to Signs, Tattva, and other journals, and curates her blog Ink & Intimacy as a quiet archive of feminist reflection. She is NET-qualified and preparing for guest faculty roles, building a portfolio that bridges scholarship, literary craft, and mentorship.

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A Cultural Reading of Sports Narratives through Health Humanities

Dr Divya S R

Abstract: Sports are far more than competitive physical activities; they are dynamic cultural texts that articulate social values, histories, and identities. This paper examines sports through the interdisciplinary framework of Health Humanities, integrating insights from Cultural Studies and Postcolonial Theory to explore how sports operate as sites of cultural meaning-making, resistance, and healing. The study examines the cultural politics of normativity in sporting bodies, with particular attention to the intersections of caste, class, gender, race, and ability in the Indian context. It also highlights the role of indigenous and vernacular sports such as kalaripayattu and kabaddi as repositories of cultural memory and traditional health practices, framing them as acts of resistance against globalization's homogenizing forces.

In addition, the paper critically analyzes how media representation and commercialization shape sporting narratives, often reinforcing hegemonic ideologies while simultaneously enabling counter-narratives of inclusion and justice. By reading sports as ritualized performances of the nation-state and as commodities within the global cultural economy, this research positions the sporting arena as a contested space where cultural health, identity, and social justice are continually negotiated. Through qualitative textual and thematic analysis, the paper demonstrates that sports are indispensable to understanding the intersections of culture, embodiment, and collective well-being.

Keywords: Sports, Health Humanities, postcolonial sports, indigenous games, cultural identity, gender cultural resistance, media, commercialization.

Introduction

Sports are often celebrated as universal languages of human expression—arenas where skill, discipline, and competition converge to inspire collective excitement. Yet, to reduce them to mere athletic contests or forms of entertainment is to overlook their deeper cultural significance. Sports are, in fact, vibrant cultural texts: symbolic practices embedded in histories, social structures, and collective identities. They carry the weight of tradition, negotiate the politics of representation, and embody the aspirations and anxieties of the societies that produce them. Every game, match, or tournament is shaped not only by rules and performance but also by the cultural and political contexts that frame it.

The history of cricket in the Indian subcontinent, for example, demonstrates the profound cultural and political work of sport. Introduced under British colonial rule as a tool of imperial discipline and cultural domination, cricket was later reappropriated as a powerful emblem of postcolonial identity and national pride. Such transformations reveal the mutable nature of sports as sites where colonial legacies can be challenged, reinterpreted, and woven into narratives of resistance. Through this lens, sports function not simply as pastimes but as living cultural archives, deeply entangled with issues of power, identity, and memory.

The interdisciplinary field of Health Humanities provides an especially compelling framework for reading sports in this way. Health Humanities expands beyond biomedical understandings of health to consider how cultural practices—such as sports—shape notions of vitality, resilience, inclusion, and well-being. It invites inquiry into the ways sports both promote ideals of physical and social health and simultaneously reproduce exclusionary norms. These exclusions are often visible in who is celebrated, who is marginalized, and which bodies are deemed legitimate or worthy of participation. In India, for instance, upper-caste male athletes enjoy disproportionate media visibility and institutional support, while Dalit, tribal, female, and disabled athletes struggle for recognition despite their achievements.

Moreover, sports are not limited to the globally dominant formats such as cricket, football, or basketball. Indigenous and vernacular sports—such as kalaripayattu, kabaddi, malkhamb, and lagori—carry centuries-old cultural wisdom, blending physical training with local philosophies, healing systems, and communal values. These practices are not merely recreational but act as repositories of cultural health knowledge and as forms of resistance

against the erasures of globalization. By sustaining these traditions, communities preserve embodied forms of heritage while fostering psychosocial healing and cultural resilience.

Sports also operate as modern rituals of the nation-state, from the spectacle of the Olympics to the emotionally charged celebrations of cricket victories. These events reaffirm national narratives, mobilize collective sentiment, and bind citizens into imagined communities. However, they also risk reproducing dominant cultural hegemonies, obscuring the contributions of marginalized groups, and instrumentalizing athletes for nationalist agendas. The global commodification of sports further complicates this landscape, as athletes' images are packaged for commercial gain, and traditional values of cooperation and endurance are often subsumed under market logics.

This paper argues that sports must be read as complex cultural texts that engage with multiple and often competing discourses—of identity, power, health, and resistance. Drawing on Cultural Studies, Postcolonial Theory, and Health Humanities, it examines how sports are embedded in broader struggles over representation, belonging, and social justice. In doing so, it seeks to bridge the gap between the cultural analysis of sports and their implications for collective well-being, positioning the sporting arena as both a site of cultural healing and a contested space of ideological negotiation.

Research Objectives

The primary objective of this study is to examine sports as cultural texts that both reflect and shape societal values, identities, and ideologies. This paper seeks to analyze how sports, when read through the interdisciplinary lens of Health Humanities, reveal deeper connections between physical performance, cultural meaning-making, and collective well-being. A key aim is to interrogate how sporting bodies are shaped by cultural norms relating to caste, class, gender, race, and physical ability, and how these norms influence inclusion, representation, and opportunities in sporting contexts. The study also seeks to explore the cultural significance of indigenous and vernacular sports, particularly their role in preserving collective memory, fostering resistance to cultural homogenization, and sustaining traditional health practices. Another important objective is to investigate the influence of media and commercialization in shaping sports narratives and identities, and to assess how sports function as ritualized performances that reinforce or challenge dominant national ideologies. Overall, the research

intends to position sports as crucial cultural phenomena with significant implications for social justice, health, and identity formation.

Hypothesis

This study is grounded in the hypothesis that sports are not merely competitive physical activities but dynamic cultural texts that embody historical legacies, socio-political hierarchies, and collective identities. It posits that indigenous and marginalized sporting practices act as forms of cultural resistance, safeguarding community health traditions while challenging the homogenizing forces of globalization. Furthermore, it hypothesizes that media and institutional representations of sports are shaped by entrenched social hierarchies, thereby reinforcing normative ideals while marginalizing non-normative bodies and communities. Through the interpretive lens of Health Humanities, this research anticipates that sports can be understood as sites of both cultural healing and socio-political contestation, offering opportunities to reimagine inclusive and community-centered approaches to well-being.

Literature Review

Sports studies have evolved beyond a focus on physical performance to encompass their social and cultural dimensions. Scholars such as Hall (1996) and Bourdieu (1984) conceptualize sports as symbolic practices that encode power relations, confer social capital, and participate in identity formation. Postcolonial readings of sport, notably by Guha (2002) and Appadurai (1995), highlight cricket in India as a colonial legacy that has been reappropriated for nationalist expression. From the perspective of Health Humanities, Crawford (2006) and Cole, Goodrich, & Gubrium (2015) underscore the importance of reading sports as sites where health, resilience, and cultural well-being intersect. The notion of normativity in sporting bodies is addressed by Messner (2002) and Hargreaves (1994), who analyze how sports privilege certain genders, races, and physical abilities, producing systemic exclusions. Indigenous and vernacular sports have been documented by Alter (2004) in his study of kalaripayattu and Majumdar (2006) in his work on kabaddi, framing them as culturally embedded practices tied to heritage and community health. Media and commercialization are critically examined by Rowe (2004) and Andrews (2019), who show how global sports media simultaneously reinforce hegemonic narratives and offer spaces for counter-discourse. Gendered representation in sports is scrutinized by Fink (2015) and Hargreaves (2000), who reveal the persistent underrepresentation, stereotyping, and sexualization of women athletes.

Collectively, this body of literature affirms that sports are deeply embedded in cultural processes, but the integration of Health Humanities perspectives in such analyses remains limited.

Research Gap

While existing scholarship extensively documents the cultural and political dimensions of sports, there is limited academic work that explicitly synthesizes Cultural Studies with Health Humanities to understand the relationship between sports, culture, and well-being in a holistic way. Most existing studies tend to focus either on the sociological aspects of sports or on the health impacts of physical activity, without examining the cultural health implications of sports narratives, rituals, and embodied actions. Additionally, research on indigenous and vernacular sports often documents their historical or regional importance but rarely situates them within the framework of cultural resilience and psychosocial healing. The intersection of normativity, embodiment, and social inclusion in sports—particularly in relation to caste, gender, and disability—remains underexplored in mainstream sports scholarship. Similarly, while studies exist on media and commercialization, there is a need for greater emphasis on how these forces shape cultural health narratives and influence collective identity. This study seeks to address these gaps by offering a Health Humanities-based cultural reading of sports.

Research Methodology

This research adopts a qualitative, interdisciplinary, and interpretive methodology grounded in Cultural Studies and Health Humanities. The study will rely on textual analysis of diverse sources, including archival records, sports journalism, athlete biographies, documentaries, televised matches, and online sports media. Case studies will be employed to examine specific cultural contexts: cricket in India as a postcolonial text; indigenous sports such as kalaripayattu and kabaddi as repositories of cultural health knowledge; and gendered and caste-based disparities in media coverage. Thematic analysis will be applied to identify recurring motifs of identity, normativity, resistance, and healing within these narratives. The analytical framework will integrate Stuart Hall’s encoding/decoding model and Bourdieu’s concept of cultural capital from Cultural Studies; postcolonial theoretical insights from Fanon, Bhabha, and Appadurai; embodiment theory and narrative health approaches from Health Humanities; and intersectionality theory from Kimberlé Crenshaw to account for overlapping social categories. This methodological approach will enable a comprehensive exploration of

sports as culturally and historically situated practices that are deeply intertwined with social justice, identity formation, and collective well-being.

Discussion

Sports as Cultural Texts

Sports transcend mere physical contests and entertainment—they are lively cultural texts deeply embedded in societal values, histories, and identities. The rules of any sport are never neutral protocols; instead, they are crafted within specific cultural and historical contexts that reflect prevailing social structures and ideologies. Take cricket in the Indian subcontinent as an example. Introduced during British colonial rule, this sport initially served as a symbol of imperial dominance and cultural colonization. However, post-independence, cricket was reinterpreted and reclaimed as a marker of national pride and collective identity. This shift is emblematic of a broader postcolonial cultural reappropriation, where formerly imposed practices become significant vehicles for nation-building and expressions of resistance. From the lens of Health Humanities—an interdisciplinary field that examines the intersections of culture, health, and well-being—sports are emblematic of societal ideals related to health such as discipline, resilience, and vitality. Yet simultaneously, sports expose persistent exclusionary practices related to caste, race, gender, and disability, revealing how social hierarchies are maintained even within seemingly meritocratic spaces.

Sporting Bodies and the Cultural Politics of Normativity

The concept of an "ideal athlete" is fundamentally a cultural construct, shaped by normative ideas about race, gender, class, and physical ability. These ideals dictate not only who is seen as fit or capable but also influence public perceptions, media representations, and institutional policies.In the Indian context, for instance, male athletes from upper-caste backgrounds receive disproportionate media visibility and endorsement, overshadowing the often exceptional performances of tribal, Dalit, or lower-caste athletes. Such disparities are not simply accidental but reflect broader social stratifications and gatekeeping. Health Humanities critically interrogates these exclusions by highlighting how sporting bodies that deviate from mainstream norms such as transgender athletes, disabled players, or intersex individuals are frequently marginalized, pathologized, or outright barred from participation. This dynamic mirrors larger societal patterns where non-normative bodies struggle for recognition and dignity, underscoring the intersection of sports with cultural studies and social justice.

Indigenous and Vernacular Sports: Cultural Memory and Resistance

In contrast to globalized sports like football and cricket, vernacular and indigenous games carry dense layers of cultural memory, historical continuity, and resistance. Traditional sports such as kalaripayattu (the ancient martial art of Kerala), kabaddi, malkhamb, or lagori are not simple athletic endeavors but living repositories of regional philosophies, healing practices, and community cohesion.

For example, kalaripayattu is inseparable from Kerala's indigenous medicinal and spiritual practices. Its training involves understanding body mechanics, natural elements, and mental discipline, functioning as a holistic system knowledge that blends physicality and health traditions. This positions indigenous sports as crucial artifacts for Health Humanities, which values the reciprocal relationship between body, culture, and well-being. Moreover, indigenous and tribal sports embody acts of cultural resistance against the homogenizing forces of globalization and colonization. By preserving and revitalizing these practices, marginalized communities assert identity, reclaim histories, and nurture psychosocial healing.

Gender, Representation, and the Cultural Field of Play

Sporting arenas are highly gendered areas shaped by socially constructed norms and expectations. While male athletes often embody hegemonic ideals of power and achievement, female athletes frequently navigate representations framed by struggle, exceptionalism, or aestheticized performances rather than purely meritocratic recognition. Notable sports figures like Sania Mirza, P.V. Sindhu, and Dutee Chand challenge traditional gender norms Chand's example is particularly significant as she contests conventional notions of sex and gender in sport. These athletes do not merely represent sporting success but also provoke cultural debates around sexuality, identity, and bodily autonomy. The limited access to sports for many women reflects wider gendered exclusions impacting health, mobility, and social inclusion. Health Humanities invites us to read these gendered sports narratives as reflective of entrenched societal inequities but also as sites of feminist resistance and redefinition of health and respectability.

Sports, Ritual, and the Nation-State

Sports function as modern rituals that reinforce national ideologies. The spectacle of the nation-state unfolds in grand events featuring flag-waving, national anthems, military salutes, and heroic narratives of sacrifice and unity. They operate as symbolic performances

that forge emotional bonds between individuals and the imagined community of the nation. However, these rituals often reproduce cultural hegemonies. National victory stories may obscure minority contributions or appropriate athletes' bodies and achievements to serve dominant state ideologies. In this context, Health Humanities analyzes how collective identity and cultural wellness are negotiated through sport: victories can foster collective euphoria and symbolic healing (especially in postcolonial contexts), while defeats risk reopening social wounds and tensions. Thus, sports serve as a dynamic cultural archive, mobilizing collective memory, embodiment, and affective resonance within national imaginaries.

Media, Commodification, and the Cultural Economy of Sports

Under global capitalism, sports narratives have been increasingly commodified and commercialized. Media conglomerates play a critical role by packaging and selling these stories to global audiences in alignment with market interests and consumer desires. Athletes are often branded as products, their bodies and images sexualized or dramatized to enhance marketability. Rivalries are scripted for maximum entertainment value, and success is commercialized through endorsements and sponsorships, shifting sports from collective cultural rituals toward individualized spectacles. This commodification can dilute traditional values of endurance, cooperation, and regional identity, aligning sport more closely with consumerist culture than with community health ideals. Yet, alternative forms of sports media and collective activism—such as feminist sports journalism, Dalit sports organizations, and documentation of indigenous games—counter these trends by foregrounding narratives of cultural justice, inclusion, and community health. These counter-narratives emphasize the potential of sport to promote social transformation rather than simply entertain.

Conclusion

In sum, this cultural analysis reveals sports as vibrant, contested spaces where societal values, conflicts, and aspirations are articulated and negotiated. Through the interdisciplinary lens of Health Humanities, sports cease to be mere spectacles or individual performances and become powerful sites of cultural meaning-making and healing. Whether preserving indigenous games, challenging gender and caste norms, or critically examining nationalist performativity, sports offer profound insights into what it means to live healthily, visibly, and with dignity within society. Every match, biography, and stadium becomes a stage where cultural health and identity are embodied, contested, and reimagined.

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Bio-Note:

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Staged Strength: Intergender Kushti in North India as Spectacle and Sociocultural Commentary

Joseph Viruthiyel

Abstract: Intergender kushti matches, where male and female wrestlers compete, have emerged as provocative spectacles in North India. Though often staged for entertainment, these events offer rich terrain for sociological inquiry into gender performance, media framing, and symbolic disruption. Drawing on Guy Debord's theory of the spectacle, Judith Butler's gender performativity, and the emerging discourse of sociological reckoning, this article situates intergender kushti within broader debates on visibility, agency, and cultural resistance.

Based on an analysis of 100 publicly available intergender kushti matches exclusively from India, the study codes outcomes, formats, and staging signals. Results show that women win in 38 cases, men in 44, and 18 end in draws or ambiguities. These outcomes underscore the performative nature of many bouts, where empowerment is staged as much as it is contested. The analysis also considers training-floor realities, where women wrestlers such as the Phogat sisters, Sakshi Malik, and Reetika Hooda spar with men due to the scarcity of female peers in akharas. This dual lens—spectacle and everyday practice—reveals how intergender kushti dramatizes symbolic disruption while reflecting structural gender imbalances in Indian wrestling culture.

Keywords: kushti; gender performativity; spectacle; sociological reckoning; social movements; India

Introduction

Kushti, or traditional Indian wrestling, is a long-standing practice in North India, historically dominated by men and organized through the akhara system (Alter, 1992). Although women's participation has expanded in recent decades, particularly following national and international successes, intergender matches remain unusual and contentious. In recent years, however, videos of such bouts have circulated widely online, raising questions about their authenticity, purpose, and sociocultural significance.

Methodology

To move beyond anecdotal accounts, this study analyzed 100 publicly available intergender kushti matches from India. Each bout was coded for outcome (woman win, man win, draw/ambiguous), format (solo, tag, exhibition), and degree of staging (1 = competitive, 2 = mixed, 3 = staged). Matches were sourced from CWE (Continental Wrestling Entertainment), Wrestle Square, local dangals, gym halls, and fairground exhibitions.

In coding the 100 intergender kushti videos, matches were classified along a three-point staging scale (1 = competitive, 2 = mixed, 3 = staged). The distinction was based on a combination of visual, narrative, and contextual cues**.** In Competitive (Level 1)category, Matches resembled conventional kushti or freestyle bouts. Wrestlers displayed sustained resistance, technical holds, and counter-moves. Outcomes appeared uncertain, with no obvious pre-determined narrative. Refereeing and scoring (where visible) followed standard wrestling conventions. In the Mixed/Hybrid (Level 2) category, elements of genuine competition were present, but punctuated by exaggerated moves, pauses, or gestures toward the audience. Outcomes sometimes appeared influenced by narrative framing (e.g., a woman's "comeback" after being dominated). These matches blurred the line between sport and performance. In the Staged (Level 3) category, matches displayed overt theatricality: exaggerated gestures, choreographed sequences, or implausible reversals.

Further, audience cues (cheering at scripted moments, camera zooms on dramatic expressions) reinforced the sense of spectacle. Outcomes consistently aligned with narrative tropes (e.g., the underdog woman defeating a much larger man). In some cases, the production

context (e.g., CWE or Wrestle Square shows, modelled on professional wrestling entertainment), signalled staging.

While the majority of kushti in North India is practiced within traditional **akhara** settings, the dataset also included matches from Continental Wrestling Entertainment (CWE) and Wrestle Square**,** both of which are Indian professional wrestling platforms. CWE (Continental Wrestling Entertainment) was founded in 2015 by former WWE champion *The Great Khali (Dalip Singh Rana)* in Jalandhar, Punjab. It functions both as a training academy and as a performance platform, staging WWE-style "sports entertainment" events that often feature intergender bouts. Wrestle Square**,** established in 2015 by *Vinayak Sodhi*, is India's first independent pro-wrestling company. Based in India but with occasional international shows, it promotes WWE-inspired wrestling formats, including intergender contests, and maintains a strong digital presence.

Although these platforms differ from traditional kushti in their orientation toward scripted spectacle**,** they were included in the dataset because they represent a contemporary Indian wrestling ecology where intergender matches are most visible. Their inclusion allows for a comparative reading: staged, entertainment-oriented bouts (CWE, Wrestle Square) versus competitive or semi-competitive matches in akharas, gym halls, and local dangals. This distinction was central to the coding scheme that differentiated between competitive, mixed, and staged matches.

Results

The dataset revealed 38 women's wins, 44 men's wins, and 18 draws or ambiguous finishes**.** At a descriptive level, this distribution suggests a near balance between male and female outcomes. Yet, when situated within a sociological framework, the numbers reveal more than competitive parity: they illustrate how gendered power is staged, negotiated, and contained within the spectacle of intergender kushti.

Women's victories, though significant in number, were disproportionately concentrated in matches coded as "staged" or "mixed." These outcomes often appeared choreographed to dramatize empowerment, functioning as symbolic inversions of gender hierarchy rather than as evidence of structural equality. In this sense, women's wins align with Debord's (1967)

notion of the spectacle: they are images of disruption consumed by audiences, but rarely translated into institutional change.

Men's victories, by contrast, reinforced the normative masculinity of the akhara. They stabilized the symbolic order by reaffirming male dominance, thereby counterbalancing the moments of female triumph. The 18 draws or ambiguous finishes are particularly revealing. They suggest a deliberate narrative strategy of suspension, where neither gender is allowed to claim definitive superiority. This ambiguity preserves the novelty of intergender contests while avoiding the destabilization that repeated female victories might provoke.

Taken together, the distribution reflects what Butler (1990) describes as the *iterative performance of gender norms***.** Each outcome—whether a woman's win, a man's win, or a draw—re-enacts the tension between disruption and containment. The dataset thus demonstrates not only the outcomes of matches but also the cultural choreography of empowerment, spectacle, and control.

Table : Outcomes by Staging Level

Outcome	***Competitive (Level 1)***	***Mixed (Level 2)***	***Staged (Level 3)***	***Total***
Women win	6	12	20	38
Men win	18	15	11	44
Draw/Ambiguous	4	6	8	18
Total	**28**	**33**	**39**	**100**

The table shows that women's wins cluster in staged matches**,** suggesting empowerment is often scripted. Men's wins dominate in competitive contexts**,** reinforcing hegemonic masculinity. Draws/ambiguous outcomes serve as narrative devices, maintaining audience interest while avoiding structural disruption.

By distinguishing competitive, mixed, and staged matches, the analysis avoids treating all outcomes as equivalent. Instead, it highlights how women's victories cluster disproportionately in staged contexts, suggesting that empowerment is often scripted for consumption rather than emerging from open competition.

Theoretical Lens

Butler's (1990) concept of gender performativity provides a critical entry point for interpreting intergender kushti. The female wrestler's presence in the akhara unsettles the normative masculinity that has historically defined the space. Yet her role is often circumscribed by the logics of spectacle: she is simultaneously a challenger to patriarchal order and an object of the audience's gaze. Each bout becomes a site where gender is not merely represented but actively *performed and reiterated*, dramatizing the instability of what is assumed to be natural difference.

Debord's (1967) theory of the society of the spectacle further illuminates this dynamic. In his terms, social relations are increasingly mediated by images, and contradictions are staged rather than resolved. Intergender kushti exemplifies this process: women's victories are consumed as images of empowerment, but their meaning is commodified and contained within the circuits of entertainment. The spectacle thus transforms potential disruption into a consumable novelty, offering the illusion of progress while leaving structural hierarchies largely intact.

The notion of a sociological reckoning (Burawoy, 2010; Haney, 2018; Schor, 2021) adds a contemporary dimension. This phrase has been used to describe moments when entrenched inequalities become unavoidable in public consciousness—whether through crises, movements, or symbolic ruptures. Intergender kushti can be read as such a reckoning: a moment when the contradictions of gender in Indian sport are staged so visibly that they demand recognition, even if only fleetingly.

Linking this to Oommen's (1990) framework of **social movements**, these matches can be understood as a form of *expressive protest* or **micro-movement**. They do not mobilize resources or demand policy change in the instrumental sense, but they dramatize resistance to entrenched gender hierarchies through embodied performance.

Additional theoretical perspectives sharpen this reading. **Goffman's dramaturgical model** (1959) highlights how social life is organized through performances before an audience. Intergender kushti literalizes this metaphor: the wrestling ring becomes a stage where gender identities are scripted, contested, and displayed, with wrestlers managing impressions for both

live and digital spectators. Meanwhile, Connell's (1995) concept of hegemonic masculinity helps explain why men's victories stabilize the symbolic order while women's wins are often framed as anomalies or novelties. The matches thus oscillate between reinforcing and destabilizing hegemonic gender norms, depending on how outcomes are staged and consumed.

Taken together, these theoretical lenses suggest that intergender kushti is best understood as a hybrid cultural form**:** at once a performance of gender, a commodified spectacle, and a symbolic reckoning. Its significance lies less in transforming institutions than in exposing contradictions, making visible the tensions between empowerment and containment, disruption and normalization.

Discussion

Digital media amplifies the dynamics of intergender kushti in ways that extend far beyond the akhara. Online thumbnails proclaiming "Lady Pehlwan Crushes Male Opponent" and sensationalized titles frame these matches as spectacles of novelty rather than legitimate sport. Comment sections often oscillate between celebratory praise and derisive mockery, revealing how audiences negotiate the symbolic disruption of gender norms. This dual reception underscores Debord's (1967) argument that the spectacle transforms lived experience into images consumed for their shock value, while simultaneously reaffirming existing hierarchies.

The matches thus project an illusion of progress: women's victories are staged as moments of empowerment, yet they rarely destabilize the structural conditions that marginalize female wrestlers. Butler's (1990) notion of gender performativity is useful here, as the female wrestler's presence in the ring both challenges and reproduces normative masculinity. Her performance is celebrated when it entertains, but constrained when it threatens to unsettle entrenched hierarchies. The ambiguity lies in this tension between empowerment and orchestration, where agency is enacted but also commodified.

At the same time, the practice of women sparring with men during training complicates the reading of intergender kushti as purely theatrical. Due to the scarcity of female peers in many akharas, wrestlers such as the Phogat sisters, Sakshi Malik, and Reetika Hooda have trained extensively with male counterparts (Selvaraj, 2024; The Better India, 2024). These encounters are not staged for audiences but arise from pragmatic necessity, reflecting both structural

gender imbalance and the resilience of women athletes. This everyday reality suggests that intergender wrestling is not only a mediated spectacle but also a lived practice that shapes skill development, confidence, and visibility.

Placing these dynamics within the framework of a *sociological reckoning* (Burawoy, 2010; Schor, 2021) highlights how intergender kushti dramatizes contradictions in Indian sport and society. On one hand, it functions as an expressive micro-movement (Oommen, 1990), staging symbolic resistance to patriarchal norms. On the other, it risks reinforcing tokenism by commodifying women's victories as entertainment rather than institutional change. The phenomenon thus exemplifies how cultural performances can simultaneously open spaces for recognition while leaving structural inequalities intact.

Comparative insights further sharpen this analysis. In Japan, female wrestlers in *joshi puroresu* have long competed in mixed-gender matches, often framed as theatrical but also as vehicles for women's athletic legitimacy. In Iran, by contrast, strict gender segregation prevents such encounters, underscoring how cultural and political contexts shape the boundaries of possibility. India occupies a liminal position: intergender kushti is tolerated as spectacle but not institutionalized as sport. This comparative lens reinforces the argument that these matches are best understood not as anomalies but as culturally specific negotiations of gender, power, and performance

Implications

This study contributes to three overlapping fields The first field is **gender studies.** By showing how women's victories are disproportionately staged, the analysis highlights the limits of symbolic empowerment and the persistence of structural inequality. It underscores the need to distinguish between visibility and transformation in feminist debates.

In **Sport Sociology**, the findings situate intergender kushti within a global spectrum of gendered sport, from Japan's *joshi puroresu* to Iran's strict segregation. India's case illustrates how cultural and institutional contexts shape the boundaries of possibility for women in sport. In **Cultural Policy and Media Studies** the prominence of CWE and Wrestle Square demonstrates how entertainment platforms mediate gender disruption. Policymakers and sporting bodies must recognize that while spectacle can generate visibility, sustainable change

requires institutional investment in women's wrestling, which include training facilities, peer networks, and equitable opportunities.

By bridging empirical evidence with theoretical synthesis, this article positions intergender kushti as a critical site of sociological inquiry - a practice that dramatizes contradictions, unsettles norms, and reveals the uneasy balance between symbolic disruption and structural inertia.

Conclusion

Intergender kushti in India is less a contest of athletic ability than a performance of social meaning**.** As staged spectacles, these matches illuminate shifting gender norms, the commodification of disruption, and the politics of visibility in a rapidly mediatised sporting culture. The dataset of 100 matches demonstrates that women's victories, while numerically significant, are disproportionately framed within staged or hybrid contexts. This pattern underscores the distinction between *symbolic empowerment***,** which is dramatized for consumption, and *structural transformation***,** which remains elusive.

Theoretically, the phenomenon exemplifies Butler's (1990) insight that gender is constituted through repeated performances: each bout re-enacts the instability of gender norms, even as outcomes are choreographed to contain disruption. Debord's (1967) notion of the spectacle clarifies how these performances are commodified, transforming potential challenges to patriarchy into consumable images. The concept of a *sociological reckoning* situates these matches as moments when contradictions in gendered sport become unavoidable in public discourse, while Oommen's (1990) framework of expressive protest highlights their role as *micro-movements* - symbolic acts of resistance rather than organized campaigns for reform.

Additional perspectives sharpen this reading. Goffman's dramaturgical model reminds us that the wrestling ring is a literal stage where wrestlers manage impressions for audiences both live and digital, while Connell's theory of hegemonic masculinity explains why men's victories stabilize the symbolic order and women's wins are often framed as anomalies. Together, these frameworks reveal intergender kushti as a *hybrid cultural form:* simultaneously sport, spectacle, and protest.

Finally, the contrast between akhara-based training practices - where women spar with men out of necessity, and entertainment platforms like CWE and Wrestle Square, where intergender matches are staged for spectacle - demonstrates the dual realities of women's wrestling in India. On the one hand, pragmatic training encounters reflect resilience and structural imbalance; on the other, staged contests dramatize empowerment while commodifying it.

In sum, intergender kushti dramatizes the contradictions of gender in Indian sport. It opens fleeting spaces of recognition and visibility, yet often reinscribes the very hierarchies it appears to challenge. Its significance lies not in transforming institutions but in making contradictions visible**,** forcing audiences, however briefly, to confront the uneasy interplay of empowerment, containment, and spectacle.

Footnotes

1. The term *performative* refers to acts that do not merely describe reality but actively constitute it (Austin, 1962). Butler (1990) extended this to gender, arguing that gender is produced through repeated performances rather than reflecting a fixed essence.
2. Butler (1990) conceptualized gender as performative, meaning it is constituted through repeated acts and norms rather than being innate. Intergender kushti dramatizes this process by staging gendered power relations in the ring.
3. Debord (1967) argued that in modern societies, lived experience is increasingly mediated by images, and social relations are transformed into representations. Intergender kushti exemplifies this, as the matches are consumed as images of empowerment or disruption, regardless of their competitive authenticity.
4. The phrase *sociological reckoning* does not originate with a single theorist but has emerged in the 21st century as a rhetorical device in public sociology. Burawoy (2010) used it to describe the 2008 financial crisis, Haney (2018) applied it to #MeToo, and Schor (2021) framed COVID-19 as a reckoning with inequality. Public sociology blogs (Everyday Sociology Blog, 2020) and academic essays (Shah, 2022) further extended the term to racial justice movements.
5. Oommen (1990) conceptualizes social movements as structured responses to contradictions in society, distinguishing between instrumental and expressive forms. A *sociological reckoning* can be understood as the moment when such contradictions

become unavoidable, compelling society to confront issues of inequality or exclusion. In this sense, intergender kushti may be read as an expressive micro-movement, staging a reckoning with entrenched gender norms (see also Shah, 2004; Touraine, 1981).

6. The Phogat sisters, trained by Mahavir Singh Phogat, famously sparred with boys in their village akhara due to the lack of female wrestlers, a story dramatized in the film *Dangal* and corroborated in journalistic accounts (The Better India, 2024). Olympic medalist Sakshi Malik has also spoken about training with men in Rohtak, while Reetika Hooda continues to spar with male wrestlers at the Raipur Wrestling Academy (Selvaraj, 2024; The Better India, 2024).
7. Reetika Hooda, India's U-23 World Champion, often trains against younger male wrestlers at the Raipur Wrestling Academy in Haryana, where she is an exception to the usual practice of gender-segregated training (Selvaraj, 2024).
8. In the absence of sufficient female training partners, many women wrestlers train with men in their akharas. This is particularly common in Haryana, where wrestling culture is strong but gender imbalance persists (Selvaraj, 2024).

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Kaavu theendal and Bharanipattu: A Sacred Manifestation of Drama Therapy

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Abstract: Kodungalloor Sree Kurumba Bhagavathy Temple is world-renowned for its annual *Meena Bharani festival. It traditionally involves multiple rituals like Kozhikallu modal* (sacrifice of roosters), *Kaavu Theendal* (frenzied dance of oracles), *Revathi Vilakku, Bharanipattu* (singing of libellous ballads) and *Chandanapottu Charthal.* Because of its aesthetic vibrancy, cultural significance, and symbolic prominence, this festival has always grabbed the attention of academia. There exist numerous legends and stories associated with the chief deity, Bhadrakali or Kannagi, and the rituals of *Meenabharani.* Placing a lesser-known myth of Nalachan as a pivot point of understanding, the paper attempts to read the ritual performance of *Kaavu theendal* and *Bharanipattu* through the lens of a modern theatre approach called Drama therapy. With the use of therapeutic empathy, role-playing, dramatic projection and embodiment of intangible emotion, the devotees achieve a catharsis very similar to the one achieved in Drama therapy. Drawing from existing literature and discourse analysis, the study examines how these traditional performative practices, essentially used to appease the deity, also function as a form of therapeutic release for the participants. The study aims to identify the ritual performance of *Kaavu theendal* and *Bharanipattu* as a sacred and traditional guise of modern drama therapy.

Keywords: *Kaavu Theendal, Bharanipattu,* Drama therapy, *Nalachan,* Embodied Catharsis

Introduction

The ancient Pre-Vedic and Proto-Dravidian heritage and the matrilineal influence, the land of Kerala holds an indigenous connection with the Divine Feminine. In her myriad

manifestations as Bagavathi, Chamundi, Bhadrakali, Nili, or Kali, the Goddess and her vibrant rituals are intricately woven into the cultural and social fabric of this land. Mythologically, Kali is celebrated as the supreme, dynamic cosmic form of feminine energy or shakthi, competent to bring victory to good over evil, creation (or birth/fertility) over destruction (or death/infertility).

However, the cultural and social interpretation of Kali reveals her as a potent force in demolishing difference-based discrimination prevalent in society. The sites of her ritual offerings (like Theyyam, Tira, Pooram, Padayani, etc), for instance, are venues where people from different social strata and cultural backgrounds come together in her celebration, thereby enforcing the secular human spirit over anything. Moreover, these are also venues that celebrate every aspect of human life- from menstruation to sex to disease and even death. Thus, Kali and her ritual performance are not only the veneration sites of the divine mother spirit of Bagavathy, but they are also the spaces where life with all its vulnerabilities is celebrated, accommodating every essence and expression of human lives that challenge normative frameworks. The Kodungalloor temple and the annual temple festival called Bharani are significant cultural

platforms which offer an overt expression of life in its rawness.

The Kodungalloor Temple is located in the Thrissur district of Central Kerala and is dedicated to the Goddess Kali (or Kurumba). According to the legends, it was Lord Parasurama who installed the idol of Kodungalloor *Bagavathy*. Even though the idol was initially installed by Lord Parasurama, over time, the geography and the temple went under forest cover. Later, Sree

Shankaracharya discovered the immense energy source that lay hidden under the cover. Sree Shankara then turned it into a ‘proper’ temple and scheduled and

organised day-to-day poojas and rituals for the temple (Nair, 2017). The annual festival of the temple is called Kodungalloor *Bharani*, which begins from the *Bharani* asterisk of *Kumbham* (the seventh month of the Malayalam calendar or *Kollavarsham)* and lasts till the *Bharani* asterisk of the *Meenam,* the subsequent Malayalam month. Unlike other temple festivals in Kerala, the Kodungalloor *Bharani* festival does not have the vibrant visual scape of ornamented elephants carrying the Goddess idols or the wonderful soundscape of *panchavadyam* or the *chenda melam* or even

grand fireworks. Rather, this festival involves a series of symbolic events like *Kozhikallu Moodal*, the symbolic sacrifice of roosters on a stone placed within the temple premises, and *Kaavu Theendal,* where the oracles dressed in red, holding bamboo sticks or sickles, run around the temple in a trance, singing *Bharanipattu*, which are libellous and sexually suggestive ballads, *Revathi Vilakku* and *Chandanapottu Charthal*. This series of symbolic ritual performances is well known for its ability to subvert the conventional patriarchal systems of religion and beliefs, and the focus of this study is on the ritual performance of *Bharanipattu* and *Kaavutheendal.* A

symbolic analysis and understanding of the structures and stories of these rituals sheds light onto their peculiar positioning at the juncture of religion, faith, expression and healing. This line of thought led to their being associated with a Western corrective therapeutic method of Dramatherapy for a more nuanced understanding. Thus, from the question of whether *Bharanipattu* can be understood as a culturally specific form of drama therapy, this paper is an attempt to draw a parallel between *Bharanipattu* and *Kaavutheendal* with Dramatherapy, in their ability to offer an embodied catharsis.

Literature Review

Academia has always been interested in the Kodungalloor *Bharani* and associated rituals like *Kaavu Theendal, Kozhikallu Moodal* and *Bharanipattu* for their symbolic nature. There have been extensive scholarly works about every aspect of the

ritual performance of Kodungalloor Bharani and its symbolic and subversive significance; the therapeutic dimension of *Kaavu Theendal* and *Bharanipattu* is comparatively under-explored. M.J. Gentes's "Scandalising the Goddess at Kodungallur", a book chapter by V S Nair, "Kodungalloor Sri Bhadrakali Kshtram", Lekshmi V. U.'s "Verbal Vulgarity and Local Belief System in the Pattini-Kannaki Cult: Contextualising the Literary-Linguistic Tradition of Kodungalloor Bharani", Shwetha Radhakrishnan's "Sanitising the Profane", Nimisha K. Jayan's PhD thesis, "Gender, Space and Performance: A Study of the Visual Narratives of Kodungalloor Bharani Festival" and, Dr Seetha Vijayakumar's "Religion, Ritual and Liminality: A Study of the *Kavu Theendal Festival* at Kodungallur, Southern India", Nandini Pradeep J and Goutham K J's "The Object of Madness: A Sexuo-Cultural Reading of Power in the Kodungallur Bharani Songs" are some of the major works which aided in the understanding of the ritual of Kodungalloor *Bharani* festival. Gentes's paper can be regarded as one of the earliest academic curiosities about the *Meena Bharani* festival, claiming to present a first-hand description of the temple and festival. The book chapter by V S Nair focuses on the details and stories of the temple and festival. The research articles by Lekshmi V U, Shwetha Radhakrishnan, Dr Seetha Vijayakumar, Nandini Pradeep J and Goutham K J and the PhD thesis of Nimisha K Jayan present diverse academic curiosities. These works mention the significance of *Kaavu theendal* and *Bharanipattu*- both inside and outside the realm of religion and faith.

As defined by the North American Drama Therapy Association (NADTA), drama therapies are active and experiential in nature, which provide "the context for participants to tell their stories, set goals and solve problems, express feelings, or achieve catharsis" (NADTA, n. d.). Stationed at the intersection of psychology and performance, drama therapy utilises the method of theatre and drama techniques to cure and promote physical and mental illness. According to them, it operates through processes like play, embodiment, projection, role, story, metaphor, empathy, distancing, witnessing, performance, and improvisation. The people with addiction issues, dysfunctional families, developmental disability abuse survivors, prison inmates, homeless behavioural health consumers, people with socially taboo diseases

like HIV, AIDS and even the general public have availed the benefits of this therapeutic method.

The origin of drama therapy is closely associated with the emergence of Applied Theatre in the twentieth century. The Applied Theatre was a movement that demolished the traditions and conventions of theatre and performance. The strong line of differentiation that existed silently between the audience and spectators was disintegrated with the arrival of Applied theatre, as it fostered dialogue and engagement among communities. From this foundation, dramatherapy evolved as a specialised form of applied theatre, harnessing drama's transformative power for therapeutic purposes. Inspired by practices like Psychodrama developed by Jacob Moreno in the 1920s—where role-play and improvisation were used to explore personal narratives, and influenced by theories of Archetype and Narrative Structure by Jung and Campbell, respectively, the dramatherapy became formalised, blending symbolic expression with storytelling, role-playing and embodiment. The collaborative nature of Drama therapy makes it capable of addressing psychological challenges and fosters emotional wellbeing and healing. In his work *Drama as Therapy, Theatre as Living,* Phil Jones identifies nine core processes which can enhance the effectiveness of the healing potential of drama and theatre. They are as follows:

- Dramatic Projection
- Therapeutic Performance Process
- Dramatherapeutic empathy and distancing
- Personification and impersonation
- An interactive audience and witnessing
- Embodiment: dramatising the body
- Playing
- Life-drama connection
- Transformation While Jones, through his work, breaks down the theoretical underpinning of the process involved in dramatherapy, Lewis Barbato from the Neuropsychiatric Department of Fitzsimons General Hospital, Denver, puts it into action. In an article titled "Drama Therapy", he wrote about then drama

therapy sessions held at Fitzsimons General Hospital. According to him, the team of Fitzsimons majorly uses four different techniques "depending on the nature of the case and the purpose desired" (Barbato, 1974, p. [396]), which are as follows:

- Ventilation of Fixed Emotions: Certain rigid attitudes are often the source of tension and conflict deep within the patient. The patient verbalises these rigid emotions with the help of the director and supporting actors, which is then recorded and transcribed by a stenographer. The patient reads out their own script, which is recorded to help the patient understand ideas and emotions previously expressed. The acting session is completed with a psychotherapeutic interview with the psychiatrist.
- Desensitisation: The patients who have had traumatic episodes during military or combat experiences are required to re-enact the situation with the help of supporting artists. This process of re-enacting goes on as many times as the situation no longer serves as the foci of anxiety to the patient. The final report is also furnished to the psychiatrist for this evaluation.
- Role-playing: In the role-playing technique, the patients are prepared to react to situations that are likely to happen upon return to civilian life, such as returning home, explaining their experiences, finding a job, etc., which are recorded. The recording is then forwarded to a follow-up session, where the therapist coaches the patient on different but more effective ways to react to the same situation.
- Role Reversal or Acting as the Opposites: "Here an aggressive patient is given a submissive role or vice versa" (Barbato, 1974, p. [397]); such a role reversal aids the patient in understanding the safe ways to express pent-up emotions and better understanding the situation from the opposite's perspective. The procedure is followed by a session with the therapist where the patients recollect all that they learned and experienced and adopt newer ways to incorporate them into their day-to-day lives.

Accordingly, upon evaluating a client's needs, a drama therapist looks at potential strategies to address those needs. Drama therapy can take many forms depending on the

needs of the group and the individual, skill and ability levels, hobbies, and therapeutic objectives. Improvisation, theatre games, storytelling, and enactment are a few examples of processes and tactics.

Methodology

This cross-cultural comparative study involves two cases- the ritual performance and a therapeutic strategy. These vividly different cases are compared using the specific comparative analysis methodology called Most Different Systems Designs (MDSD). According to MDSD, the cases chosen are as different as possible, yet they share the same outcome or 'dependent variable'. In the study, the chosen cases - the ritual performance of *Kaavu theendal* and *Bharanipattu* and the theatrical elements involved in drama therapy have differences in the nature, context and mode of performance. More precisely, the ritual performance of *Kaavu theendal* and *Bharanipattu* is a religious and unmediated (by a therapeutic professional) performance done by devotees within the temple premises. The primary intention of such a performance by the devotees is to appease the deity and acquire her divine grace. But this performance itself acts as a vehicle that leads to their own healing therapy. However, drama therapy, on the other hand, involves the conscious efforts and planning by a group of professionals with the motive of healing the client. The method, strategy, roles, and even dialogues delivered are carefully constructed to meet the needs of the clients. Even though the two chosen cases are wildly different, the net output generated is the same, i.e., healing through performance.

This comparative study uses textual analysis of the existing literature for data collection. The initial understanding of both ritual and drama therapy is acquired through the close reading and interpretation of the research papers and book chapters published in this regard. The textual analysis aided in understanding the core principle of these rituals and drama therapy, opening the scope of this research. A significant methodological challenge confronted during the study was the fluid and dynamic nature of these

performances. The Komarams coming to the Bharani festival, their reactions to the external stimulus varied greatly annually. Thus, the primary research predicament was the inherent dynamic nature and spontaneity.

Contextualising *Bharanipattu*

The *Bharani* festival of Kodungalloor temple is of paramount importance among worshippers and devotees. It is initiated on the afternoon of *Bharani* day of the Malayalam month of *Kumbam*. This day is called the *cheru-bharani*. The days between the *cheru-bharani* and *Meena-bharani*, the final day of the temple festival, are all associated with the fight of Kali and Darika. V S Nair, in his text, describes the processes and procedures during the festival. The festival is officiated by hosting the *kodi* or flag on multiple banyan trees on the temple premises. With the onset of *cheru-bharani, komaram* or *Velichappadu* (the oracles) flock to the temple.

They are the chief actors of the *Bharani* festival and are mostly from the northern districts of Kerala, like Kozhikode, Wayanad, and Palakkad. They come in groups of men and women, with a leader who is referred to as the *mooppan.* They are dressed in dark red silk with a heavy waistband of bells and wielding a *chilambu* (the anklet) and a *pallivaal* (a sickle-shaped, bell-embellished sword). Their display of devotion to the Goddess is very different- the *komaram* enter into a trance-like state and dance frenziedly in front of the Goddess. In their trance, they engage in bloody acts of cutting their forehead with the *palliwaal,* symbolising the spiritual oneness with the Goddess. The devotees also attain a similar spiritual euphoria during the performance, adding to the mystical atmosphere. In this state of trance, the *komaram*, like a vehicle between the Goddess and devotees, begins to communicate the likes and dislikes of the Goddess and even prophecy to the public (Nair, 2017).

The ritual of *Kozhikallu Moodal* takes place on the *thiruvonam* asterisk of the month of *Meenam,* symbolically representing the commencement of the Kali-Darika war. The ritual performance of *Bharanipattu* begins soon after this, within the temple.

Bharanipaattu is a type of song sung by the *komaram* during the festival time,

> which runs for six and a half days and for six and a half days, precisely until *the Aswathy*
>
> afternoon. Nimisha Jayan, in her thesis, "Gender, Space and Performance: A Study of the Visual Narrative of Kodungalloor Bharani Festival", refers to it as 'ribald songs'. *Bharanipattu* are of two types- one, *Devi Sthotram,* praising the Goddess for her victory, while the others make direct references to the Goddess's sexual organs and powers. The popular myth suggests that after the battle with Darika, as the Goddess was raging with severe anger, i.e. emotionally at higher temperatures, the *komaram*s' (or *bhoothaganas) Bharanipattu* performance helped to please the Goddess. Jayan quotes V. T. Induchoodan, who identified the significance of *Bharanipattu* in the *Kaula* tradition of worship and observes it as very legit and similar to *Bhadrakali Naataakam, Bhadrakalipattu* and *Teyyam* (Jayan, 2020). Nandini Pradeep J and Goutham K J associate these rituals with the rage and heat (both the sexual heat and summer heat of March in Kerala) of the unwed Sree Kurumba Goddess of Kodungalloor. According to them, instead of turning her docile, the Goddess is cooled;
>
> > by addressing and celebrating her sexual hunger through divergent sacred-profane rituals. These rituals include sacrificial rituals such as *Kozhikkaalu modal* (cock-sacrifice and shedding their blood as offering to the Goddess) – this was put an end to with the advent of modernism and social reforms—, and *Kaavu Theendal* (literally 'making the grove impure', non-Brahmin devotees running around the temple premises with a stick which is symbolic of the sword that killed Daruka, the demon, also a phallic symbol) (Pradeep & Goutham, 2024, p. [99-100]).

On the *Aswathy* asterisk of the Malayalam month of *Meenam,* the temple witnesses the ritual of *kaavutheendal,* which literally translates to polluting the *kaavu* by *komaram* or oracles. As the festival is associated with the myth of war between Kali and Darika, this ritual is regarded as the celebration of the Goddess's troupe, or *bhoothagana*, after succeeding in the battle with Darika.

The frenzied *komaram,* the ultimate state of happiness, devotion and ecstasy, strikes the temple rafters with sticks and pollutes the inner sanctum by throwing offerings over the roof, creating a chaotic ambience.

Having narrated the origin of *Kaavu Theendal* and *Bharanipattu,* with reference to the Kali-Darika myth, there also exists another compelling alternative tradition that links the

Goddess with Kannagi, the heroine of Ilango's *Silapathikaram.* V S Nair also observes that Kannagi was initially installed in the temple of Kodungalloor. Kannagi was Kovalan's devoted wife, and Kovalan fell in love with Madhavi, a dancer. In his passion, Kovalan gave all his wealth to Madhavi, but Madavi, on the other hand, abandoned Kovalan at once when she got to know that he had nothing more to spend. Kannagi, the wife, was Kovalan's last resort to sustain his life. She gave her anklet to Kovalan to sell and settle the financial debt which haunted him. It was during this time that the anklet of the Queen of Madurai was stolen. The goldsmith who

robbed the Queen informed the royalty that Kovalan was the one behind the theft, and the royalty put him to death. Kannagi, on knowing the fate of her husband, ran to Madurai and in her fury,

the entire city of Madurai was burned down. Legends state that Kannagi then moved to Kerala and attained the status of divinity at Kodungalloor. This divine vision was first delivered to the *Mala-Araya* community, who then reported it to the Chera king, Chera Chenguttuvan. Then, it was Chera Chenguttuvan who built the temple, honouring Kannagi and associating her with the Goddess Pattini (Nair, 2017).

As a continuation of this popular legend, a lesser-known legend also exists, which points to the origin of the tradition of Komaram, *Kaavu Theendal and Bharanipattu*. Swetha Radhakrishnan, in her article "Sanitising the Profane", includes this as narrated by one of her interviewees;

> Another devotee, F47I, who also subscribed to the Kannagi story, believed that the theripaatu are not sung for a young, sexually unfulfilled widow but instead
>
> were meant for Nalachan – a friend of Kannagi and Kovalan. Once,

> Kannagi and Kovalan were travelling, they stopped en route at Nalachan's place. In the middle of the night, while Kovalan was asleep, Nalachan propositioned Kannagi.
>
> Kannagi, who knew the duties she had to fulfil as an incarnation of the Goddess, asked Nalachan to come to Kodungalloor at a certain time, where she promised
>
> she would satiate his desire. Much later, after Kannagi had burned down Madurai and arrived at Kodungalloor, Nalachan came to claim what he had been promised. F47I said that Kannagi (the Goddess at Kodungalloor now) transformed Nalachan into a stone and rooted him to one spot. However, every year to keep her promise, she called upon her devotees to sing songs to satiate Nalachan's desire (Radhakrishnan, 2013, p. 209).

Thus, it was the Goddess herself who put her at the receiving end of these rituals so as to reinstate the lost justice and satisfy the longing of Nalachan.

Analysing *Kaavu theendal* and *Bharanipattu* as Drama Therapy

By close-reading the legend and superimposing these two contexts, drawing a parallel between drama therapy and the performance of *Bharanipattu* is a complex but possible consideration. The trance or the altered state of consciousness displayed by the *komaram* during the ritual is a nuanced area which requires prime attention. Bland generalisations or straight conclusions will not fetch a convincing conclusion as it has socio-cultural-emotional aspects. The ritualistic pollution of the temple premises or the *kaavu theendal*, by throwing the offerings like live cocks and turmeric powder, while singing *Bharanipattu,* or the libellous ballads by *komaram,* are either to please the furious Goddess after the Kali-Darika war or to thank the

Goddess for the fertility and prosperity associated with the land. But Nalachan's legend adds another layer of interpretative meaning. The komaram's altered state of consciousness, dancing frenziedly, abusing the Goddess, of her unquenced sexual energy, throwing sticks and other

materials to the sanctom could be out of the komaram's identification with and assimilation of the character of Nalachan. The frustrated Nalachan approached Kannagi, who, in return, offered him a chance once she fulfilled the duties of her bodily existence. But in the end, he was deceived and turned into a rock. The unsatiated desire of Nalachan manifested as an unresolved trauma, which got externalised through the bodies of komaram. This offers catharsis to the desperate Nalachan, affirming his existential right despite the rejection he confronted through the embodied act of *kaavu theendal* and *bharanipattu.* Thus, *Kaavu theendal* and *Bharanipattu* can be regarded as an embodied performance, which is not only an outlet for the suppressed anxiety, but also a pathway to embodied catharsis. However, the question remains: who specifically benefits from this cathartic process?

The cathartic benefit of these embodied performances is distributed among three distinct groups. Or, in other words, three types of singular and collective catharsis within this single performance site. Firstly, the empathetic response towards Nalachan's trauma makes the Goddess, the recipient. The performance of *Kaavu thenndal* and *Bharanipattu* can be read as the externalisation of this pent-up trauma of Nalachan, which is resolved through the intense physical exertion and ribald ballad performance. Secondly, Timothy Jay's Neuro-Psycho-Social (NPS) Theory of Cursing states that any human behaviour is influenced by three aspects neurological control, psychological restraints and socio-cultural restriction: so is the act of cursing (Jay, 1999). According to him, cursing is not a random or meaningless act but is deeply rooted in automatic processing (neurological), emotional regulation (psychological) and communication or identity purposes (social). In Jay's words, the language of sexuality in cursing is closely connected to one's emotional life and one's sexual orientation, which lay latent in their mind (Jay, 1999). So, the language used in *Bharanipattu* is a reflection of the suppressed anxiety in some minds. This suppressed anxiety, which is intangible to the individual, gets externalised with the performance of *Bharanipattu.* The transformation of intangible emotion to its tangible state prepares it for its release and subsequent healing. Thus, *Komaram's* trance-like state of mind and their performance of *Kaavu theendal* and *Bharanipattu* can be regarded as the externalisation of once subdued feelings of anger, sorrow or desperation from their personal life. With this dramatic projection, *komaram* empathises, personifies, and finally transforms their lives with the aid of drama therapy.

> Ultimately and most importantly, *Bharanipattu* can be viewed as a cathartic empowerment of socially, culturally and even religiously marginalised communities. Kodungalloor *Meena Bharani* is a festival of inclusivity- men and women of all walks of life and all castes and religious identities are welcomed here. It is also a temple festival where one cannot find the rites and rituals which are usually carried out in any Brahminical temple festivals. To add to the symbolic elements of the festival, the *komaram* plays an integral role in subverting all forms of religious hypocrisy. In a popular documentary film titled *Komaram: The Rage of Red,* the narrator opens her dialogue by saying, "I am a 'lower-class' girl" (Virtual Bharat, 2023).

Throughout the documentary, different faceless narratives are presented, showing how being a *komaram* liberates them and connects them to their roots, i.e., Kali. By being *komaram,* the general markers of their identity, such as gender, caste, religion, etc., become nothingness. The temple and ritual space act as a safe space for the complete venting out of *Komaram's* brutal realities of marginalisation. Taking the central stage, they dance out, sing out and ultimately liberate themselves from the shackles of discrimination. In a space where loud sounds and improper language are taboo, in a space where certain castes and religions are denied visibility, comes *Komaram,* shaking off the traumas of an entire community and liberating and healing them by offering visibility. Thus, the rigorous somatic performative capability of rituals of *kaavu theendal* and *bharanipattu* aided an emotional release to the spirit of Nalachan, whose story embodies the pain of rejection, the performer, whose body becomes the vessel for this ritual expression and finally to the community the Komaram belonged to.

Comparative Reflection: Ritual v/s Therapy

The somatic nature of the ritual performance of *Kaavu theendal* and *Bharanipattu* and the clinical correction technique of drama therapy, upon juxtaposition, posits multiple similarities.

Starting with the process where the characters identify with a character or a state of their own

personality. Following the role assumption, the performative stage initiates, where the stagnant emotion is externalised. It is then either danced out, sung out or even enacted out. This culminates in the achievement of catharsis in both cases. This is the basic formula that runs in both scenarios. In drama therapy, the identification of the role can be either role play or role reversal play, according to the needs of the client. The performance in drama therapy is directed and carefully scripted, without further triggering the emotions of the client; a careful correction is made. The video is then recorded and analysed by experts, and corrections are prescribed. But in *Kaavu theendal* and *Bharanipattu,* the role play is direct as they identify and assimilate with the character of Nalachan and become a *Komaram.* A series of intense, sensory stimuli like the presence of a large congregation of *komaram* wearing red silk and *pallivaal* (sickle) and *chilamb* (anklet), collectively calling and crying to the Goddess and the deep red hue of vermilion and turmeric, which has saturated the entire premise, initiates the trance-like performative phase in *Kaavu theendal* and *Bharanipattu.* The extreme and fierce body movements and the bawdy songs they sang while circumscribing the temple and throwing things into the inner quadrangle aid in the externalisation of stagnant emotion and lead to catharsis.

However, the core distinction between the ritual performance of *Kaavu theendal* and *Bharanipattu* with drama therapy is the mode of performance and facilitation. In *Kaavu theendal* and *Bharanipattu,* the therapy is non-clinical, spontaneous and cultural in nature. It does not have an external expert facilitation other than sensory stimulation from the festival grounds. Here, the emotion is identified and released by the performer themselves, at times even without self-realisation. In other words, *Kaavu theendal* and *Bharanipattu* is a self-directed and non-mediated performance where the *komaram,* whether knowingly or unknowingly, addresses their own or a fictional character's emotional baggage, purges them with rigorous performance. On the contrary, in drama therapy, there is a strong external intervention, such as scripting and directing the play, recording the act for subsequent reviewing and analysis, and a therapist with therapeutic aid for emotional exploration, processing, and understanding. Furthermore, in dramatherapy, the therapist needs the

cooperation of the patient, who has a thorough understanding of the client's socio-cultural-mental and familial position. Thus, the drama therapy requires complete acknowledgement from the client.10

Conclusion

The performative ritual of *Kaavu theendal* and *Bharanipattu* held in Kodungalloor temple, in association with the annual Meena Bharani festival, is very peculiar because of its capability to facilitate the emotional realisation and embodied catharsis. Drama therapy, on the other hand, is a clinical method where theatrical and somatic techniques are used in the therapy of the client. Even though both the cases chosen for this study have their own contextual differences, both of them engage in embodied catharsis. It is based on the fundamental idea of mind-body connection, wherein emotions like fear and frustration are not cognitive phenomena; rather, they are tangible and physiological experiences. Not identifying, addressing and resolving an emotion affects the physical body, leading to tension and discomfort. But a bodily action helps in the easy release of the trapped emotion, achieving emotional healing and integration. Thus, the universal nature of embodied catharsis can be traced here.

This study posed challenges of cultural appropriation, difficulty in standardisation and chances of misinterpretation and over-medicalising the religious experience because of the presence of culturally and emotionally sensitive elements. Acknowledging the paucity of information due to multiple socio-cultural-religious and emotional elements, an essential finding can be drawn; i.e., the rituals of *Kaavu theendal* and *Bharanipattu* and the drama therapy have a similar therapeutic potential, with the aid of art and theatre. It helps individuals confront and understand their unaddressed dark side and initiate a corrective journey, leading to personal growth, healing and community wellbeing. Thus, understanding ritual performances as a form of the traditional mode of modern drama therapy, this study offers a new perspective on the relevance of age-old tradition in the modern therapeutic world.

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Redefining Mental Health Care: A Human-Centred, Ethical Approach to Reducing Stigma

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Abstract: The article explores the importance of adopting a human-centred, bioethical approach to mental health care to combat the pervasive stigma surrounding mental illness. Despite increasing awareness, societal prejudices and systemic inequities continue to hinder access to care, often exacerbating isolation and impeding recovery. The paper advocates for a trauma-informed, culturally responsive, and inclusive mental health framework, emphasizing autonomy, respect, and justice as bioethical principles essential for reducing stigma. It discusses various forms of stigma: self-stigma, public stigma, and institutional stigma—and their impact on individuals' well-being and healthcare outcomes. By incorporating trauma-informed care, cultural competency, and peer support programs, mental health systems can foster a more compassionate and inclusive environment.

Keywords: Mental health stigma, bioethics, trauma-informed care, cultural responsiveness, autonomy.

In recent years, mental healthcare has come under scrutiny for its need to address not only the conditions it treats but also the pervasive stigma that surrounds them. Despite increased awareness, individuals seeking mental health support often encounter barriers rooted in social prejudice and systemic inequities. These barriers can deter treatment and exacerbate isolation, ultimately hindering recovery. To combat this, mental health treatment must embrace a trauma-informed care approach, foster cultural responsiveness, and ensure inclusive support systems, allowing mental healthcare to become a natural part of overall wellness. Advocating for mental health as a fundamental human right is essential to drive systemic change, ensuring equitable treatment and reducing stigma within healthcare institutions and the broader society.

Through this lens, mental health care can be reimagined as a shared responsibility, demanding a compassionate and ethically robust approach to care. The integration of bioethical principles, such as autonomy, respect, and justice, into mental health practices is crucial in reducing stigma and improving treatment outcomes.

Mental health stigma is a multifaceted issue, encompassing societal attitudes, institutional practices, and individual perceptions. Stigma often manifests as overt discrimination or more subtle biases that influence the treatment of individuals with mental health conditions within both society and healthcare systems. Effectively addressing stigma requires a comprehensive understanding of its origins, consequences, and the ethical frameworks that can guide meaningful change.

Goffman defines stigma as an "attribute that is deeply discrediting and as something that reduces its bearer from a whole and usual person to a tainted, discounted one" (22). This understanding is central to the concept of mental health stigma, which can lead to psychological distress, social isolation, and reluctance to seek necessary care. It is important to recognise the distinct forms of stigma: self-stigma, public stigma, and institutional stigma—each with unique implications for individuals and the healthcare system. Self-stigma occurs when individuals internalise negative stereotypes, leading to feelings of shame and a diminished sense of self-worth. These internalised beliefs often prevent people from seeking treatment, as they may feel undeserving of help or fear judgment from others. "We are all just actors trying to control and manage our public image, we act based on how others might see us" (Goffman 22). Public stigma, on the other hand, is rooted in societal attitudes and beliefs that marginalise those with mental health conditions. Reinforced by media portrayals and cultural narratives, public stigma can have profound effects on individuals' mental health, social relationships, and opportunities for recovery. Institutional stigma refers to discriminatory practices within organisations and healthcare systems, such as inadequate funding, a lack of trained professionals, or systemic biases that prioritise physical health over mental health. Mental health stigma can be exacerbated by other intersecting forms of stigma based on race, gender, sexuality, or socioeconomic status. Recognising and addressing these intersectional layers of stigma is crucial for ensuring equitable mental health care. Tailored approaches that account for diverse lived experiences help make care more inclusive and responsive to varying cultural or socioeconomic challenges. Addressing these forms of stigma is essential for equitable mental healthcare, which is where bioethics can play a key role in fostering more human-centred practices that reduce stigma and improve treatment outcomes.

A transition toward a human-centred and ethically grounded approach to mental health care is imperative. Such a paradigm shift necessitates a concerted effort among healthcare professionals, policymakers, and community organisations to establish a healthcare framework that foregrounds principles of dignity, respect, and inclusivity. Central to this model is the implementation of trauma-informed care, which prioritises safety and empowerment, fostering an environment where patients are both secure and respected throughout their treatment. This approach not only acknowledges the profound impact of trauma on mental health but also seeks to mitigate the reactivation of traumatic experiences within the healthcare setting, promoting holistic recovery and sustained well-being. Technology can play a positive role in making mental health care more accessible and less stigmatised. Online platforms for therapy and mental health apps allow individuals to seek support privately, minimising fears of judgment. Additionally, digital education campaigns can be powerful tools for combating public stigma, promoting awareness, and normalising mental health conversations on a broader scale.

Incorporating cultural responsiveness is another crucial aspect of this shift. Healthcare providers can meet the diverse needs of individuals by receiving targeted training that enables them to engage with patients in a culturally sensitive manner. Additionally, integrated care models that connect mental and physical health services promote a holistic approach to wellness, normalising mental health treatment as part of overall healthcare. This can reduce the stigma that often surrounds mental health care. There have been several attempts at creating instruments to measure and understand stigma as a psychological construct in the context of mental health. In this vein, the Internalized Stigma of Mental Illness (ISMI) scale and the Perceived Devaluation-Discrimination Scale, among others, seek to quantify stigma more objectively.

> The ISMI scale, as defined by Ritsher et al. (2003), measures the subjective experience of stigma, including the internalization of negative stereotypes and beliefs about mental illness. It includes five subscales: Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal, and Stigma Resistance. These subscales were further defined as follows: (i) Alienation: The feeling of being less than a full member of society due to one's mental illness, (ii) Stereotype Endorsement: The extent to which the individual agrees with common negative stereotypes about people with mental illness, (iii) Discrimination Experience: Personal experiences of rejection or exclusion due to mental illness, (iv) Social Withdrawal: The extent to which the individual avoids

social situations for fear of being stigmatized, and (v) Stigma Resistance: The individual's ability to resist or counteract stigma. (Ahad et al)

Promoting autonomy and dignity in mental healthcare involves actively addressing stigma by involving patients in treatment decisions. Collaborative decision-making respects patients' preferences, builds trust, and helps them feel more engaged and in control of their recovery. This process allows individuals to voice their preferences without fear of judgment, encouraging greater engagement in their care. However, stigma can emerge when patients feel excluded from decisions or perceive that their opinions are undervalued, reinforcing feelings of disempowerment. Establishing advisory councils with individuals who have lived experience in mental health can help address these issues. These councils can highlight where services or policies inadvertently stigmatise or overlook patient needs, providing feedback to improve care. Peer supporters with lived experience can also bridge communication gaps, offering mentorship and promoting a more empathetic and accepting environment. Training healthcare providers in shared decision-making is another way to reduce stigmatising interactions. This approach fosters a collaborative atmosphere where patients feel heard, respected, and free from judgment—ultimately enhancing trust and satisfaction in their care.

Several actionable strategies can help promote a human-centred approach in mental health care. One effective approach is empowering patient voices by involving them directly in treatment decisions. Formal feedback mechanisms, such as patient surveys, suggestion boxes, and digital platforms, allow patients to express concerns and share satisfaction levels with their care. These mechanisms not only provide valuable insights into patient needs but also allow healthcare providers to adapt and improve care in response to patient input. Implementing peer-led initiatives has proven effective in reducing stigma and fostering a supportive community. Peer support programs, where individuals with personal experience in mental health challenges assist others, alleviate the feelings of isolation caused by stigma. Structured peer-led initiatives, supported by comprehensive training for peer supporters in active listening, confidentiality, and crisis management, can significantly contribute to reducing stigma and promoting a more inclusive care environment. Community mental health initiatives can play a vital role in reducing stigma and increasing access to care. Local support groups, community outreach programs, and accessible resource centres can help normalise mental health conversations in informal settings. Community engagement also enables a preventive approach, promoting mental wellness and early intervention. Ethical research practices are essential to ensure that mental health studies respect participant privacy and autonomy,

particularly when handling sensitive data. Transparent practices in mental health research can build public trust, reduce stigma, and promote a more evidence-based approach to treatment improvements.

Integrated care models that emphasise the treatment of mental and physical health together provide a holistic approach to wellness. These models reduce stigma by embedding mental health services within primary care settings, normalising mental health treatment as part of general healthcare. Co-locating mental health services within primary care settings helps patients access care without the added stigma of visiting a specialised mental health facility. Healthcare professionals must also receive cultural competency training to provide care that is ethically inclusive and respectful of diverse cultural backgrounds. This ensures that treatment is tailored to each patient's context, promoting a more empathetic approach that resonates with individuals from various backgrounds. Additionally, ethics training helps healthcare providers respect patient rights, confront personal biases, and reduce stigmatising behaviours. Compassion-focused therapy (CFT) has been attracting attention in mental health practice and research. CFT is effective in reducing a variety of negative mental health symptoms.

> Compassion-focused therapy (CFT) was developed by Paul Gilbert, aiming to reduce shame and self-criticism [1]. Shame and self-criticism are detrimental components in many mental health problems including depression. CFT integrates cognitive behavioural therapy with components from other sciences such as evolutionary psychology, social psychology, developmental psychology, Buddhist psychology, and neuroscience. (Kotera et al)

Real-world case studies provide valuable insights into how bioethical principles can reduce mental health stigma and improve treatment outcomes. One such example is the Recovery Model in mental health care, which focuses on strengths-based approaches that prioritise an individual's inherent capacity for growth, resilience, and recovery. This model empowers patients to participate actively in their treatment planning, encouraging autonomy and personal agency. The Recovery Model has been shown to improve patient outcomes, reduce stigma, and enhance empowerment. Similarly, NAMI (National Alliance on Mental Illness) has effectively reduced stigma through education and awareness programs like "In Our Own Voice," where individuals with lived mental health experiences share their stories. NAMI's peer-led programs create networks where individuals with similar challenges can connect, offering emotional support and practical assistance. These initiatives help dispel

myths and stereotypes, reduce isolation, and foster empathy and understanding within the community.

The integration of bioethical principles such as autonomy, respect, and holistic care into mental health practices is crucial for reducing stigma and improving outcomes. By emphasising autonomy, beneficence, and justice, bioethics can help challenge the discriminatory practices that contribute to the marginalisation of individuals with mental health conditions. These principles promote respect for individuals' dignity and rights, ensuring that those affected by mental health issues are treated with fairness and empathy. Furthermore, the integration of bioethics in mental health policy and practice encourages a holistic approach that not only focuses on medical interventions but also considers the social and psychological aspects of stigma, ultimately facilitating a more supportive environment for recovery and well-being.

By promoting patient engagement, supporting peer networks, and advocating for systemic changes, healthcare systems can create a more compassionate and stigma-free environment. This will not only enhance recovery but also ensure long-term mental well-being, paving the way for a future where mental health care is universally regarded as a fundamental right. Global initiatives, such as Finland's Mental Health Strategy and Action Plan, and the Mental Health Parity and Addiction Equity Act in the United States, have shown that integrating mental health care with general health services reduces stigma and enhances access to treatment. These initiatives, along with culturally sensitive approaches like those employed by The Banyan in India, offer valuable lessons in reducing stigma through inclusive, compassionate care. Various countries have implemented comprehensive strategies to mitigate mental health stigma and promote mental well-being through both policy interventions and community-based initiatives. In the United Kingdom, the "Time to Change" campaign has been pivotal in challenging societal attitudes towards mental health, fostering open discourse, and providing support for individuals affected by mental health conditions. Similarly, in Canada, the Mental Health Commission has employed anti-stigma campaigns, public education, and advocacy to incorporate mental health into broader public health policies. Japan has adopted community-based models, integrating mental health services within primary healthcare systems and promoting peer support networks, thereby reducing stigma and enhancing access to care. Australia's "Mindframe" initiative focuses on training media professionals to ensure accurate and respectful representations of mental health, thus reshaping public perceptions and reducing harmful stereotypes. These national efforts, alongside global initiatives such as the World Health Organization's "Mental Health Action Plan," contribute to the ongoing

transformation of cultural and institutional attitudes towards mental health, fostering a more inclusive and supportive environment.

By continuing to prioritise human-centred, ethical care and advocating for policies that promote mental health as a fundamental human right, society can create a more inclusive healthcare system that respects the dignity, autonomy, and well-being of all individuals. In low- and middle-income countries, financial barriers often hinder access to mental health services. Without sufficient resources, implementing stigma-reducing bioethical practices becomes challenging, perpetuating negative perceptions of mental illness. This is further complicated for individuals in the LGBTQ+ community, who experience compounded stigma—not only due to mental health conditions but also because of societal discrimination. This intersectional stigma contributes to higher rates of mental health issues within this group, necessitating specialised care approaches that address both layers of stigma. Implementing long-term educational programs in schools and workplaces can be crucial in reshaping societal attitudes. Early education on mental health promotes understanding from a young age, helping prevent stigma before it can form. “Stigmatized individuals can also turn to other stigmatized people or sympathetic others for support and coping. They can form or join self-help groups, clubs, national associations, or other groups to feel a sense of belonging” (Crossman). Similarly, workplace training can make employees feel safer discussing mental health challenges and reduce stigma in professional environments.

Technology, particularly telehealth services, has shown promise in reducing stigma. Studies indicate that 85% of patients feel less stigmatised when accessing mental health care through digital platforms, which provide greater privacy and reduce the social barriers associated with in-person visits. Moreover, data reveals that about 30% of individuals with schizophrenia report not being fully informed about their treatment options, highlighting a gap in the informed consent process. This lack of transparency can undermine patient autonomy and exacerbate stigma surrounding mental health care. Research suggests that virtue ethics, which emphasises empathy, compassion, and respect for individuals, has proven effective in reducing stigma within healthcare. The application of these virtues in clinical practice has been linked to improved therapeutic outcomes and more positive patient experiences. By prioritising respect, empowerment, and a holistic approach, these models of care have demonstrated success in reducing mental health stigma, improving access, and promoting recovery. These case studies underscore the importance of human-centred care and illustrate how ethical frameworks can transform mental health care, showing that when individuals are treated with

dignity and regarded as capable agents in their care, stigma is diminished, and overall outcomes are strengthened.

Integrating bioethical principles into mental healthcare offers a comprehensive framework for combating mental health stigma and improving patient outcomes. By upholding the principles of autonomy, beneficence, and justice, healthcare providers can create a human-centred approach that promotes dignity and respect while ensuring equitable and inclusive treatment for individuals with mental health conditions. These principles, when applied consistently, encourage patients' involvement in their own care, ensuring their voices are heard and their rights respected. A focus on beneficence also ensures that the treatment provided is not only effective but also compassionate, fostering a therapeutic environment where patients feel safe and valued. To reduce mental health stigma effectively, a multifaceted effort is required, one that brings together healthcare providers, policymakers, and communities in a collaborative endeavour. This holistic approach must prioritise patient empowerment and address societal misconceptions that often contribute to the marginalisation of individuals with mental health challenges. Strategies such as peer-led initiatives, integrated care models, and education on cultural competency in healthcare can help challenge stigma at both individual and systemic levels. Additionally, reforming institutional practices to include patient-centred policies—such as the inclusion of patients in treatment planning and decision-making—can promote a more inclusive healthcare environment.

By fostering a culture of respect and empathy within healthcare systems, we can break down the barriers that prevent individuals from seeking care or fully engaging in their recovery process. Advocacy for rights-based approaches, alongside the provision of accessible, comprehensive services, can reduce disparities in mental health treatment and ensure that every individual, regardless of background or condition, has access to the support they need. The collaboration of stakeholders across all levels—from clinical settings to communities and policymakers—can create an environment that not only supports mental health treatment but also actively works to reduce the stigma surrounding it. Ultimately, fostering an inclusive and compassionate mental healthcare system will require sustained efforts, but the long-term benefits will be profound. Not only will it improve individual recovery outcomes, but it will also contribute to a societal shift toward viewing mental health care as an essential, normalised part of overall healthcare. As mental health continues to gain recognition as an integral aspect of overall health, it is essential to advocate for ethical practices that honour the experiences and rights of individuals with mental health conditions. Through continued advocacy and

collaboration, we can reduce stigma, improve the quality of care, and ensure positive treatment outcomes for all individuals navigating the complexities of mental health.

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Role of Narrative-Memory Synergy in Memoirs Discussing Mental Illness

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Abstract: Life narratives have gained significant traction lately with the influx of different types of literary forms within them. Autobiographical memory plays a pivotal role in formulating life narratives, imparting insight into the way memory encapsulates life and embodies experiences. Narrative and medicine come at a crossroads in the medical humanities that aim to enhance the interdisciplinary network between medicine and the humanities. Narratives offer a salient space for articulating the sufferings and embodying the inextricable conditions of an individual's life. By allowing a vent to the bottled-up emotions and memories of hallowing experiences, autobiographical narratives like memoirs aid in distancing oneself from those unsettling experiences and embodying and encapsulating them authentically and effectively. The interdisciplinarity of the emerging medical and health humanities disciplines primarily stems from the illness narratives that aim to counter and interrogate the dominant voices of the biomedical approach. The present study qualitatively approach first person narratives of mental illness in the framework of Mad Studies, which is an emerging, activism-oriented theoretical framework, that rethinks madness by challenging prevailing understandings around it by It is a This paper explores how pertinent it is to integrate narrative-memory synergy into the field of medicine and specifically the mental health discipline to reiterate the power of narratives to bolster the subjectivity of those individuals often deemed as marginal and passive recipients in the discourse of medicine.

Keywords: life narratives, medical humanities, Mad Studies, memoirs, memory, interdisciplinarity, biomedicine

Life narratives are riveting for the regenerative potential that they provide for the author as well as the reader who engages with them. They have a significant role in engendering

critical engagements across the humanities. There has been a boom in life writings, and this essentially points to the growing relevance of life narratives in articulating unheard experiences. Memory, though abstract as a categorical concept, breathes into inevitably in any discourse pertaining to life writing.

Illness narratives illuminate the illness experiences by giving a glimpse of the subjective perception, which is often overlooked. This paper examines the relevance of integrating narrative-memory synergy into the fields of medicine and mental health, highlighting the power of narratives by positioning them in the framework of Mad Studies as a means to enhance the subjectivity and perspectives of those often marginalised and passive recipients in the medical discourse.

G. Thomas Couser, who has extensively theorised on the possibilities of life writing and memoirs in particular, emphasises the need to maintain "methodological transparency"(17) while memoirs are composed. Mark Freeman suggests that autobiographical writing in itself is a narrative inquiry into one's self. Freeman notes, "Autobiography is the inroad par excellence into exploring the dynamic features- as well as the profound challenges of narrative inquiry, or at least that portion of it that looks to the comprehensive study of lives as an important vehicle for understanding the human condition."(120) Geoffrey Cubitt suggests the criticality of memory in the introduction to his book *History and Memory*, "Memory is the enabling capacity of human existence; 'the scaffolding upon which all mental life is constructed', an apparently seamless and omnipresent function at the heart of our existence." Autobiographical memory plays a pivotal part in formulating life narratives, imparting insight into the embodied experiences in manifold ways. "When we speak of autobiographical memory, we are referring to the memories a person has of their own life experiences. Like many other aspects of human behaviour, the study of personal recollections predates the emergence of psychology as a discipline." (Robinson 19)

Autobiographical memory holds relevance when it comes to the narrativisation of self and thereby the conceptualisation of identity. It also has to do with the temporal aspect of narration by facilitating referentiality to memories of the past, its contemporaneity and future implications of the authorial self. Self and self-experiences are represented through life narration. Oliver Sacks purports the function of self-narration in life as, "It might be said that each of us constructs and lives a 'narrative', and that this narrative is our identities."(qtd in

Eakin 101) It is basically from the imperative to tell a story, that is, to delineate one's stance, that narrativising as a process emerges.

Telling one's story involves addressing the unattended, unidentified crisis or shortcomings within an individual. This process is not a solitary quest, but will also have societal influences as it continues to intersect with other fields of knowledge. Writing one's life embodies subjectivity and stimulates the pursuit to discover aspects of oneself that have been overlooked. Writing is an enterprise that involves restructuring reality, and it is at the same time exploratory as well as purgative. There is regenerative power to writing that enables the author to inform the authorial self and engage the reader about the transformative potential in it.

The mainspring of life writings is due to the increased awareness of experiential knowledge. It allies with the concept of coproduction, which is also related to the legitimisation of personal experiences. Experiential knowledge is inevitably gauged in almost all disciplines to ensure, as well as to enrich, the efficient functioning of interdisciplinary knowledge transactions. Life narratives entail substantially autobiographical memories, which significantly contribute to an individual's knowledge capital, allowing active transaction of those embodied experiences to readers, too.

> A complete understanding of autobiographical memory would require: a knowledge of basic memory processes in the individual as well as of the influences of the society in which the individual lives; a knowledge of memory processes in the individual at one age and time as well as of the effects of changes in development and environment over a life time; a knowledge of the intact as well as of the impaired individual; a knowledge of cognition as well as of affect. (Rubin 1)

Autobiographical memory operates in the composition of illness narratives and specifically illness memoirs. It has grown as a thriving genre, and affective possibility of the genre is connected to the mechanics of crafting memoirs. Although it apparently seems like a simple recollection of the past, autobiographical memory has a complex relation to the experiences of the author positioned in a socio-cultural milieu to which/ they belong.

The philosophical integration of medicine and the humanities has opened novel possibilities to meditate on the experiences. This act of validating experiential knowledge is a counteract of

giving primacy to the individual experiencing the distress. Psy disciplines like Psychology and Psychiatry possess an unprecedented appeal to laypeople owing to their enigma. In the case of mental illness, the articulation of the experiential reality of the individual identified with the condition can illuminate the gaps and fissures that spring up with the biomedical hierarchy.

Memoirs are mainly written in the form of vignettes, which look fragmented and discontinuous. They are instances of self-disclosure. Individual narratives can be analysed by phenomenologically exploring the role of memories. They do not adhere to fixed structural forms but are experimental in idiosyncratic ways, complementing the way the author seeks to convey the content. Illness narratives have gained significant critical momentum lately, growing as a corpus of writings that play a key role in sensitising the humanitarian aspects of any illness condition. By aiding in framing embodied experiences, illness narratives facilitate a space to bridge the gap that exists between the medical domain and the humanities. In mental health, there is always a complexity embedded in its interpretation.

Medical humanities also attempt to form linkages and bridges across other disciplinary domains using the narrative approach. A significant void exists in the experiential perspective when the discipline of medicine is examined. Mary O'Hagan asserts in her paper, "Responses to a Legacy of Harm", that the disillusionment prevalent in the field of mental health after listening to "hundreds of people's stories of their experiences of receiving mental health services in many parts of the world. (10) These life narratives, discussing mental distress, aid in critiquing as well as challenging the dominant biomedical approach perpetuated by the psy disciplines, like Psychology and Psychiatry, that tend to ostracise the survivor's perspective as illegitimate and incompetent, discarding the potential of survivor knowledge.

Narrative turn has happened in all disciplines and without exception in the health domain too. Erick Fabris, who is allied to Mad Studies Scholarship, notes in his article on Community Treatment Orders that the act of writing is a form of resistance. He suggests that writing is the ability to normalise feelings and ideas and make them consistent with common sense, and thus supports the experiences and thoughts already inscribed."(99) As a significant aspect of the humanities, narrative intervention becomes crucial in deciphering the meanings associated with lived experiences. Living with any mental illness, or madness as commonly referred to, brings about a range of complexities, as the condition essentially questions the construct of rationality, raising questions regarding the constitution of normalcy as well as its prerogatives.

While illness as a term is referential to the distressing experience of the individual, the term madness is imbued with the social and cultural perceptions toward the condition as well as the responses toward it. The exact halo behind the term shifts with the counterintuitive. It is this deconstructing mode embedded in the idea of madness that overthrows any monolithic explanation of its causes and effects. Composing memoirs involves recollection and appropriation of memories. As the name suggests, memoirs are structured synchronously with the nature of memories.

In *Manic: A Memoir*, by Terri Cheney, the author, who is a litigator, has had bipolar disorder since childhood. Bipolar disorder, as a condition, is very much related to the radical acceptance of this condition. In the preface to her memoir Manic, the author asserts that for her experiencing manic- depression, memory becomes the primary casualty and warns her readers that a journey through her condition, reading her memoir, "is not a safe ride". (Preface, Cheney)

> It doesn't go from point A to point B in a familiar, friendly pattern. It's chaotic, unpredictable. You never know where you're heading next. I wanted this book to mirror the disease, to give the reader a visceral experience. That's why I've chosen to tell my life story episodically, rather than in any chronological order. It's truer to the way I think. (Preface)

The aforementioned words by Terri Cheney set the tone for the memoir, indicating the unconventional writing used for recounting her experiences. The social understanding about any illness, and particularly mental illness, is infested with a mixture of dismay, fear and hate for the affected. Even terms used to address those who experience any mental distress are found to be inadequate, because all existing ways of addressing them essentially jeopardise their sense of identity. Selfhood and agency are denied to them owing to their condition. As with terms that prove to be inadequate in properly addressing them, disciplinary frameworks also lack the efficacy to address the nuanced experiential reality, while only making medical diagnoses with rigid criteria.

It is in this context that the emerging theoretical paradigm of Mad Studies gains relevance. Mad Studies give primacy to the voices and study of mad practices and activism. It is an action-oriented discipline, and so it is adequately called a disciplinary praxis. It is a call to shift the focus of power from the stakeholders, that is, the medical system and psychiatric institutions. As Shery Mead and Beth Filson, Mad Studies practitioners advocates, peer support is of

seminal importance in the act while also informing about the mutuality that is anchored mainly in "subtle power differences between the helper and the person being helped." (110) The praxis of Mad Studies is informed by the idea that social perception could be redefined. It is where the potential of narratives resides that they can contest the stereotypical notions ingrained in the concepts of normality.

The overreliance on standards based on medical diagnosis has given rise to a power dynamic that overlooks the perspectives of those who endure the condition. Narrativising experiences becomes an act of resilience, a constructive response to their distressing condition. Though there is a cathartic purpose to the literary expression, mental illness user narratives are looked for their political stance rather than therapeutic end, which again is a reiteration of the subtle coercive pattern in the medical model that accentuates the concept of normality. Memoirs befit the content that they intend to convey by their unconventional and fluid structural features. The interiority of the author gets easily translated through memoirs. Memory plays a crucial role in the process of composing memoirs and resonating with their recollection of experiences.

William Styron's memoir, *Darkness Visible* (1990), is an account of his experience with clinical depression. He was an acclaimed author who was diagnosed with clinical depression. Styron describes his condition of depression as, "a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self to the mediating intellect as to verge close to being beyond description."(3) Styron expresses his anxieties and retrospection toward depression in his memoir while also recounting the lives of other literateurs and philosophers who have battled the condition. He explores the phenomenology of depression in his memoir by trying to inform readers about the condition while also trying to combat the stigmatised perception around it. Styron tries to illuminate the darkness that envelopes the social understanding around depression by delineating the indistinguishable undefinable nature of depression by reminiscing on the literature and movies that had left an imprint on him as a means to educate himself on the depression that he was experiencing. He also attempts an inquiry into himself to find the roots of depression. As Styron puts it,

> The genetic roots of depression seem now to be beyond controversy. But I'm persuaded that an even more significant matter was the death of my mother when I was thirteen: this disorder and early sorrow- the death or disappearance of a parent, especially a mother, before or during puberty- appears repeatedly in the literature on depression as a trauma sometimes likely to create nearly

> irreparable emotional havoc. The danger is especially apparent if the young person is affected by what has been termed "incomplete mourning"- has, in effect, been unable to achieve the catharsis of grief, and so carries within himself through later years an insufferable burden of which rage and guilt, and not only dammed-up sorrow, are a part, and become the potential seeds of self destruction. (44)

Autobiographical narratives, while satisfying the writer's urge to express themselves, also furnish the affective function of the embodied experiences. Self-reflection and self-knowledge invite the attention of the readers into the embodied reality of the author. This is navigated by the recollection and representation of their life experiences, irrespective of the organic wholeness with which they articulate them. Kay Redfield Jamison, professor of Psychiatry and a resolute writer who has written about bipolar disorder, is also a survivor of bipolar disorder. Her oeuvre mainly consists of her memoirs as well as texts on bipolar condition nurtured by her subjective experiences as well as professional practice. Jamison begins her memoir, *An Unquiet Mind: Memoir of Mood and Madness,* by remembering her childhood days when she used to wave at the jet overhead while listening to it.

> Being routine, however, didn't take away from the magic, and I instinctively looked up from the playground to wave. I knew, of course, that the pilot couldn't see me- I always knew that – just as I knew that even if he could see me, the odds were that it wasn't actually my father. But it was one of those things one did, and anyway, I loved any and all excuses just to stare into the skies. (Jamison 11)

The memoir strikes a lonely childhood near the Air Force base that the narrator had by referring to the "enthusiastic rendering of the Air Force song" which the narrator remembers; "fragments of which remain with me to this day, nested together, somewhat improbably, with phrases from Christmas carols, early poems, and bits and pieces of the Book of Common Prayer: all having great mood and meaning from childhood, and all still retaining the power to quicken the pulses."(12) The memories are vividly navigated by the author to implicate the contrasting emotions that she associates with the same sky and Air Force jet owing to the recollection of the plane crash she witnessed.

> The noise of the jet had become louder, and I saw the other children in my second-grade class suddenly jerk their heads upward. The plane was coming in

> very low, then it streaked past us, scarcely missing the playground. As we stood there clumped together and absolutely terrified, it flew into the trees, exploding directly in front of us. The ferocity of the crash could be felt and heard in the plane's awful impact; it also could be seen in the frightening yet terrible lingering loveliness of the flames that followed. (Jamison 12)

Jamison's memories have moulded her narrative voice that navigates through the polarities that she had to brave while enduring a bipolar condition. An extricable connection is there with the traumatic memories that she had to confront and her later life of balancing the polarities of her condition. The narrator asserts, "I never looked again at the sky and saw only vastness and beauty. From the afternoon on, I saw that death was also and always there."(13) The incident portended the reality of the polarities inevitable in life and in a way foreshadowed the endurance that demanded her by her bipolar condition. The writing is indebted to the potentially exposing and compelling connection the memories possess in the dynamic narration for self-revelation.

Language of writing, as well as the characteristics of writing, is very much influenced by the play of memories, thus shaping the sense of the past. Memory becomes indispensable in the constitutive process of life narratives that aid in communicating the immediacy and palpability, especially in narratives of mental illness. An inclusive and holistic approach is facilitated by the dynamics of memory that surfaces in narratives of mental health service users. The trenchant political angle of the memoirs also gains traction when we analyse the primary purpose of performing the autobiographical memory. "One of the main functions of the autobiographical memory is to contribute to the development of a coherent sense of self, and it achieves this function throughout the lifespan, as individuals process their experiences and devise meanings from them."(Cili and Lusia118) It is more in an episodic fashion that each memory triggers the next one, forming an endless network of recollections that defy temporal dimensions. Recollection and remembering quintessentially interlace in autobiographical narrative inquiry in a seamless way.

Narratives act as a bridge for interdisciplinary inquiry, and they are anchored in embodied experiences. Intersections of memory and mental illness condition negotiate with the collective perception of the condition. It is appropriate to infer that memories and their play are interspersed through the narrative construct, and to reconstruct the coherence assumed to life as well as narrativised life. Narrative animates the reality of their condition, initiating a critical

conversation geared toward social understandings of what constitutes normality. Narrativisation in life writing enables validation of perspectives that are otherwise sidelined by dominant paradigms. It is, in a way, a documentation of knowledge to illuminate social reality from the vantage point of an individual's standpoint regarding the experiential reality that the person is exposed to.

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Bio Note

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Embodied Otherness and the Semiotics of Disability in the *Ramayana*

Ankush Mishra

Abstract: This study investigates how bodily difference is narratively constructed in the Ramayana and argues that physical variance functions as a symbolic device through which moral hierarchy is articulated. In epic discourse, corporeal description is rarely neutral; instead, it becomes a medium for encoding ethical meaning. Drawing upon Disability Studies and cultural theory, this paper examines the representation of Manthara and Surpanakha in the Valmiki tradition. It contends that Manthara's spinal deformity and Surpanakha's mutilation are configured not merely as physical traits but as narrative signs that consolidate ideological order. Through close textual engagement, the paper demonstrates how bodily asymmetry is aligned with disruption, while physical integrity is associated with dharmic legitimacy. By situating the epic within contemporary theoretical frameworks, the study challenges reductive villain-centric readings and foregrounds the cultural logic that links embodiment with moral evaluation in classical Indian literature.

Keywords: Disability Studies; Embodiment; Maryada; Epic Narrative; Myth Criticism

Text of the Paper

The Ramayana holds a foundational position within the literary and cultural consciousness of South Asia. While it is conventionally approached as a narrative of ethical restoration and divine justice, the epic simultaneously constructs a system of signs in which the body becomes a carrier of ideological meaning. Descriptions of physical form frequently operate beyond aesthetic detail; they contribute to a moral grammar in which harmony of body

parallels harmony of order. As scholars in Disability Studies observe, literary traditions often transform bodily difference into narrative significance rather than presenting it as ordinary human variation (Mitchell and Snyder 47). Within this framework, corporeal variance becomes structurally meaningful.

In Sanskritic thought, the concept of *maryada* signifies regulated conduct and cosmic balance. This principle extends metaphorically into bodily representation. The idealized epic body reflects symmetry, restraint, and composure, mirroring the stability of social hierarchy. Rosemarie Garland-Thomson conceptualizes the "normate" as the cultural construct that defines and privileges certain embodiments over others (8). Read through this lens, depictions of bodily difference in the Ramayana reveal a coded evaluative structure. Physical irregularity is positioned not simply as deviation but as a marker of instability within the moral cosmos.

The characterization of Manthara illustrates this semiotic strategy. Identified in the epic tradition as hunchbacked (Valmiki, trans. Sattar 23), she inhabits the margins of royal power while exerting profound narrative influence. Her curved spine is subtly paralleled with political intrigue, suggesting an alignment between bodily configuration and perceived ethical distortion. David T. Mitchell and Sharon L. Snyder describe disability in literature as "narrative prosthesis," a mechanism that generates plot movement and symbolic tension (49). Manthara's embodiment thus operates as a catalyst for exile and dynastic upheaval, transforming physiological difference into a structural device.

Surpanakha's episode further dramatizes the politics of embodiment. Her articulation of desire disrupts normative gender expectations embedded within epic patriarchy. The violent severing of her nose (Valmiki, trans. Goldman 112) functions as both punishment and spectacle, converting agency into abjection. Michel Foucault's analysis of disciplinary power suggests that social order is maintained through visible regulation of bodies (136). In this context, Surpanakha's mutilation becomes emblematic of a system that inscribes moral boundaries upon female flesh. The damaged body is rendered as evidence of transgression.

Such representations align with broader mythic structures in which corporeal form signifies ethical status. Wendy Doniger argues that myth frequently encodes cultural anxieties through symbolic bodies (Doniger 54). Similarly, A. K. Ramanujan emphasizes the multiplicity of

Ramayana traditions, demonstrating how narrative variation reflects shifting social priorities (Ramanujan 46). When considered within this interpretive plurality, embodied otherness in the Valmiki text appears less as incidental description and more as ideological inscription. The epic's ethical mapping relies upon visible difference to stabilize its moral hierarchy.

Re-examining these figures through contemporary theory complicates inherited interpretations that reduce them to archetypal villains. Instead, their portrayals reveal how epic narrative naturalizes a hierarchy of bodies. Physical wholeness is equated with dharmic legitimacy, whereas corporeal variance signals threat or disruption. Disability, therefore, functions as a semiotic resource embedded within the architecture of the text. Recognizing this dynamic enables a more critical engagement with the cultural assumptions embedded in classical literature and invites reconsideration of how embodiment is ethically coded in mythic discourse.

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The Effectiveness of RPwD Act, 2016 in Providing Inclusive Education for Women with Disabilities in Mizoram

Dr. Lawmsangpuia Ralte

Abstract: Women with disabilities have faced certain obstacles and barriers in their life. They have faced double burden and hardships of disabilities which is firstly exerted by their disabilities followed by their gender. Laws and legislations are crucial in providing inclusive development to all persons with disabilities, including the women with disabilities. Without proper implementation of legislations, women with disabilities are only confined to the four walls of their home and are further stigmatized and stereotyped by society. Hence, inclusive education is crucial to allow them to engage in educational activities which will enable them to progress further in life. This study uses mixed methods of quantitative and qualitative methods to analyze the effectiveness of the Rights of Persons with Disabilities (RPwD) Act, 2016 in providing inclusive education to persons with disabilities in Mizoram. This study focuses on selected 163 women with disabilities in Mizoram and studies their socio-economic conditions and the level of inclusive education's success or failure in the state. The study ends with an analytical discussion of the issues and provide suggestive measures for the implementation of special inclusive education in the state.

Key words: RPwD Act, 2016, women with disabilities, inclusive education, disability, Mizoram.

Introduction

Disability has affected the individuals at the family, medical, social, technical and health levels. The conditions of disability led to a marginalized place in society, culture, economics and politics. The hardships associated with disability are centuries old and persons with disabilities have

constantly fell into a state of stigmatization and inferiority complex, which in turn denied them of their chances for holistic development in society. In present day, disability has been constructed and studied with a more humanist attitude, especially in the field of academics. The study of disability has started to point out problems associated with disabilities stating that persons with disabilities are not the problem but rather, the problem lies in the creation of "normalcy" by society which in turn leads to the creation of "problems" centred around persons with disabilities (Lennard, 2017). Amongst persons with disabilities, women with disabilities are the worst sufferers of disability by facing double the hardships as compared to men. The hardships faced by them are firstly exerted by their disabilities followed by their gender, thus creating a double burden for them. Their rights are often violated and many times, their rights are being denied to them.

The term "disability" is a word which is largely associated with hardships and problems. It can be acquired right from the onset of birth or can be acquired at later stages in life due to old age and accidents. The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 has laid down seven types of disabilities namely-blindness, hearing impairment, leprosy-cured persons, locomotor disability, low-vision, mental illness and mental retardation. The Act also defined disability stating that it refers to a person who has more than 40 per cent disability in conditions such as blindness, low vision, persons with intellectual disabilities and mental illness, hearing impaired and leprosy cured as certified by medical authorities. To counter disability and the various obstacles associated to it, special legislations, including specific focus on education are required which can uplift women with disabilities and provide sustainable living for them.

Legal introspection of Rights of Persons with Disabilities (RPwD) Act 2016

On 1st October, 2007, India witnessed a remarkable feat as it signed and ratified The United Nations Convention on the Rights of People with Disabilities (UNCRPD) which came into force on 3rd May, 2008. The UNCRPD serves as the heart of the disability rights movement and has been regarded as a landmark international treaty that laid down the fundamental rights of persons with disabilities. It has also requested all the signatories of the convention to amend their existing laws to comply with UNCRPD's principles (Bose, 2021). The UNCRPD has viewed disability as a result of clashes between impairments with that of societal attitude and ignorance leading to

roadblocks for persons with disabilities. This has prevented their chances to freely interact equally with others in society.

The outcome of the signatories for India was the introduction of the Rights of Persons with Disabilities (RPwD) Act, 2016 after passing many rounds of scrutiny in the Parliament. It was finally passed by the two houses of Parliament in the year 2016 and it replaced the previous Persons with Disabilities Act, 1995. It further received the Presidential assent and was finally notified on 28th December, 2016 and immediately came into full force from 19th April, 2017 onwards. This Act was meant to be a game-changer in the country and aimed to end the centuries-old discrimination and neglect faced by persons with disabilities in all spheres of society such as education, employment and accessibility (Bose, 2021). The country also witnessed paradigm shift in which the perspectives of disability have changed from charity-based to human-rights perspective. High hope was placed on the Act to empowered the disabled communities and to impart awareness on the issues of disability and to inculcate feelings of acceptance among the general public.

The Rights of Persons with Disabilities (RPwD) Act 2016 has stated 21 types of disability and it assures that all the persons with disabilities in India assures the provision of "right to equality, life with dignity, and respect for his or her own integrity equally with others" by the government (Bose, 2021).

The RPwD Act, 2016 has ensured that the government should take appropriate measures towards the upliftment of women and children with disabilities and to ensure that they enjoy their rights equally with others in society. According to this Act, the government should take full matter to safeguard all persons with disabilities from experiencing abuse, exploitation and violence of all types. The state governments and local authorities are tasked with the role of promotion, protection and ensuring education to all persons with disabilities in society along with others. In a similar instance, the government should provide adequate support and facilities for persons with disabilities so that they could avail to specific training in vocational training centres and have further scope for self-employment. In terms of education, section 16 (i), (ii) and (iii) of the RPwD Act, 2016 has stated that inclusive education should be provided to all children with disabilities without any discrimination and that educational institutions should be barrier free and easily

accessible by all. Facilities and special teachers should be provided and sports and recreational activities should be accessible to all, irrespective of their disabilities so as to promote inclusive education.

Theoretical Framework

The past 40 years has witnessed that social model of disability has shaped the study of disability in academics, politics and human rights contexts. This model of disability has stated that disability arises not from an individual's impairments or problems but rather from the oppression and roadblock caused by society towards persons with disabilities (Lawson & Beckett, 2021). When society denies the inclusive approach or holistic development for persons with disabilities and ignores their participation and access in society, it increases their disability and it resulted to their confinement to the four walls of their home. Social model of disability has stated that society's attitudes and failure of inclusive approach have prohibited persons with disabilities from reaching their highest potential. Persons with disabilities are not disabled because of their so-called "impairments" but rather because of the barriers exerted to them in the form of attitudinal, legal, architectural and various other barriers within society (Campling, 1981; Ladau, 2021).

It is imperative that laws and legal legislations be made and implemented by the authorities to uplift the persons with disabilities and to give them better opportunities on an equal basis with persons without disabilities in society (Menon & Ferose, 2014). The provision of better laws and legislations can transform persons with disabilities into better versions of themselves and help them become successful in following their educational and employment aspirations (Srilata, 2022). Without proper laws, it becomes difficult for persons with disabilities to chase their academic aspirations and have lower opportunities to achieve employment chances (Menon & Ferose, 2014).

When persons with disabilities are denied their chances of growth and development, they are mostly stuck in their houses and are further stigmatized by society as that conveys negative stereotypes (Goffman, 1963). They are misunderstood by the rest of society and they are further labelled because of their differences with persons without disabilities and the labels have caused discrimination against those who are labeled as "disabilities" (Clair, 2018). Children with disabilities are five times more likely to drop out of school and hardly progress beyond primary

level of education due to absence of inclusive education (Aggarwal, 2024). Even amidst difficulties, it is crucial to provide inclusive education for all persons with disabilities to engage them in learning activities for their overall inclusive development (Hayes & Bulat, 2017).

Focus on women with disabilities

Women with disabilities' lives are burdened by the onset of impairments which in turn, lead them to experience barriers in society. The focus on women with disabilities has swerving ideologies and shifting paradigms at the level of feminists, gender specialists, and academic sociologists. However, the common concern among all of them is to study the nature and nuances of problems encountered especially by women with disabilities, and to address the issues (Bhuimali, 2009). Feminists' theory has aimed to foster feminist disability theory in their study. The writings and study in feminist disability study lay in augmenting the terms and in confronting the limits to how human diversity is understood. The feminist theory also focuses on understanding the materiality of the body, multiculturalism, and social formation in interpreting the bodily differences of human beings. The inclusion of disability studies in feminist studies widens and challenges the study through deeper knowledge and stronger representation.

A specific focus on women with disabilities by gender studies points straight to the double discrimination faced by them. This double discrimination is exerted in the form of sexism and their disability, while women of colour are subjected to even face third layer of discrimination in the form of their skin colour (Braunmiller & Dry, 2022). The main points highlighted in gender studies concerning women with disabilities are the lower income, lower employment, and educational opportunities, and also the higher rate of poverty as compared to their male counterparts.

Academic sociologists started incorporating the study of disability after the writings of The Politics of Disablement (Oliver, 1990) in which the influence of disability made its way into sociological discourse after being objects associated with stigma for decades. Disability evolved into a starting point, a basis, and a means of basing theories about the world because most mainstream sociological theories have neglected or marginalized disability, it was and is still a very strong step to make. Therefore, it is imperative that sociology critically examine its ontological assumptions (Goodley, 2021).

The policy measures adopted for women with disabilities in many countries are often not enough which led them to fall prey to several people and led them face various forms of discrimination and their inclusive development being blocked (Frohmader & Meekosha, 2010). They have faced violations of their human rights quite a few often and the horrific experiences they encounter cannot be understood at a local level which calls for a global scale analysis. Women with disabilities often face social exclusion unsurprisingly and 'they are surrounded with stigmas and are left out of several family and community activities which left them to feel unwanted, isolated and even ashamed of themselves (Rao, 2004).

A detailed academic study of women with disabilities will shine a light on their lives and the various hardships that they face. It can be assumed that the exclusion of women with disabilities from various development programs in society will automatically lead to poverty. Taking into account the demographic data from across the world, some two-thirds of the women with disabilities dwell in developing countries with unfavourable bio-socio and economic conditions, leading many people to label disability as a divine curse (Sarker, 2025; Degener, 2016). Hence, the strict implementation of RPwD Act, 2016 can go a long way to solve many issues faced by women with disabilities, specifically the education issues.

Methodology

This study uses mixed methods and incorporates both quantitative and qualitative method. For quantitative method, interview schedule, frequency and percentages are used and for qualitative method, observation and interview are used to gather data. The study has been approved by Human Ethics Committee, Mizoram University and verbal consent are taken from all the respondents. Pseudonyms are given to all the respondents in order to adhere to research ethics and maintain anonymity throughout the study.

In terms of universe and sample, Mizoram is the 23rd state in India which houses 15,160 persons with disabilities where 8,198 are men and 6,962 are women according to the census of 2011. Mizoram has one of the lowest population of women with disabilities in northeast India. There are 11 districts in Mizoram in which Aizawl and Lunglei are the two districts having the highest overall number of populations. For this study, only Aizawl and Lunglei districts are earmarked for the selection of respondents as these two districts contain 80 per cent of the population of women with

disabilities in the state. 163 women with disabilities from Aizawl and Lunglei were selected using simple random sampling. The methods for this study were used to gain deeper understandings of the cases being studied (Goodwin & Horowitz, 2002). The results were displayed in the form of tables in which frequency is written followed by percentages which were written in the form of brackets. The main objective is to analyse the conditions and status of the respondents in terms of socio-economic conditions and educational status of women with disabilities. In this sense, The Rights of Persons with Disabilities (RPwD), Act 2016 came into context and the researcher singled out sections related to education from this Act to know whether women with disabilities in Mizoram enjoy the rights stated by this Act.

Objectives of the study

This study has three objectives which are as follows:

1. To analyse the socio-economic conditions of women with disabilities in Mizoram including age, educational and employment status
2. To study the effectiveness of RPwD Act, 2016 in the context of education for women with disabilities
3. To suggest actionable measures and policy recommendations

Age of the respondents with disabilities

Age can simply be defined as the number of years a person has lived on earth from birth till one breath last. It is a period of a person's life expressed in years from the moment of birth, typically denoted by a certain stage or level of mental or physical development and entailing competence and normative responsibility. In sociology, age is defined not only by the number of years individuals have lived but also by the societal roles they play and the expectations that society places on them at different points in their lives. Hence, age has played a significant factor in determining the various responsibilities of a person. In this study, the age group of the respondents is arranged into five categories such as below 20 years, 21 – 30 years, 31 – 40 years, 41 – 50 years, and above 50 years.

Table 1: Age of the respondents

District	Age Categories					
	Below 20 years	21-30 years	31-40 years	41-50 years	Above 50 years	Total
Lunglei	8 (4.9%)	7 (4.3%)	1 (0.6%)	3 (1.8%)	1 (0.6%)	20 (12.3%)
Aizawl	41 (25.2%)	32 (19.6%)	24 (14.7%)	17 (10.4%)	29 (17.8%)	143 (87.7%)
Total	49 (30.1%)	39 (23.9%)	25 (15.3%)	20 (12.3%)	30 (18.4%)	163 (100%)

Source: Field Survey

In the above data, the age parameters of the respondents are highlighted. In Lunglei, there are 8 (4.9%) women who are below the age of 20 years old and 7 (4.3%) women are between the age of 21 – 30 years. There is 1 (0.6%) woman who is between the age of 31 – 40 years and there are 3 (1.8%) women who are between the age of 41 – 50 years. There is only 1 (0.6%) woman who is above the age of 50 years.

In Aizawl, there are as many as 41 (25.2%) women who are below the age of 20 years of age and there are 32 (19.6%) women who fall between the age group of 21 – 30 years. In the age group of 31 – 40 years of age, there are as many as 24 (14.7%) women and there are 17 (10.4%) women who are in the age group of 41–50 years. There are 29 (17.8%) women who are above the age of 50 years in Aizawl.

A maximum of the respondents falls in the age category of below 30 years of age (54%). It is a matter of great concern while looking at their unlived future and career ahead. Similarly, of all the women PwDs in Lunglei, a maximum of them (40%) are below 20 years of age and those below 30 years of age form 75% of the total respondents. Little above 50% of the respondents from Aizawl are those who fall below 30 years of age. 18.4% of the total respondents have experienced

disability for over 50 years and more. Situations warrant that government interventions shall be necessary to care for the young and older people suffering from disability.

> *'I find it unfortunate that I have a disability at such a young age because it hinders my educational and employment opportunities. I still have many years to live, and I feel like my youth is being wasted and I have no chance to progress further in life. The authorities should take measures to rehabilitate and find ways for us to make use of our abilities so that life becomes better meaningful to us.' Miss P1, hearing impairment.*

Educational background

The act of learning something new or transferring knowledge is known as education. Education involves getting children ready for adulthood. The process of education begins right when a child is born. At first, it started as an informal process as the child watches and imitates others around them. Then, the process becomes more formal as the child gets older in which the education becomes more formal through pre-school and play dates.

This education process then becomes academic lessons and is much more than learning simple facts. Education is a means to socialize humans into society and is an important socialization method. All cultural expectations and norms are taught through education by teachers through textbooks and classmates. The respondents in this study are asked about their educational status and the education level of the respondents is divided into primary, upper primary, high school, pre-degree, graduate, post-graduate, Ph.D., technical, and no education.

Table 2: Education

District	Educational background of women respondents								
	Primary	Upper Primary	High School	Pre-Degree	Graduate	Post-Graduate	Ph. D	No Education	Total
Lunglei	15 (9.2%)	0 (0%)	3 (1.8%)	1 (0.6%)	0 (0%)	0 (0%)	0 (0%)	1 (0.6%)	20 (12.3%)
Aizawl	55 (33.7%)	17 (10.4%)	19 (11.7%)	10 (6.1%)	13 (8%)	6 (3.7%)	1 (0.6%)	22 (13.5%)	143 (87.7%)
Total	70 (42.9%)	17 (10.4%)	22 (13.5%)	11 (6.7%)	13 (8%)	6 (3.7%)	1 (0.6%)	23 (14.1%)	163 (100%)

Source: Field Survey

The educational level of the respondents is depicted in the above table. It is evident that in Lunglei, most of the women, i.e., 15 (9.2%) have reached only the primary level of education, while there are 3 (1.8%) women who have reached the high school level of education. There is only 1 (0.6%) woman who has reached the pre-degree level of education and there is 1 (0.6%) woman who did not receive any education at all.

The situation is somewhat similar in Aizawl as there are 55 (33.7%) women who have reached only the primary level of education and there are 17 (10.4%) women who have reached the upper primary level of education. 19 (11.7%) women have achieved a high school level of education and 10 (6.1%) women have reached pre-degree level of education. In terms of graduate women, there are 13 (8%) women who have graduated at their bachelor's level, and 6 (3.7%) women are post-graduate. There is 1 (0.6%) woman who currently pursuing her Ph. D from Assam and as many as

22 (13.5%) women did not receive any formal education at all. These women did not go to any conventional schools and educational institutions but they had received informal education in the form of reading and writing from their caregivers.

Among the women, 70 respondents have attained only a primary level of education which accounts for as many as 42.9% of the entire respondents. In Lunglei, as many as 75% of these women have achieved only a primary level of education while in Aizawl, the number is a bit lower at 38.47% but the category still forms the highest number in the district as compared to other categories of education. 17 (10.4%) of the women have an upper primary level of education and 22 (13.5%) of the respondents have reached high school level. 11 (6.7%) of the women have a pre-degree which is equivalent to a higher secondary level of education in modern days. In terms of graduates, there are 13 (8.0%) women who are graduates in this study and 6 (3.7%) women who have post-graduate degrees. There are no graduate and post-graduate women from Lunglei district. Among the women, there is only one woman who is currently pursuing a Ph. D which accounts for 0.6% of the entire women respondents. As many as 23 women or 14.1% of the respondents did not receive any type of education in their lifetime because their disability prohibits them from receiving formal school education. It is noted that these women are not illiterate despite receiving no education but have received basic alphabet and number of lessons taught to them by their caregivers.

> *'…what is the use of education for a disabled girl like me? All my life I have lived off the emotional, financial, and physical care of my family and I don't have many opportunities in life anyway. Besides, my analytical thinking and memories did not permit much education as I could not learn many things academically. One of my family members had to accompany me to school every day which is time-consuming for them as they all must work as well. So, I had to drop out from school after reaching primary level as I felt that I only disturbed my families.' – Miss P2, autism spectrum disorder.*

The data revealed that access to formal education tends to be quite formidable for women with disabilities due to multiple reasons as most of the respondents have attained only a primary level of education followed by women who had not received any kind of formal education at all. Disability has formed a major obstacle to the promotion of the educational career of the

respondents. The majority of them have either dropped out after primary level or have not gained entry into formal education. So, it is crucial to provide special education with a syllabus that is customized based on their respective ability.

Occupation and employment

Occupation can simply be defined as the work that people are engaged in to earn an income. It is basically an activity that fills most of the working hours to receive a financial or equivalent award. It is a sociological criterion that is interrelated to the positions held by individuals in society and is also used as a determinant of health and income in society. This study is conducted to know the occupation status of the women, and a cross-examination between their educational level and their occupation status is also conducted in the process. The respondents are asked whether they are currently employed, unemployed, or are still studying.

On the other hand, employment is the state of being employed to receive financial or equivalent rewards. Among the women who had occupations, they were further asked whether they were employed in the field of government, private, self-employed, or unemployed. A further cross-examination is done based on their occupational status.

Table 3: Occupation of the respondents

District	Occupational status			
	Employed	Unemployed	Studying	Total
Lunglei	3 (1.8%)	3 (1.8%)	14 (8.6%)	20 (12.3%)
Aizawl	21 (12.9%)	97 (59.5%)	25 (15.3%)	143 (87.7%)
Total	24 (14.7%)	100 (61.35%)	39 (23.9%)	163 (100%)

Source: Field Survey

In the above data, the occupation status of the respondents is pointed out and it shows that among the women in Lunglei, there are only 3 (1.8%) women who are employed and another 3 (1.8%) unemployed women. As many as 14 (8.6%) women are still studying in a special school and a few girls are enrolled in government schools as well.

The situation presented in Aizawl is somewhat similar as there are 21 (12.9%) women who are employed as against 97 (59.5%) unemployed women. Only a handful of women, i.e., 25 (15.3%) women are still studying either in special schools or government schools. Among all the girls who are still studying in both districts, there are no girls with disabilities who are enrolled in private schools as they are enrolled either in special schools or government schools.

> '*No one wants to hire me! They have no faith in my ability and the employer cannot see past my disability when I gave my interview in private company recruitment. Besides, my family was always worried about me and did not trust me to move about in the street as well, which lowered my confidence level. This further lowers the chances of finding employment for me.' – Miss P3, low-vision.*

Overall, 100 (61.35%) women are unemployed while 39 (23.9%) of the women are still studying, and only 24 (14.7%) women are employed. In Lunglei, most of the women are still studying and they form 70% of the entire population in the district and 15% of them are also unemployed. Whereas in Aizawl, unemployed women form the majority of the population as 67.83% of them are currently without a job followed closely by women who are still studying which is 27.27%. Between the two, the unemployment rate of women is higher in Lunglei.

Unemployment is extremely high amongst women with disabilities in Mizoram and the occupation rate of respondents is very low. Most of the women are dependent on the income of their family members and only a handful of them (14.7%) are financially independent. The reason for their unemployment is due to the reluctance of employers to hire them due to their disability and also because their family members do not encourage them to find employment. Few women are currently studying and the data also reveals that the education level of the respondents is very low which propelled the women to be in a state of unemployment.

Table 4: Employment status

District	Employment status of the women respondents				
	Government	Private	Self-employed	Others	Total
Lunglei	2 (1.2%)	1 (0.6%)	0 (0%)	17 (10.4%)	20 (12.3%)
Aizawl	9 (5.5%)	8 (4.9%)	4 (2.5%)	122 (74.8%)	143 (87.7%)
Total	11 (6.7%)	9 (5.5%)	4 (2.5%)	139 (85.3%)	163 (100%)

Source: Field Survey

In the above table, it is evident that among the employed women in Lunglei, there are only 2 (1.2%) women who worked in the government sector which is due to the reservation claimed through their disability. There is 1 (0.6%) woman who is employed in the private sector and as many as 17 (10.4%) women's status is not applicable because all the other women are either still studying or are unemployed.

In Aizawl, 9 (5.5%) women worked in the government sector and 8 (4.9%) women worked in the private sector. It is found that there are 4 (2.5%) self-employed women and the employment status of 122 (74.8%) women is Aizawl is not applicable and they are included in the category of 'others' because they all are unemployed currently. Amongst the unemployed women, there are 4 (2.5%) women who were very vocal about their current unemployed status as they are passionate about finding high-ranking jobs under the government and did not like to be labeled as 'unemployed.' They felt that they were more than able to achieve and pursue their goals and had higher hopes as compared to others. Among the self-employed women, they have their businesses like beauty parlors, shop-keeping, and working in their family-owned restaurants.

Minimum women are self-employed (2.5%) who all belong to the Aizawl district and no self-employed women exist in Lunglei. A handful of the women (5.5%) work in the private sector with Lunglei contributing 5% while the rest 5.6% are from Aizawl. A limited number of government

servants are found only 6.7% of them worked under the government and all these women claimed their jobs through their merit and not through disability reservation policy. The rest of the 139 women (85.3%) are either unemployed or are currently studying so the employment status does not apply to them and are included in the 'others' category.

> '*You can only imagine how difficult it must be for women like us to find employment, no vocational training, no higher education, and no physical ability. Many of us cannot even venture into self-employment because we have no capital. Life is hard for us. No employment agency will want to hire unskilled, low-education, and low- capabilities women like us. This is the exact reason why I am still unemployed even at the age of 29 years old.' – Miss. P4, intellectual disability.*

There are very few women who are capable of engaging in self-employed and private sector and so, disability stands in the way of the occupation and employment status of women with disabilities in Mizoram.

RPwD Act, 2016 and issues in education

Education is the process of receiving or giving systematic instruction at schools, colleges, or universities. There are two types of education such as formal and informal type of education. Formal education is the type of education that one receives through traditional means in schools, colleges, and universities. An informal type of education is the education that is provided by the parents and caretakers inside one's own home. Education is an important factor to achieve inclusive development, without which, holistic development cannot occur. In this study, the issues about education are thoroughly investigated and the women are asked about their opportunities in terms of education, educational facilities, the inclusivity of education, the syllabus as well as the issues in shortage of specially trained teachers.

Table 5: Educational opportunities

District	Education opportunities for women with disabilities					
	Very high	High	Medium	Low	Very low	Total
Lunglei	1 (0.6%)	0 (0%)	0 (0%)	2 (1.2%)	17 (10.4%)	20 (12.3%)
Aizawl	8 (4.9%)	15 (9.2%)	10 (6.1%)	14 (8.6%)	96 (58.9%)	143 (87.7%)
Total	9 (5.5%)	15 (9.2%)	10 (6.1%)	16 (9.8%)	113 (69.3%)	163 (100%)

Source: Field Survey

From the above data, the educational opportunities of women with disabilities in two districts of Mizoram are highlighted. In Lunglei, there is only 1 (0.6%) woman who stated that education opportunities are high while 2 (1.2%) women have stated that the opportunities are low. At the same time, as many as 17 (10.4%) women have stated that the educational opportunities for them are very low. One of the respondents said, *'…try as I may, I will never have educational opportunities like other girls without disabilities because my capabilities do not permit me.'*

In Aizawl, the situation does not vary much as only 8 (4.9%) women have said that educational opportunities are very high. 15 (9.2%) women have said that the opportunities are high and 10 (6.1%) women have said that the opportunities are neither high nor low. 14 (8.6%) of the women have expressed that the opportunities for them for education are low while the remaining 143 (87.7%) women have stated that the opportunities for education in Mizoram are very low for them. This finding is in favour of low educational opportunities for women with disabilities in Mizoram as 113 (69.3%) of the women from the total respondents have stated the low chance for them to achieve education in the state. The main reasons as to what restricts their educational opportunities are studied further and shown in the following table.

Table 6: Lack of inclusivity in education

District	Lack of inclusivity in education					
	Strongly agree	Agree	Medium	Disagree	Strongly disagree	Total
Lunglei	20 (12.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	20 (12.3%)
Aizawl	114 (69.9%)	22 (13.5%)	6 (3.7%)	1 (0.6%)	0 (0%)	143 (87.7%)
Total	134 (82.2%)	22 (13.5%)	6 (3.7%)	1 (0.6%)	0 (0%)	163 (100%)

Source: Field Survey

When enquired about the lack of inclusivity of education in Mizoram, all 20 (12.3%) women from Lunglei have said strongly agreed that education is not inclusive in Mizoram, as observed from the above table. In Aizawl, as many as 114 (69.9%) women have strongly agreed that education is not inclusive in the state and an additional 22 (13.5%) women have also agreed on the lack of inclusion in education. Only 6 (3.7%) women have neither agreed nor disagreed with the statement and there is only 1 (0.6%0 woman who disagrees that education is not inclusive. The situation also does not fare well in Aizawl.

> *'Education is neglected in Mizoram for women with disabilities in the sense that it is still not inclusive. Mainstream schools hesitate to enrol as they claim that they do not have specially trained teachers to look after their disabled students. We need to make education more inclusive and to make that happen, mainstream schools should not hesitate to enrol disabled students in their respective schools and adjust their curriculum accordingly. Besides, there is a constant lack of educational facilities even in the special schools in Mizoram like braille, audio aid, and visual aids.' Miss P5, cerebral palsy.*

The overall data has pointed out that a total of 134 (82.2%) women from both districts strongly agree on the lack of inclusivity in education. In Lunglei, it appears that education is more exclusive all the women from the district have expressed their concerns over the exclusivity.

Table 7: Lack of special-trained teachers

District	Lack of special-trained teachers					
	Very high	High	Medium	Low	Very low	Total
Lunglei	20 (12.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	20 (12.3%)
Aizawl	118 (72.4%)	23 (14.1%)	2 (1.2%)	0 (0%)	0 (0%)	143 (87.7%)
Total	138 (84.7%)	23 (14.1%)	2 (1.2%)	0 (0%)	0 (0%)	163 (100%)

Source: Field Survey

The previous heading has highlighted the problems faced by women in terms of lack of educational facilities but in this section, the lack of specially trained teachers is analysed through the data displayed in the above table. In Lunglei, all 20 (12.3%) women have said that there is a very high lack of special-trained teachers in Lunglei. The district fared rather low in terms of having qualified special-trained teachers. In Aizawl, 118 (72.4%) women have also said that there is a very high lack of special-trained teachers and an additional 23 (14.1%) women have also said that there is a high lack of special-trained teachers. The remaining 2 (1.2%) women have said that there is neither a high nor low lack of special trained teachers and there are no women in both the districts who have expressed the abundance of special teachers in Mizoram. 138 (84.7%) women have said that there is a very high need for special-trained teachers in the state while another 23 (14.1%) women have also stressed the high need for special-trained teachers. Only 2 (1.2%) women have expressed that there is neither a high nor low need for specially trained teachers for women with disabilities. Another problem that can arise in the field of education is the lack of an inclusive curriculum which limits the chances of attaining education among women.

Table 8: Need for a separate inclusive curriculum

District	Need for a separate inclusive curriculum					
	Very high	High	Medium	Low	Very low	Total
Lunglei	20 (12.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	20 (12.3%)
Aizawl	114 (69.9%)	25 (15.3%)	3 (1.8%)	0 (0%)	1 (0.6%)	143 (87.7%)
Total	134 (82.2%)	25 (15.3%)	3 (1.8%)	0 (0%)	1 (0.6%)	163 (100%)

Source: Field Survey

The above table indicates that in Lunglei, 20 (12.3%) women have said that there is a need for a separate inclusive curriculum in the district. In Aizawl, as many as 114 (69.9%) women have said that there is a need for a separate inclusive curriculum as there is a very high lack of inclusive syllabus in the state. As many as 25 (15.3%) women have also said that there is a high lack of separate inclusive curriculum and 3 (1.8%) have said that there is no high or low lack of separate inclusive curriculum. In Aizawl, there is only 1 (0.6%) woman who is satisfied with the current curriculum used among the students. One of the special educators in Lunglei has commented on the issue of inclusive curriculum and said,

> *'I customised the syllabus of Mizoram school textbooks which suits the level of my students best because there is no formal inclusive syllabus as of now. My students are not capable at all to learn the Mizoram school textbooks and so, there is a very high need for an inclusive curriculum and special syllabus for students with disabilities.'*

The current condition in terms of the curriculum followed in both districts is still not up to mark as 134 (82.2%) women have expressed their dissatisfaction with the current syllabus. Since the syllabus is tough for these women, most of them felt inferior and did not feel the desire to have a high educational degree. This, in turn, affects their occupation status as low educational

qualifications lead them to be either unemployed or engaged in low-paying jobs. This led to the need to study about the current condition of vocational training centres in the state.

Analytical discussion and policy recommendations

From the findings in terms of their age in Mizoram, women below 30 years of age comprise the most population and women above the age of 60 years comprise the second largest population in both districts. As the number of women below the age of 30 years is greater, this shows the importance of rehabilitating these women and providing certain vocational skill training and inclusive education to them. The findings show the need of the government and concerned authorities to take mitigative measures and actions for these young women as they have years ahead of them. In terms of education, the results obtained show that the education level of the respondents is low as most of them have achieved only the primary level of education in both districts. The main reason is because they find it difficult to cope with the syllabus which is not inclusive and also because many of the women find it difficult to access special schools. Besides, even among those women who attend special schools and government schools, they all stated their education level to be "primary" because, in government schools, they are made to repeat primary level every year as higher studies are difficult from them due to absence of inclusive curriculum. In special schools of both districts, there is no proper division such as primary, middle, and high school sections and so, they are all listed in the category of primary level which is also the reason why women with primary level of education are in abundance. Overall, the education level of the respondents is low, and education has little impact on their lives, which aligns with the findings of Aggarwal (2024). This, in turn, may be attributed to the neglect of the government in framing a more inclusive syllabus and in building more accessible and inclusive schools that also cater to women with disabilities in Mizoram. This finding relates to the study of Srilata (2022) who has stated that women and girls with disabilities have found it difficult to pursue higher education due to lack of accommodations such as elevators, wheelchair ramps, sign language interpreters and accessible restrooms which is also the exact reason why the women respondents did not pursue higher education.

In terms of occupation, most of the women with disabilities in Mizoram are still unemployed and without jobs. Hence, it is evident that providing basic education or any vocational training to women with disabilities is crucial for them to find an occupation.

The issues in the field of education are analysed, and various problems which burden girls and women with disabilities are singled out. Our query in this section is related to five parameters which are as follows: 1. Level of education opportunities 2. Lack of inclusivity in education 3. The lack of educational facilities 4. Lack of specially trained teachers and 5. The level of the need for a separate inclusive curriculum. The issues raised in this section show that the educational opportunities for women with disabilities are very low and most women and girls with disabilities have expressed that they have only little chances to acquire education in Mizoram. The low level of educational opportunities is found due to a lack of inclusivity in the field of education as mentioned by most women from both districts. In Lunglei, all the women have raised their concerns about the low level of inclusivity and educational opportunities in the district. There are no women from both districts who seem to disagree with the statement that there is no lack of inclusivity in education. Again, all the women from Lunglei agreed that the level of educational facilities is very high in their district while most women from Aizawl have also agreed that there is a very high lack of educational facilities in the district. The lack of specially trained teachers is also very high in both districts. The need for a separate inclusive curriculum is also very highly needed as the women from both districts raised their concerns in this regard. Since the level of education and related fields is found to be underdeveloped, this shows that the goal of inclusive development cannot be progressive and calls for the need to improve the area of education for these women in Mizoram. This finding relates with the study of Sarker (2025) who have stated that the absence of inclusive curriculum, facilities, resources and services for women and girls with disabilities in higher educational institutions led to their low enrolment rate in higher education. Claire's (2018) study that describes the contributions of stigma and stereotypes of women with disabilities is also another reason for the low educational qualifications and issues faced in the field of education by the women respondents.

Conclusion

This study has shown that most of the respondents have low educational degree and lower educational opportunities which led them to have limited scope to find an employment. The implementation of RPwD Act, 2016 is yet to see more success in terms of providing inclusive educational settings for women with disabilities in Mizoram. The weak implementation of the laws by concerned authorities contributed to the state's low educational advancements for women with disabilities and combined with unsatisfactory special schools and special education further aggravated the conditions of women with disabilities. This has a profound effect on their opportunity to find an employment and this study shows the current failure of RPwD Act, 2016's implementation in the state in terms of special education. However, with combined efforts by the government and concerned authorities, the state is yet to see a desirable outcome in terms of providing special and inclusive education for women with disabilities in the state.

Scope and limitations of the study

This study has its own set of limitations. Firstly, since the research is confined only to two districts of Mizoram, the research might not serve as a total representation of the entire persons with disabilities in the state and also, the research confines particularly only to women and the educational hardships and struggles of the disabled women may not be the same with the men with disabilities.

Since only the educational aspects of women with disabilities is analysed and compared, arguments can be directed which state how the "study can be vague" since only one gender will not represent the needs on inclusive development of persons with disabilities in Mizoram.

The theoretical foundations of this study included only three theories which are social model of disability, stigma and labelling theory. Future scholars can employ other theories and disability models to build strong foundations for their study and to study disability from different theoretical perspectives.

While conducting fieldwork, the Hawthorn effect was experienced among the respondents. Many women altered their normal behaviour and attitude while interacting which makes rapport-building difficult. To counter this problem, the researcher had to re-visit the respondents' houses numerous times which was time-consuming. This study only focuses on socio-economic conditions such as

age, educational and employment status of the respondents and also studies only the educational sections of RPwD Act, 2016. Future researchers may study the effectiveness of other sections of the Act.

Since this research only deals with the inclusive development of women with disabilities in Mizoram, future researchers shall take into account other areas such as rehabilitation, economic struggles of disabled people, and achievements of the disabled. It would also be monumental if disabled people from other districts of the state could also be studied and analysed in future studies.

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