Gender Audit of Budgets in India (2001-2002 to 2009-2010)

Professor Vibhuti Patel

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SOCIAL MODERNITY

Asian Journal of Social Science

Special Issue on Social Equality

Editor

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'Social Modernity' is a peer-reviewed Journal aims to highlight and promote research orientation among bright and young research scholars of the Asian Universities in particular and to make additions in the field of knowledge in general. The objective of the 'Social Modernity' Journal is to provide an independent platform for publication of empirical and qualitative orignal researches done in the various disciplines in social science. The Journal is being published bi-annually i.e. twice a year in June & December.

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'Social Modernity' Asian Journal of social science (ISSN : 2229 – 6050) is being published in June and December from Ranchi (Jharkhand), India by a group of eminent scholars. The current issue focuses on 'social is equality'.

The noble beginning of the Journal aims to highlight and promote research orientation among bright and young researchers of the Universities and Educational Institutions. The objective of the Journal is to provide an independent platform for publication of empirical and qualitative origional researches done by the young researchers from various disciplines of social science.

The concept 'Modernity' emerged as a socio-psychological explanation of development in social science literature. 'Modernity' includes scientific discoveries and innovations, higher level of education, urbanization, industrialization, contemporary against ancient, new against old.

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The first issue (June, 2011) of the Journal 'Social Modernity' has been concentrated on 'social equality' in respect of socio-economic, political, legal, psychological and health development of man-women and children in different societies.

We are grateful to the contributors and the referees for their valuable time and opinions given to fullfil the objective of our mission.

We welcome suggestions and remarks of the scholars for moving forward.

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## BOOK REVIEW

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The micro business/services are supportive provisions and relevant to current business practices. They form a facility for business operations and especially to existing Self Help Groups (SHGs) and the same is essential to encourage or equip the women's force to become entrepreneurs. The much needed approaches focusing on SHGs need to explore opportunities, understanding the needs and demands of micro business trends within the desirable limits. In this paper, an attempt has been made to represent the SHGs' various forms of operational issues based on the wide variation of background, exposure, opportunities and the personality traits of the women SHGs in the three community development blocks of Western Kangra District in Himachal Pradesh. The case studies have brought forward the cultural life, impositions, implications and operational difficulties of women SHGs in social-economic contexts. The study reveals that how the male-dominant society enforces several conditions over the involvement of women in different activities.

The current social structures signifying the character of diversified geo-demographic, socio-political and cultural representations retain the regional character which are unique and in a distinguishable form. The women micro segments represent the communities facing constant deprivation due to their deprived environmental conditions which are inter-locked, paving way to vulnerable lifestyles. The component of deprivation in terms of exploring opportunities, capacity to invest in terms of inputs needed for suitable contribution, capacity for appropriate decision making and capacity to withhold the risks associated to accommodate in realistic conditions. These social segments form the bottom-line of inverse pyramid and witness considerable homogeneity in their approach towards community cult, adaptable abilities, challenges, preferred life styles and survival skills, etc.

The socio-structural variability proves to be critical factor in several applicable conditions. They are inclusive of segregated compositions of prototyped progressions, localized planning and realistic effects, non/under valued producible forms, highly selective consumption patterns and acute need-based marketable considerations, etc. The “criteria of possibilities” is the context based approach and at grassroot levels the perspectives exhibit negligible alignment with other related skills prevalent in the capacity of their prototyped forms viz., interactive, communication, entrepreneurial, promotional, information/knowledge routing/channel, facilitating/intermediation and integration, etc.
The major incapacities of micro-segments (SHGs) witnessed are:

- The incapacity to appropriately rationalize the operational loans taken;
- The incapacity to remain stable in a given business option (to complete gestation limits or to opt further financial support);
- The incapacity to assess the market demands and accommodate to market needs;
- The incapacity to overcome the business risks as the major consequence of ineffective decision making;
- The incapacity to locate a position which can substantially serve services-in-need;
- The incapacity to organize and manage the micro business talents help reducing their volume of vulnerability etc.

The SHGs discussion of integrated approaches aiming at exploring the womens’ innate competence is the measure of experiences creating income earning opportunities and empowering them through capacity building, training, support, mentoring and co-operative support in the challenging areas. These areas need both exposure and experience. The micro business/service supportive provision relevant to business skills form a facility for business operations to existing SHGs and need to encourage or equip the womens’ force to become entrepreneurs.

**SHGs Operational Environment:** A highly interactive environment understands the needs and aspirations of both “initiator and benefit segments”. It also widens the operational radius irrespective of the level of operational involvement. These limited conditions glorify:

- the self-centric view enables the SHG communities to permit function-based operational effects in definite spaces, and
- the much needed approaches of exploring opportunities, understanding the needs and demands of micro business trends and attending the simplistic need portfolios within desirable limits.

Thus, micro-credit as an interventional strategy has shown different performances and achievements. According to economic survey 2007-08, a credit of Rs 20,114 crores was advanced to 30.15 lakhs beneficiaries. These SHGs, and NGOs have corroborated the government’s effort to reach out to the poor masses. The micro credit as a strategy flows into rural and urban areas but utilization shows different factors pragmatically. For example, in urban areas its target is self employment. The slum residents availed loans for health, social ceremonies, household (repair, advances, etc). In rural areas these micro finances are also availed and utilized for different purposes. In fact, these policies help poor people gain assets like land, agricultural implements, mitigating social conflicts, etc.

Development Agencies/Nodal Agencies in India, like NABARD, SIDBI and RMK provide funds for credit. They support MFOs and have separate allocations for SHGs and micro-credit. These organizations have developed guidelines and training materials to help MFOs implement micro-credit activities covered under their perview. The Indian experience of micro credit is incomplete without references to SEWA banks whose clients are all SEW (Self Employed Women). The SEWA Banks offer varied services along with
micro credit. Noteworthy contribution of SEWA along with credit has been able to extend its role into special nutrition programme, universal immunization, child survival and safe motherhood programme.

In order to be the beneficiary of the micro credit, the process could be multi-dimensional in approach. Firstly, the individuals could approach the donors or the banks to seek micro credit and establish a micro enterprise. This micro enterprise would fulfill the consumption needs of the economic farm related activities. The second process refers to the organization of the SHGs through awareness, promotion and the formation. Once these groups are consolidated with significant savings and credit delivery system, this leads to income generation and economic empowerment. The third process is related to non-farm economic activities where an individual can contact the government or the banks for micro credit.

**Line Experience and Arena of SHGs:** If operational excellence is needed in the much sought areas (i) It would enhance assured profitability; (ii) promote competent leadership; (iii) value to customer and market services; (iv) supplementing the competitive forces etc., understand the operational issues as the area which wrap the functional contributions in the form of business decisions made by the SHGs. These issues have important bearing on the diversified backgrounds in terms of environment, infrastructure support, bureaucratic approaches and the significant role of facilitators which nurture the very idea of self-standing among vulnerable women segments.

**Micro Operational Radius and Autonomy:** The operational situations and corresponding challenges remain varied in all the contexts of SHGs. The women in their vulnerability are permitted to select the activities which are familiar, controllable, well within their capacities and are also based on factors of homogeneity, stereo-typing, traditional knowledge, infrastructural difficulties and not the least with socio-cultural influences which play dominant role in the business applicability. The gender-based comparative analysis suggests that the women remain vulnerable in the business context and have limited scope and opportunities as compared to men. The major attributing factors for this discrimination are in terms of purchase decisions, refinement of skills, participation as senior member, heavy dependence on NGOs, facing time constraints and criticism from family members for negligence in family responsibilities, etc.

**Methodology**

The case study approach has been followed in the study to identify the implications and their progressive trends in the realm of operational difficulties faced in the process of observation, implementation and association of the SHGs. The case study investigation was restricted to only three community development Blocks of Western Kangra District i.e., Nurpur, Fatehpur and Indora. Location, identification and selection of suitable sample respondents for participation i.e., the self-help groups and its members were on the criteria of convenient sampling.
The following factors were taken into consideration:

(a) General Information with reference to Self-Help Groups
(b) Group Effects and Challenges
(c) Specific Questions (Group View)

Tools

The tools used for collection of information for the study were: Informal Interviews and Focused Group Discussions (FGDs), etc. Formal and informal meetings were organized with self-help groups (SHGs) and it included the appropriate strategy of step-wise execution of the investigation and fact reporting by the investigator. The case study has adopted both the descriptive and analytical approach.

Some Case Studies

Case Study- 1:

The Samriddhi SHG was initiated on 28th July, 2009 in village Jagnoli under the Fatehpur Community Development Block with 15 women members. The chairman has passed class VIII and rest of the members were illiterate, working as agricultural seasonal labourers. The local NGO initiated the women to form into SHG, under the Block Development Employment Scheme supported with a grant. The women were approached to attend the meeting and were selected for one month training for making wax candles. The SHG was formed and decided to save Rs. 50/- p.m. per head. The banking habit was developed and after six months of the formation of SHG, grading exercise was done by Block officials and bankers. The group was qualified for getting revolving fund of Rs. 25,000/-. The Kangra Co-operative Bank of Fatehpur sanctioned a loan of Rs. 25,000/- which was meant to strengthen their corpus fund. The group was asked to survey the market and get the initial business idea and the demand in the market. There was positive response from the local retailers and shops to promote their business. The group constructed a shed in the compound of chairman and necessary infrastructure for making candles. The NGO helped them in getting the needed tools and moulds. The training officials appointed by BDO were visiting them from time to time to check the status of the work, production systems and quality of candles made by women. The product had a local demand and there was no other group for this business line. The group was successfully generating self-employment through candle making. The NGO was extending the marketing to the group, which participated in SHARAS last year. The women were satisfied to earn Rs. 800-1200 p.m. The candle making was proved to be profitable and successful step for the women in generating self-employment and regular income.

1.1. Operational Problems: The women who were given training assembled to form a SHG of their own. The pre-conceived idea of business was absent to get adopted and constant interventions were needed. After several rounds of training, the women became comfortable in the candle making. They actually learned the process of candle making and took the support of NGO for all ground work viz., arranging the loan from bank, periodical deposit of accumulated amounts into the bank and later the repayments of the
loan installments. These women never went to buy the raw material, as it was always done by the chairperson who was also a supervisor. She was the communicator on behalf of the group members with NGO, collected the ready-to-sale candles and took the responsibility of selling them. The women of self-help group were happy, as they were not gone in search of the market. But, the underlying problem was that the NGO had taken a good proportion of grant provided by Block Development Authorities (which in turn had its share too) and a meagerly amount of Rs. 4,000 was given out of Rs. 25,000/. The women were provided with training and this actually made them skillful in candle making only, not in the business operations and communications needed to promote the business. The withdrawal of NGO support was lead to business collapse, as the women neither went to the market nor the bank for any business deal. The facility of marketing of finished product only gave the women their labor charges, not the benefit of profit on the business deal. The profit margins were the privilege of NGO which took over the selling activity needed marketing skills, competence in locating potential markets, price and client dealings, etc.

1.2. Implications: The women were only partially empowered, as they were able to earn some regular income but the expansion of business was not the decision of members but of the NGO. An end-to-end business plan needed to be taught to women rather than partial involvement. The vital areas of purchase, finance, marketing and distribution were ignored and keeping only production function as a token of empowerment could not remained feasible condition.

Case Study - II:

The SHG was formed on 23rd Nov. 2009 by 15 BPL women members of the village Bhaleta under Nurpur Community Development Block. They opened a Savings Bank Account in State Bank of India and a C/C loan was sanctioned for Rs.25,000/ to the group by the bank. They took up weaving as economic activity and started selling the products such as shawls, sweaters and woolen garments for children. They increased their corpus fund up to Rs. 60,000/. They qualified as grade II and an amount of Rs. 1,52,820/ was sanctioned as loan. They expanded their activities and also engaged three BPL women labors from the same village. Thus, the group enhanced their standard of living and also helped the labor from other BPL families. The recovery was satisfactory and the annual income of each member of the SHG went up to Rs. 26,400/.

2.1. Operational Issues: The familiarity of the skill existed among women as a traditional and inherited skill. Women were versatile weavers of various patterns and designs. Majority of them were already in the business and this formation of group only made them to work unitedly. Some of the women members were in weaving by caste and the entire family including men folk was engaged in the business. Very few members were the women knowing weaving, their families were engaged in agriculture. The combination actually did not produce parity in involvement and the members decided to be regular in loan repayments. The loan amount was provided and this was shared in disproportionate form by the members. The chairperson of the group has not come from the family where weaving was done traditionally, but had good knowledge of weaving due to her own
interest. Her husband was a petty contractor and has nothing to do with weaving. The NGO has insignificant and temporary role in forming the group. The weaving families had knowledge of banking and marketing of the products, as they were already in the business. The SHG was merely for the purpose of fund raising and for expanding their business. All women were engaged in weaving and the established weaving families took over the show and volunteered to sell the finished products. They were engaged in transport, credit dealing, regular supply of raw material at good bargain able price.

2.2. Implications: The women involvement varied due to the family backgrounds i.e., the women from weaving families and women from non weaving families. The chairman belonging to non-weaving family became an ornamental head of the SHG as the dominant weaving families know more about the business than the chairperson or even the NGO. The established links were further strengthened and the non-weaving families were made to be dependent and were not given any idea to the purchase of raw material, bargain quality, color combination, design patterns, designs in-demand, sale price and the typical business favors and tie-ups. In short, the women only promoted the business of weaving families and were better-positioned labor force that goes paid promptly by weaving families. The NGO was kept aside as the bank and market dealings were undertaken by the men of the weaving families. The risk was conditioned but the growth was sealed. It was not difficult for the women from non-weaving background to establish the business as they were not by caste belonging to the weaving community, nor have caste-based market contacts and knowing the loopholes of the business. As new entrants in to unfamiliar business did not help them as they were forced to share their profit margin with traditional weaving families. It was easy for the women to remain indoors and continue to weave without being bothered about other business complications. This situation does not actually made them empowered due to their part involvement. The SHG in fact became a real business platform where the members’ competencies and resourcefulness mattered more than the supportive measures.

Findings

The case studies drawn from different situations depict different forms of operational issues, from various natures of background, exposure, opportunities and the personality traits of the women SHG. The women had taken initiative in the SHG formation revealed in their instant acceptance and willingness to work, who otherwise were fully engaged in the familial responsibilities and sparing limited time for any other activities.

The common features identified among the SHGs under investigation were volunteering and had positive attitude, sympathetic views towards the common cause, and concern for their families, despite their busy engagements. Majority of the members were well versed with traditional crafts and versatile like knitting, tailoring, cooking, weaving, mehndi designing, usage of dyes and fabric colors, etc. The negative attitudes in terms of taking decisions, were using individual autonomy despite family willingness, over concern for families, comfortable in familiar activities but reluctance in learning new skills, unwilling to do anything additional, without disturbing their current routine, spouse-involvement was more than self-involvement and prefer to maintain self-prescribed conditions.
The institutional involvement was not out of its criticism. Despite effective objectives, availability of qualified professionals, offer of infrastructural facilities and continuous support, the offered services were not timely, potential and qualitative. However, it needed to be accepted that their efforts created massive awareness towards the concepts of micro-credit, group formation among women and watershed and other utility ventures of mega nature etc. would not have entered into the peripheries of SHGs. A close monitoring and some dedication towards the objectives, enabled the concerned officials to concentrate on the developmental activities.

The women SHG framework identified their fundamental components based on the assumptions which decide the attributes and character of these micro groups. This helped them to decide the outcome of developmental process, rather than inputs into it. It is the will power, determination and aggressive input behavior which matters more than the appropriate physical facilities or persuasion which might developed as successful ventures.

**Developmental Approach of SHGs**

| 1. | SHG encouraged the women in participatory management | Attitude of self-standing was replaced by the group concern and the loaded responsibility of group allocation, assignment group think and shared responsibilities created a practical experience of participation. |
| 2. | SHG as a community developmental measure | The work concept, community prior individual, mapping of tasks, critical outlook, profitability, survival strategies, competition and autonomy in expression and understanding enabled the women to look at the life issue in a more resolved form rather than a problematic form. |
| 3. | SHG as a livelihood measure | The women in vulnerability felt that the SHG especially supported with grants and donor support not only concentrated on the women empowerment but also looked into other areas of equal vitality like health, education and child care etc. |
| 4. | SHG as a social resource | The women’s groups were given opportunities to meet with other SHGs of same and different localities and the regional SHGs fall under Federations under the promotion of NGOs have several issues shared and discussed. These networking enabled the women to have different outlook of self-building and dedication towards the new role of women. |
| 5. | SHG as contributor to economic growth | The petty views, ideas and contributions of SHGs were the practical life aspects enabled to create large number of service activations, commercial networking, facility interdependencies and social recognition. The petty entrepreneurship systems in their turn had become the core points of localized growth and development. |
Conclusion

To conclude, the case studies from multiple situations and the SHGs formulated on the criteria of intended improvement in the life styles of vulnerable women, defined the innate stronger intentions, confirmed and analytical capacities and the initiatives were the most volunteering character of majority of the women. The women in their exposure of illiteracy, cultural and ethnic prerogatives have volunteered to the new external support system, which was competent in motivating them to deal with the issues, consequences and learning systems. The operational challenges posed in the above mentioned case studies, revealed the continuous bold measures adopted, stern decisions taken and the capacities to dominate the situations, whenever needed could be observed and the women were self-motivators and initiators of change in their livelihood strategies in the concerned localities.

Reference


Gender Audit of Budgets in India (2001-2002 to 2009-2010)

Vibhuti Patel*

Budget is an important tool in the hands of state for affirmative action for improvement of gender relations through reduction of gender gap in the development process. It can help to reduce economic inequalities, between men and women as well as between the rich and the poor. Hence, the budgetary policies need to keep into considerations the gender dynamics operating in the economy and in the civil society. There is a need to highlight participatory approaches bottom up budget, child budget, green budgeting, local and global implications of pro-poor and pro-women budgeting and inter-linkages between gender-sensitive budgeting and women's empowerment. Understanding the relationship between macroeconomic policies and the Union Budget, state budgets and the local self-government institutions in the context of economic reforms and globalization is a MUST as it has influenced women's lives in several ways. It is good economic sense to make national budgets gender-sensitive, as this will enable more effective targeting of government expenditure to women specific activities and reduce inequitable consequences of previous fiscal policies. The Gender Budget Initiative is a policy framework, methodology and set of tools to assist governments to integrate a gender perspective into the budget as the main national plan of public expenditure. It also aims to facilitate attention to gender analysis in review of macroeconomic performance, ministerial budget preparations, parliamentary debate and mainstream media coverage. Budget impacts women's lives in several ways. It directly promotes women's development through allocation of budgetary funds for women's programmes or reduces opportunities for empowerment of women through budgetary cuts.

Gender budgeting is gaining increasing acceptance as a tool for engendering macroeconomic policy-making. The Fourth World Conference of Women held in Beijing in September 1995 and the Platform for Action that it adopted called for a gender perspective in all macroeconomic policies and their budgetary dimensions. The Outcome Document of the UN General Assembly Special Session on Women held in June 2000, also called upon all the Nations to mainstream a gender perspective into key macroeconomic and social development policies and national development programmes. Emphasis on gender budgeting was also placed by the Sixth Conference of Commonwealth Ministers of Women's Affairs held in New Delhi in April 2000.

In India, till 2004, the process of gender budgeting was a post-facto effort to dissect/analyse and thus offset any undesirable gender-specific consequences of the previous budget. But 2005 onwards, the scenario has changed. Due to consistent lobbying by the

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gender economists and women’s groups; for the first time, in 2005, the Ministry of Finance gave a mandate to all ministries to establish a Gender Budgeting Cell by January, 2005. At present, 54 ministries and departments have formed gender budget cells and have provided annual reports and performance budgets highlighting budgetary allocations for women. The first Gender Budgeting Statement (GBS) in the Union Budget 2005-06 included 10 demands of grants. In 2006-07, the GBS got expanded to 24 demands for grants under 18 ministries/ departments of the Union government and 5 Union Territories. During the current financial year, i.e. 2009-10, the GB Statements covered 34 demands for grants under 27 ministries/ departments and 5 Union Territories.

**Macro Economic Scenario**

India’s economic reforms- Structural adjustment programmes and globalization policies have directly increased women’s unpaid work burden, thereby increased women-provided subsidy in the economy (Patel, 2009). Devaluation of real income due to inflation leading to price rise of essential commodities and services, erosion of public distribution system and reduction of services offered by the public health system, trafficking of girls for child-labour, sex trade and forced marriage as a result of destitution, privatization of education and rising male unemployment in traditional sector have made women bear disproportionate share of burden. In the patriarchal families women have to shoulder responsibility of providing meals and looking after the sick family members. Women have high stakes in preventing an increase in the proportion of indirect taxes on essential commodities and in budgetary provisions to guarantee food security, good quality of education and health care. Hence, careful study of the working of PDS and local taxonomy on food security and impact on nutrition, education, employment generation, health and health services of budgetary allocations is must. (Patel, 2002).

**Implications of the Planning Process on Gender Budget**

The Planning Commission of India has always focused on women’s issues as per the perceptions of their members on women’s status within the economy.

**The First Five Year Plan** (1951-1956) set up Central Social Welfare Board in 1953 to promote welfare work through voluntary organisations, charitable trusts and philanthropic agencies.

**The Second Five Year Plan** (1956-1960) supported development of Mahila mandals for grass roots work among women.

**The Third, Fourth and Interim Plans** (1961-74) made provision for women’s education, pre-natal and child health services, supplementary feeding for children, nursing and expectant mothers.

**The Fifth Plan** (1974-1978) marked a major shift in the approach towards women, from ‘welfare’ to ‘development’, labeled by the women’s studies scholar as WID (Women in Development’ approach.

**The Sixth Plan** (1980-85) accepted women’s development as a separate economic agenda. The multidisciplinary approach with three- pronged thrust on health, education and
employment. The sixth Five Year Plan onwards, the plan document has been including a separate chapter on women and children.

**The Seventh Plan** (1985-1990) declared as its objective to bring women into the mainstream of national development. During this period, the Department of women and child was established within the Ministry of Human Resource Development (MHRD) of the Government of India (GoI). The Seventh Plan introduced the concept of monitoring of 27 beneficiary oriented schemes for women by DWCD. The exercise continues and number of schemes covered is being expanded. The women’s studies scholars consider it a WAD (Women and Development) approach.

**The Eighth Plan** (1992-1997) projected paradigm shift, from development to empowerment and promised to ensure flow of benefits to women in the core sectors of education, health and employment. Outlay for women rose from 4 crores in the First Plan to Rs. 2000 crores in the 8th Plan. The Eighth Plan highlighted for the first time, a gender perspective and the need to ensure a definite flow of funds from the general developmental sectors to women. The Plan document made an express statement that “….the benefits to development from different sectors should not by pass women and special programmes on women should complement the general development programmes. The later, in turn, should reflect great gender sensitivity”. With this plan GAD (Gender and Development) approach became popular among the policy makers.

**The Ninth Plan** (1997-2002) stated that Empowerment of women was its strategic objective and adopted ‘Women Component Plan’ (WCP) as one of the major strategies and directed both the Central and State Governments to ensure “not less than 30 per cent of the funds/benefits are earmarked in all the women-related sectors.” Special vigil was advocated on the flow of the earmarked funds/benefits through an effective mechanism to ensure that the proposed strategy brings forth a holistic approach towards empowering women. The National Policy for Empowerment of Women 2001 of GOI adopted during this period envisaged introduction of a gender perspective in the budgeting process as an operational strategy.

Regarding formulation of Gender Development Indices, National Policy for Empowerment of Women 2001 stated, “In order to support better planning and programme formulation and adequate allocation of resources, Gender Development Indices (GDI) will be developed by networking with specialized agencies. Gender auditing and development of evaluation mechanisms will also be undertaken along side. Collection of gender disaggregated data by all primary data collecting agencies of the Central and State Governments as well as research and academic institutions in the Public and Private Sectors will be undertaken. Data and information gaps in vital areas reflecting the status of women will be sought to be filled in. All Ministries/Corporations/Banks and financial institutions etc. will be advised to collect, collate, disseminate data related to programmes and benefits on a gender-disaggregated basis. This will help in meaningful planning and evaluation of policies.”

**The Tenth Five Year Plan** (2002-2007) suggested specific strategies, policies and
programmes for empowerment of women. It appreciated efforts at ensuring gender-just and gender-sensitive budget and promised to continue the process of dissecting the government budget to establish its gender-differential impact and to translate gender commitment to budgetary commitments. It made provision of outlay of Rs. 13780 crores. It accepted that Women Component Plan & Gender Budget play complimentary role for effective convergence, proper utilisation and monitoring of fund from various developmental sectors. The Ministry of Women and Child Development was established during this plan period.

The Eleventh Five Year Plan (2007-2012) demands gender mainstreaming and mentions “Gender Equity requires adequate provisions to be made in policies and schemes across Ministries and Departments. It also entails ‘strict adherence to gender budgeting across the board’. It promises special focussed efforts for creation of ‘an enabling environment for women to become economically, politically and socially empowered’.

Gender Audit of Union Budgets

Women’s status and women’s bargaining power in the economy have a major bearing in the budgetary allocations. “Gender Budgeting consists of empirical exercises that focus on public policies and aim to bring out their gender specific implications.” (Banerjee, 2002).

Yearly analysis of the budget from the point of view of women is a must to enhance women’s economic interest and socio-political standing in the economy. Analysis of budget from gender perspective makes us understand what are the nature, character and content of women’s share of development cake. Women’s groups and gender economists started dissecting union budgets with gender concerns from 2001 onwards. The year 2001 was declared as ‘Women Empowerment Year’ by the government.

The gender budgeting initiative in India started in July 2000 when a Workshop on ‘Engendering National Budgets in the South Asia Region’ was held in New Delhi in collaboration with the UNIFEM, in which Government representatives, UN agencies, media, NGOs, research institutions, civil society and members of the Planning Commission in the South Asia region participated. Noted gender auditing professional Professor Diane Elson made a presentation and shared her experiences on gender budgeting through an interactive session. National Institute of Public Finance and Policy (NIPF&P) was commissioned to study Gender Related Economic Policy Issues, which included gender segregation of relevant macro data, quantification of contribution of women in economy, assessment of impact of Government Budget on women, the role women can play in improving institutional framework for delivery of public services and the policy alternatives for building a gender sensitive national budgeting process.

Certain public expenditure schemes have pro-women allocations, though they are not exclusively targeted for women. For instance, Swarna Jayanti Swarozgar Yojana, Integrated Child Development Scheme, National Education Programme, Sarva Shiksha Abhiyan, District Primary Education Programme (DPEP) etc.
The gender disaggregated public incidence analysis of elementary education budget reveals that girls received around 40 per cent of total public spending on elementary education. On a per capita basis, share of girls worked out at Rs. 286 against Rs. 344 per boy at elementary school stage.

The study concluded that gender incidence of the benefits of public expenditure is difficult to measure in precise quantitative terms, since the bulk of the expenditures are meant to provide services that are essentially public in nature, for instance, benefits of expenditures on defense, maintenance of law and order and dispensation of justice are enjoyed by all citizens irrespective of caste, creed or sex. Nevertheless, considering the gender bias inherent in a male dominated society the budget should provide some idea about how much is earmarked specifically for the benefit of women. The suggestion is not that the gender-wise break-up of all government expenditures should be provided but that the expenditures meant primarily for women be shown separately so that they can be easily culled out from budget heads of social and economic services in which it is possible to segregate such expenditures. Efforts of gender economists were targeted to evolve mechanism to collate gender disaggregated data from relevant Departments be developed to obtain the gender-wise relevant statistical database, targets and indicators; provide gender audit of plans, policies and programmes of various Ministries with pro-women allocations should be conducted and lobby for segregated provisions for women in the composite programmes under education, health, employment, housing and rural development, etc. to protect the provisions by placing restrictions on their re-appropriation for other purposes.

**Discourse on Gender Budgeting in India during the last Decade**

During last one decade the discourse on Gender Budgeting has revolved around the following issues:

**Child Sex Ratio:** The Census of India, 2001 revealed further decline in the child sex ratio in several parts of India. In the urban centers, deficit of girls has been enhancing due to pre-birth elimination. In spite of demand of women’s groups and recommendation of the Eleventh Five Year Plan to revisit the two child norm laws, several state governments continue to victimize the victim, namely poor, dalit, tribal and Muslim women and unborn girls (as the norm has resulted into intensified sex selective abortions). More budgetary allocation was demanded to implement Pre-conception and Pre-natal Diagnostic Test to prevent sex selective abortion of female fetuses.

**Reproductive and Child Health:** Evaluation of Chiranjivi Scheme to halt maternal mortality has revealed that the public private partnership in this scheme allows private practitioners milk tax payers money without giving necessary relief to pregnant woman. Only in cases of normal delivery, the private practitioner admit women for delivery and in case of complicated delivery, the concerned women are sent to over-crowded public hospital. In National rural Health Mission (NRHM), the woman health workers are not paid even minimum wages and are paid “honorarium”. More budgetary allocation is demanded to ensure statutory minimum wages to them.
**Integrated Child Development Scheme (ICDS):** Restructuring of ICDS must promote convergence of several schemes of different ministries such as health, rural development, tribal development, JNNURM targeting children. Though the Eleventh Five Year Plan (2007-2012) promised ‘Walk in ICDS centers’ at railway stations and bus stands for migrant women and children, none has started yet; not even in the megapolis such as Mumbai, Delhi, Kolkata and Chennai!!

**Under category of 100% allocation for women,** institutional support for women survivors of violence need major attention, but so far not much has been done regarding Scheme for Relief and Rehabilitation of Victims of Sexual Assault promised by the Five Year Plans since 2000. Women’s groups providing support to women survivors of Domestic violence are highly disappointed as no separate allocation for Implementation of Domestic Violence Act, 2005 which had defined major role of service providers such as hospitals, law & order machinery, protection office/ counselor and shelter homes.

**Budgetary Allocation for Water Supply & Sanitation** that affects women’s life greatly as consumers and unpaid and partially paid-workers does not mention women. This will perpetuate ‘unproductive female workload of fetching water from long distance’ avers Indira Rajaram (2007). She demands, “water-sheds in the country need to be contoured on the Geographical Information systems (GIS) platform. Using space technology for mapping of aquifers, a five year plan needs to be drawn up for creating sustainable water sources within reasonable reach of rural habitation.” (Rajaram, 2007).

**Energy Expenditure of Women:** Collection of fuel and fodder demand great deal of time and energy from women and girls. The 11th Plan document has acknowledged the fact, but in reality nothing significant is done in terms of priority alternative to bio-fuels that causes smoke related illnesses.

**Social Security for Women in Informal Sector:** The bill on Social Security for women workers, introduced in the parliament has been shelved. In the labour market, bizarre scenario is created where girl children are trafficked for sex trade/ domestic work and slave labour in occupationally hazardous condition, sexploitation, domestic work/ servitude; young women workers in Special Economic Zone are hired and fired as per the whims of employers and are paid miserable wages. Comprehensive legislation for Protection of Domestic Workers applicable throughout the country is needed urgently. Reasons for non-utilisation of funds under Maternity Benefit Scheme must be examined and concerned offices must be made accountable. In Unorganized Workers’ Social Security Act, 2008 (Bill No. LXVII of 2008), special problems of women unorganized workers must be included.

**Women’s Rights Education:** No efforts are made by the state or professional bodies for employers’ education about basic human rights of women workers. Supreme Court directive on ‘prevention of sexual harassment at workplace’ is still not implemented by most of the private sector employers and media barons.

**Utilization of Financial Allocation for Pro Women Schemes:** Only 3-4 states are taking advantage of financial allocation for Scheme for shelter, clothing and food for women in difficult circumstances, working women’s hostel, short stay homes for women in difficult
circumstances, UJJAWALA: A Comprehensive Scheme for Prevention of trafficking and Rescue, Rehabilitation and Re-integration of Victims of Trafficking and Commercial Sexual Exploitation. Implementation of crèche scheme is far from satisfactory. Three meals per child per day at the crèches recommended by Eleventh Five Year Plan are rarely provided. Except for Tamilnadu, Cradle Baby Reception Centers for abandoned babies are non-existent in rest of India. No status report is available on Integrated Child Protection Scheme (ICPS) promised in the Eleventh Five Year Plan.

**Fund Flow to PRIs** has not been streamlined even after separate budgetary allocation for PRIs made in the union budget for past 3 years. How many states have provided women’s component in the funds earmarked for the local self-government bodies at village, block and district levels? Is it utilized judiciously for fulfilling practical and strategic needs of women?!

**Road and Rail Transport for Women:** India is undergoing U-shape phenomenon so far as women’s work participation is concerned. Most of the working women in urban and rural areas travel in overcrowded buses and trains. In the transport sector top priority needs to be given for women special buses and trains in all cities. For women street vendors, seat-less buses and special luggage compartments in trains need to be provided.

**Implementation of Legislations**

Promise of the 11th Five Year Plan to allocate funds for Implementation of PCPNDT ACT, 2002 and DV Act has remained unfulfilled in most of the states a marginally fulfilled in some states such as A.P., Kerala, Karnataka and Tamilnadu.

No progress is made in providing audit of land and housing rights of women by any ministry- Urban Development, Rural Development, Tribal Development, PRIs and Urban local self Government bodies.

**After consistent highlighting of the findings of Rajendra Sachar Committee Report, 2007** on deplorable socio-economic status of majority of Muslims in India, special budgetary allocation for socially excluded minority communities is made. In sub-plan for minorities where allocation of Rs. 513 crore is made in Budget estimates, no specific allocations is made for minority women/ female headed households by Ministry of Minority Affairs.

Inadequate allocation for crucial schemes affecting survival struggles of women such as **Rajiv Gandhi National Creche Scheme for Children of Working Mothers** (Rs. 56.50 crore), Working Women’s Hostel (Rs. 5 crore), Swadhar (Rs. 15 crore), Rescue of victims of trafficking (Rs. 10 crore), Conditional cash transfer for Girl child (for the 1st time introduced and allocation of Rs. 15 crore made) need to be analysed by a scholar like Ms. Nakaray.

Dangerous consequences of tax free clinical trials with stated goal of making India a preferred destination for drug testing to private sector as it will make the poor guinea pigs at the hands of commercial minded techno-docs. Non-utilization and partial utilization of funds allocated for protective, promotive, economic and social welfare programmes for
women due to faulty design of the scheme (Maternity Benefits Scheme, non-syncronisation of financial allocation and schemes (funds targeted for adolescent girls’ nutrition) and MPLADS (Members of Parliament Area Development scheme) and funds earmarked for grain banks in the tribal areas known for starvation deaths demand urgent attention of politicians, bureaucrats, citizens organizations and women’s groups.

Studies need to be commissioned to highlight the gap between plan outlay and outcome, local and global implications of pro-poor and pro-women budgeting, alternative macro scenarios emerging out of alternative budgets and inter-linkages between gender-sensitive budgeting and women’s empowerment.

There is an urgent need to sensitize economists about visibility of women in statistics and indicators by holding conceptually and technically sound training workshops by gender economists.

Gender economists have strongly recommended tax reduction for working, self employed and business women. Lowering tax rates for women will put more money in their hands and encourage those not yet in the job market to join the work force. Similarly, property tax rules should be amended further to encourage ownership of assets among women. When women are economically independent and secure, they can exercise choice, enabling them to get out of repressive conditions. Moreover, they would contribute more to our growing economy, making it a win-win situation.

Ministry of Women and Child Development needs more vociferous and visionary leadership, political will and courage of conviction to strive to not only fulfill the promises made by the Eleventh Five Year Plan but also expand the democratic space for women and girls in socio-cultural, economic, educational and political spheres.

**Case Study of Union Budget of India, 2010-2011**

In the current Union Budget 2010-2011 by the Ministry of Finance of the Government of India, the Women and Child Development Ministry has received an additional allocation of Rs. 2446 crores over Rs. 7218 crore in 2009-10. National Mission for Empowerment of Women has been the new initiative this year. The ICDS platform is being expanded for effective implementation of the Rajiv Gandhi Scheme for Adolescent girls. Barring for this encouraging aspects, the current budget has not brought great hopes for women.

The financial allocation for the National Commission for Women that is an apex body for women’s empowerment has been reduced from 9.06 to 7.75 crores. The budgetary allocation for working women’s hostels is highly inadequate with an increase of only 5 crores at a time when the number of working women is continuously increasing. The Rashtriya Mahila Kosh allocation has come down from 20 to 15 crores that will cast serious blow to livelihoods for women. Leaving this crucial area to financial market will further increase the vulnerability of women’s self help groups.

It is shocking to know that the budget provides shamefully low expenditure for relief and rehabilitation for victims of rape. Whereas the allocation was 53.10 crores in the previous budget, the actual expenditure was only 16 lakhs, and the current budgetary outlay
has been reduced to 36.2 crores. Yet again, there has been no allocation in the central budget for providing infrastructure, etc, for the Protection of Women from Domestic Violence Act, 2005.

The budget has reduced food subsidy of over 400 crores and the fertilizer subsidy by 3000 crores. The need for a stronger public distribution system to combat widespread hunger and malnutrition which has been the demand of women’s organizations has been completely ignored. In fact, the government seems inclined to move towards a dismantling of the existing PDS, to be substituted by food coupons, which can only mean further exclusion of women and the BPL population from food security.

The mid day meal scheme has seen an increase of 16 per cent in the budget, but in the context of a 20 per cent rate of inflation, neither full coverage, nor minimum quality can be ensured. This will further exacerbate the malnutrition status of women and children, particularly those from already marginalized sections like adivasis and Scheduled Castes. The increase for ICDS is 461 crores- which is just about enough to cover existing centres, and cannot provide for the 14 lakh anganwadis to become functional, as per the Supreme Court directive.

While the announcement of the Matritva Sahayog Yojna to assist pregnant and lactating mothers is welcome, the allocations for health and education fall far short of women’s groups’ demand that each of these ministries should account for 6 per cent of the GDP. There is no mention of the ASHA worker, and no fund allocation to ensure just wages to this woman health activist.

An escalation in prices of essential commodities with the increase in the excise duty on petroleum and petroleum products by Rs 1.00 per liter will increase the retail prices of petrol and diesel by more than Rs 2.00 per liter. It will place an additional heavy burden on the shoulders of common women already reeling under an 18 % rate of inflation in the last few months.

In its Pre-budget memorandum submitted to the Finance Minister, Women Power Connect had stated that in all metropolises -class I, II, III, IV and V cities- safe public transport in terms of buses and trains must be provided to working women. For women vendors and traders, luggage compartments in the trains and buses should be provided. Budget has completely ignored this demand.

In the Budget, 2010-11, the basic threshold limit for income tax exemption will remain at Rs 1.60 lakh. Under the new proposal, 10 per cent tax will be levied between Rs 1,60,001 and Rs 5,00,000, 20 per cent on incomes between Rs 5,00,001 and Rs 8,00,000 and 30 per cent above Rs 8,00,000. For women, the tax exemption will remain at Rs. 1.9 lakh³ as it was in the previous year’s budget.

An analysis of the budgetary allocation by Centre for Budget and Governance Accountability (CBGA) has revealed that child development schemes form 97.2% of the WCD ministry’s budget. The lion’s share is taken up by the Integrated Child Development Scheme (ICDS) leaving only a measly 2.4% for women-related programmes.
Gender Analysis of State Budgets

The findings of the study of NIPFP were discussed in a workshop held on 3rd - 4th October, 2001 in which representatives from the Finance Ministry, Census, State Governments, UN agencies, gender experts and activists participated. (Lahiri et al, 2002) Another Workshop on Gender Analysis of State Budgets was convened on 6th December which was also attended by State Secretaries/Directors of the Department of WCD/ Welfare. The workshop concluded that there is a need to analyse State budgets with a gender perspective since the States/UTs account for bulk of the expenditure in social sector which impinges on the welfare, development and empowerment of women. A network of research institutes and gender experts throughout the country were selected to guide the exercise of analyzing State budgets to track the gender differentiated impact and outcome of budgetary process and policies. The workshop also agreed to a framework for undertaking State level gender budget analysis. It was decided that a quick desk analysis of the State budget documents be made to identify the following categories of schemes and programmes: Women Specific Schemes – defined as schemes where 100% of allocation was meant for women; Pro Women schemes defined as those, which incorporate at least 30% of allocation for women or significantly benefit women; Gender-neutral schemes meant for the community as a whole. These programmes were further classified in four categories on the basis of their potential impact on women’s social position: Protective services, such as allocations on women’s homes and care institutions, rehabilitation schemes for victims of atrocities, pensions for widows and destitute women etc which are aimed at mitigating the consequences of women’s social and economic subordination, rather than addressing the root causes of this subordination. Social services, such as schemes for education and health of women, support services like crèche and hostels and also water supply sanitation and schemes on fuel and fodder, which contribute significantly to women’s empowerment, either directly by building their capacities and ensuring their material well-being, or indirectly through reducing domestic drudgery. Economic services, such as schemes for training and skill development, and provision for credit, infrastructure, marketing etc. which are critical to women’s economic independence and autonomy. Regulatory services which include institutional mechanisms for women’s empowerment, such as State Commissions for Women, women’s cells in Police Stations, awareness generation programme etc which provide institutional spaces and opportunities for women’s empowerment. During last decade compilations have been made on: Scheme-wise/Sector-wise/Year-wise Budget Estimates/Revised Estimates/Actual Expenditure in both Plan and Non-Plan Heads; The percentage of Budget Estimates/Revised Estimates/Actual Expenditure in relation to total budget in both Plan and Non Plan Heads and also in relation to total social sector budget in both Plan and Non Plan Head; The percentage of gap between Budget Estimates and Revised Estimates and between Revised Estimates and Actual Expenditure in both Plan and Non Plan Heads in various identified schemes.

Problem of Utilization of Funds Allocated for Area Development:

In 2006, The Ministry of Women and Child Development was formed. Still for most
of the schemes and programmes, there is 66\% utilization of financial resources due to faulty designs, antipathy of some state governments and bureaucratic bungling. If the funds remain unutilized, in the subsequent year the allocation is slashed. In several states, funds allocated to women from minority communities whose socio-economic and educational profile is most deplorable, have not been utilized at all!!

Rs. 2 crores allocated to each M.P. for the development of the constituency as per Member of Parliament Local Area development Scheme (MPLADS). Utilisation of government funding is the maximum in the North-Eastern states because of strong horizontal and vertical networking. The prosperous states depend more on the private funding to avoid bureaucratic hassles. If poorer areas in the state don’t have a highly motivated administration or an NGO network, then too the funding remains unutilised. In the areas dominated by the lower middle class and the poverty groups, there are demands for more schools, libraries, bridges, toilets, drains, tube wells, community centres and crematorium. While in the prosperous areas, the demands are for road repairs and schools. Private sector of the economy demands banks, hospitals and shopping plaza. The (Members of Parliament) M.P. and M.L.A. (Members of Legislative Assembly) have to strike balance by keeping into consideration immediate needs and long-term considerations for the constituency.

Panchayat Update is a newsletter published by Institute of Social Sciences, New Delhi. It provides valuable state-wise information on matters related to Local Self Government (LSG) bodies.

To check corruption and bring in transparency in the implementation of rural development projects sponsored by the union government, the Union Rural Development ministry had asked all District Rural Development Agencies (DRDAs) to keep their funds only in the nationalised banks. It has also been made compulsory for the district rural bodies to record complete details of expenditure incurred by them under different heads. People’s participation in monitoring the progress of implementation and the mechanism of social audit will also be introduced as part of the new strategy to cleanse the working of the DRDAs (CBGA, 2007).

NGOs and Citizens organisations are using Right to Information Act to track proper unitisation of the financial allocation from tax payers’ money.

**Financial Matters and Local Self Government Bodies (LSGBs)**

A recent survey of panchayats working in 19 states, conducted by the National Institute of Rural Development, Hyderabad suggested that LSGBs remain toothless because functional and financial autonomy has not been granted to the PRIs. The study by the Institute of Social Sciences shows that the extent of fiscal decentralisation through the empowerment of PRIs has been very little. The report of the working group on decentralisation appointed by the Karnataka Government has been criticised severely because, “It betrays utter lack of trust in the people which is the keystone of decentralised democracy.” (Bandyopadhyay, 2002). Case studies of Panchayat finances in the Gram Sabhas of Midnapur district of West Bengal
have corroborated the above-mentioned facts in terms of lack of fiscal autonomy, neglect of girls’ education, resource crunch. But it has played substantial role in development of infrastructure, for example rural roads, drinking water, health, education, irrigation and power (Sau, 2002).

Elected representatives, officials at districts and NGOs working in the area should act as facilitators in preparation of the plan for area development and social justice ((Pal, 2002). The UN system has supported allocation of resources for women in PRIs, right from the beginning. “The evidence on gender and decentralisation in India thus suggests that while women have played a positive role in addressing, or attempting to address, a range of practical gender needs¹, their impact on strategic gender needs² is not remarkable.” (UNDP, 2002)

The most challenging task is to enhance capacity of the elected representatives in LSGB to spend funds for community development.

**Demands of Women’s Groups and Gender Economists**

The women’s groups are aware that concerns of women cannot be addressed through the Ministry of Women and Child Development alone. It is on the work of women that success of several sectors rest. The changing demographics of agriculture, with more than 75% of all women workers, 85% of rural women workers are in agriculture; women’s disproportionately large contribution to the export and services sector, in the unorganised sectors—all these need to be located in our policies. Each of these sectors needs to make concerted efforts to address women’s concerns through: recognising women’s contributions, addressing their gender specific concerns and organising their voice; investing in skills of women and upgrading their work spaces and providing common work facilities; providing women access to new technologies and credit schemes; paying special attention to caste and minority derived exclusion within gender. Hence, it is important to prioritize universalisation of Gender budgeting (including gender audit) and Gender outcome assessment in all Ministries/Departments at Central and State levels. The Gender Budget Cells located in the different ministries need to be strengthened so that women’s concerns can be mainstreamed across different sectors. Further, it needs to be ensured that each of such measures (as listed above) is backed with adequate resource allocation. Calling for implementation of the WCP across all ministries could ensure at least a minimum resource allocation targeted at women. The poor and even receding implementation of WCP as pointed by the Mid Term Appraisal of the Tenth Plan warrants special efforts at correction

Considering the large numbers of women in unpaid work and women’s central role to the care economy; to address women’s concerns in these sectors, policies need to focus on social services to support women’s care roles (old age, child care). With increasing women’s role in the care economy (both paid and unpaid), adequate resource allocations need to be made to support women’s care roles. In the absence of sex disaggregated data, evaluation of schemes through a gender lens or any effort at strengthening gender dimensions of existing schemes poses a big question. So, provision of such data should be prioritized. In the light of the present agrarian crisis and the changing face of agriculture being highly gendered,
the vulnerability of women farmers in particular needs attention in the larger context of food security.

Considering the huge gender disparities in land ownership patterns, women’s access to land needs to be strengthened immediately. This could be done by (a) improving women’s claims to family land (by enhancing legal awareness on inheritance laws, provide legal support services, etc.); (b) improving access to public land by ensuring that all land transfers for poverty alleviation, resettlement schemes, etc., recognize women’s claims; etc., (c) Improving women’s access to land via market through provision of subsidized credit to poor, by encouraging group formation for land purchase or lease by poor women, etc.,

Women’s rights organizations in India have demanded that the Government should ensure adequate gender budgeting in all ministries and departments, enact a comprehensive Food Security Bill, ensure universal PDS as a core component, allocate 6% of GDP for Health, allocate 6% of GDP for Education, Make budgetary allocation to cover special schemes for women workers, increase allocation for women farmers, enhance resource allocation for tribal, dalit, and minority women and increase budgetary support for schemes to assist women-headed households and differently abled women.

The target of 30% gender allocations under all ministries has not yet been achieved. This must be implemented immediately. There is need for gender audit and gender outcome appraisal of all ministries and departments at the central and state levels. Very often, resource allocations made under gender budgeting do not reach in time and they remain unspent. There should be proper monitoring and supervision of the allocated funds with greater transparency and accountability at all levels.

(Endnotes)

Conclusion

Budget audit from the perspective of poor, women, minorities, people with disability, children, geriatric groups and other vulnerable sections is now practiced by many countries with an objective to support government and civil society in examining national, regional and local budgets from a sectional perspective and applying the study results for the formulation of responsive budgets. There is no single approach or model of a sensitive budget exercise. In some countries, for example, these exercises are implemented by the government while in other countries individuals and groups outside government undertake the budgetary analysis.

Budgets garner resources through the taxation policies and allocate resources to different sections of the economy. There is a need to highlight participatory approaches to pro-poor budgeting, bottom up budget, child budget, SC budget, ST budget, green budgeting, local and global implications of pro-poor and pro-women budgeting, alternative macro scenarios emerging out of alternative budgets and inter-linkages between gender-sensitive budgeting and women’s empowerment (Bhat et. al., 2004). Bottom up budgets have emerged as an important and widespread strategy for scrutinizing government budgets...
for their contribution to marginalized sections of economy. They have utilized a variety of tools and processes to assess the impact of government expenditures and revenues on the social and economic position of men, women, boys and girls. Serious examining of budgets calls for greater transparency at the level of international economics to local processes of empowerment. There is a need to provide training and capacity building workshops for decision-makers in the government structures, gram sabhas, parliamentarians and audio-visual media (Patel, 2004).

Budget analysis from gender perspective should be introduced and promoted in all women’s groups, educational and research institutions. Public debate on gender sensitive budget will help the country to tilt the balance in favour of area development and peaceful use of resources in the present atmosphere of jingoism. Gender Commitments must be translated into Budgetary Commitment. By using our Right to Information (2005), transparency /accountability for revenue generation & public expenditure can be ensured. For Reprioritisation in public spending we must prepare our ‘bottom up budgets’ and lobby for its realisation in collaboration with the elected representatives. Gender economists must lift the veil of statistical invisibility of the unpaid ‘care economy’ managed by poor women and highlight equality & efficiency dimension and transform macro-policies so that they become women friendly.

The gender budget initiative has opened new vistas of research and analysis of public expenditure in the country and opened serious methodological debates for carrying out such analysis. This has also highlighted the urgency of sharpening the methodological tools for monitoring the progress of Women’s Component Plan introduced in the Ninth Five Year Plan. Efforts at ensuring gender-just and gender-sensitive budget demands continuous process of dissecting the govt. budget to establish its gender-differential impact, translation of gender commitment to budgetary commitments-Outlay of Rs. 13780 crores and Women Component Plan & Gender Budget to play complimentary role for effective convergence, proper utilisation and monitoring of fund from various developmental sectors.

\[1 \text{ crore} = 10 \text{ million}\]
\[1 \text{ lakh} = 100,000\]

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1 Strategic gender needs Strategic Gender Needs are different in different economic contexts and are determined by statutory provisions, affirmative action by the state, pro-active role of the employers to enhance women’s position in the economy and social movements. Practical gender needs Practical Gender Needs are identified keeping into consideration, gender based division of labour or women’s subordinate position in the economy. They are a response to immediate perceived necessity, identified within a specific context. They are practical in nature and often are concerned with inadequacies in living conditions such as provision of fuel, water, healthcare and employment. For details see, Moser, 1993.

ii 1 crore = 10 million

iii 1 lakh = 100,000
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- *Editor*
Vulnerability of Indigenous Children and Natural Disaster in Bangladesh

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Disasters affect people of different ethnic community differently, and the people of different age groups are subject to vulnerable in many ways. This study tried to examine the nature of vulnerability of the children of Rakhaine People in Bangladesh. The findings reveal that lack of effective support to the disaster affected children make them more vulnerable as they need to compete with adults to get their share of assistance in the event of an emergency but unable to cope with the severity of disasters. The study demonstrates how the children’s right to get support from household or local government institution or NGOs are ignored and overlooked in the process of disaster response and coping mechanism. It further assessed the children’s stress and strains in the process of involvement in disaster risk reduction activities at household and community level. The data were collected through sample survey, child focused/centered focus group discussion, case studies, researcher’s observation and KII. The study followed with an analysis of children’s vulnerability during hazards and disasters from the perspectives of social exclusion.

The present study is an attempt to highlight the nature vulnerability of the children of Rakhaine indigenous people experienced due to the natural disasters that occurred in the South-east and South-west coastal regions of Bangladesh.

Due to the geographical and territorial location, configuration, plenty of rivers and tributaries and monsoon weather, Bangladesh is highly vulnerable to the impacts of climate change and diverse exposure of natural disasters. The impacts of green house effects and global warming, like other parts in the world, are being increasingly observed in the gradual change of climatic behaviour in Bangladesh. As a result Bangladesh frequently experiences multiple hazards like floods, cyclones, droughts, salinity, water-logging, coastal and river erosion, intrusion of salinity, hailstorms, nor’easter and tornados, tidal surge, earthquake, landslides, tsunami and fire. Particularly, high magnitude floods have devastating impacts on livelihoods and the economy. Besides, the country remains as one of the worst sufferers of cyclone casualties in the world. Riverbank erosion causes the loss of productive land areas annually. Droughts are also the common occurrences resulting in less or no yield of crops. Because of the high vulnerability and occurrences of the worst sufferings, Bangladesh is currently ranked as the most climate – vulnerable country in the world1. According to the projection of the Inter-Governmental Panel on Climate Change (IPCC, 2002), both the frequency and intensity of cyclones in the Bay of Bengal are likely

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to increase and the depth and spatial extent of flooding in the Ganges-Brahmaputra-Meghna Basin are likely to alter because of climate change. This has significant implications across all sectors including agriculture, housing, transport, health, sanitation, safe drinking water and consequently on socio-economic development and poverty. Additionally, the likely consequences of sea level rise can cause economic losses of an unprecedented magnitude in low-lying Bangladesh. There are also the human induced disasters like river and marine accidents, drowning, country boat and ferry tragedies and collapse of kattcha houses and trees. For example, the way Cyclone Sidr in Bangladesh damaged, destroyed and devastated has been highlighted in the Needs Assessment for Disaster Recovery and Reconstruction, a Report prepared by the Government of Bangladesh with the assistance of International Development Community, in April 2008. (GoB, 2008 & Children and Disaster Risk Reduction: Background Paper by Bangladesh 2010; Disaster Management Strategy in Bangladesh - From Response to risk Management, Mitigation and Resilience; Children and Disaster Risk Reduction: Background Paper by Bangladesh, 2010). Among the major ethnic community people, the minority Rakhaine community people of South-east Bangladesh are worse sufferer of cyclonic storms, tidal surge, intrusion of salinity, river and sea erosion and water logging. Moreover, it is the children, women and elderly members of Rakhaine community who are the prime sufferer of these disasters.

Adversities of nature as mentioned in the previous paragraph appear to be disastrous only when the natural disasters and hazards negatively affect the livelihoods of most disadvantaged and vulnerable people. As the people of Rakhaine community in Bangladesh are minority and marginalized and live within the fragile environment of coastal belt, they are subject to further vulnerable due to the natural disasters like cyclonic storm, tidal surge, intrusion of salinity water, standing crop failure and devastation of homesteads and other resources to fall back for the means of livelihood. For example, in the year 1991, the cyclone that struck Bangladesh along the south-east coast massacred livelihoods of and killed about 140000 people (Morrow, 1997). Similarly the cyclone Sidr claimed 3,406 lives and 1001 people are missing, and more that 55,000 were injured and close to 9 million people of 30 districts were affected (GOB, 2008). Again the cyclone Aila that happened due to torrential rains resulted in at least 179 fatalities from flooding. More than 400,000 people were reportedly isolated by severe flooding in coastal regions of Bangladesh. Numerous villages were either completely submerged in floodwaters or destroyed. Dozens of people are reportedly missing throughout the country. A storm surge of 3 m (10 ft) impacted western regions of Bangladesh, submerging numerous villages (Wikipedia). In Patuakhali, where the Rakhaine community people live, numerous homes were destroyed by the subsequent flooding and tens of thousands of people were left stranded in the villages. Following Table depicts the feature of tropical cyclone that recently affected the coastal regions of Bangladesh and it is the women, children and elderly people of Rakhaine community who became worse affected more than the people of young and potential age group.
Table 1: Wettest Tropical Cyclones in Bangladesh

<table>
<thead>
<tr>
<th>Rank</th>
<th>Precipitation (mm)</th>
<th>(in)</th>
<th>Storm</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>452</td>
<td>17.8</td>
<td>03B 2005</td>
<td>Coastal Belt</td>
</tr>
<tr>
<td>2</td>
<td>~300</td>
<td>~12.00</td>
<td>Rashmi 2008</td>
<td>South-East Coast</td>
</tr>
<tr>
<td>3</td>
<td>280</td>
<td>11.02</td>
<td>Monsoon Depression - Sep. 2004</td>
<td>South-East Coast</td>
</tr>
<tr>
<td>4</td>
<td>227.2</td>
<td>8.94</td>
<td>Trop. Depression - Oct. 2004</td>
<td>North Bengal</td>
</tr>
<tr>
<td>5</td>
<td>220.0</td>
<td>8.66</td>
<td>Bhola 1970</td>
<td>South-east Coast</td>
</tr>
<tr>
<td>6</td>
<td>200</td>
<td>7.87</td>
<td>Sidr 2007</td>
<td>South-east and South-west Coast</td>
</tr>
<tr>
<td>7</td>
<td>130</td>
<td>5.11</td>
<td>Aila 2009</td>
<td>South-east and South-west Coast</td>
</tr>
<tr>
<td>8</td>
<td>129</td>
<td>5.07</td>
<td>Bijli 2009</td>
<td>Coastal Belt</td>
</tr>
<tr>
<td>9</td>
<td>53</td>
<td>2.13</td>
<td>Akash 2007</td>
<td>Coastal Belt</td>
</tr>
</tbody>
</table>

Source: wikipedia.org/wiki/Cyclone_Aila # Bangladesh

According to the Study Report of ADB on Damage, Loss, Needs Assessment for Disaster Recovery and reconstruction (2008), most of the cyclones that struck along with South-east coast and out of the affected persons, about 85 per cent are children, women and elderly people. The vulnerability of Rakhaine children in the event of disaster is considered to have several components which include initial conditions, livelihood resilience, opportunity for self protection and access to social protection and social capital (Blaikie et al. 1994; Cannon, 2002).

The present study is therefore an attempt to examine all kind of vulnerability that the children of Rakhaine community encounter during the events of disasters and also to assess the possible means and strategy of resilience for their sustainable livelihood.

Objective of the Study

The main objective of the study was to examine the nature vulnerability of the children of Rakhaine indigenous community experienced during natural disasters.

The specific objectives of the study were:

- To assess the nature of overall impacts of cyclonic storms on the children of Rakhaine community
- To examine the impact of cyclone on health and reproductive health care system of Rakhaine children
- To assess the impact of cyclone on nutritional status of Rakhaine children
- To examine the Rakhaine children’s exposure to risks due to natural disasters
- To assess the gender specific problems of Rakhaine girl children during and after disasters
- To assess the impact of displacement of population to other shelter places and the nature of vulnerability of girl children
Figure 1: The impact of Side in the Coastal Bangladesh
Methodology

The study heavily relied on the information collected through triangulation of quantitative and qualitative methods of data collection. The quantitative method adopted the sample survey technique while the qualitative method combined the researcher’s observation, focus group discussion and case studies. Moreover, the study also relied on secondary sources including the report of GO, NGOs and Development Partners.

The data were collected from 50 Rakhaine households located in the Hariapara Village under Kalapara Upazila of Patuakhali district.

Theoretical Framework of the Study

Application of Ulrich Beck’s Risk Model

One of the most world famous European sociologists in the late twentieth century, Ulrich Beck, has contributed a groundbreaking analysis on the discourse of “Risk”. His most influential book “Risk Society: Towards a new Modernity” was first published in German in 1986 in which he described risk issues in late modern society. In his book he, inferred risk may be defined as a systematic way of dealing with hazards and insecurities induced and introduced by modernization itself. Risks, as opposed to old danger, are consequences which relate to the threatening force of modernization and to its globalization of doubt. They are politically reflexive (Beck, 1992). Beck assumed that, in advanced modernity the social production of wealth is systematically accompanied by the social production of risks. Accordingly, the problems and conflicts relating to distribution in a society of scarcity overlap with the problems and conflicts that arise from the production, definition and distribution of techno-scientifically produced risks. The promise of security grows with the risks and destruction and must be reaffirmed over and over again to an alert and critical public through real interventions in the techno-economic development.

Findings

The study findings reveal that disasters especially the cyclonic storms of 1991, 2007 and 2009 adversely affected all aspects of Rakhaine children’s daily life and life chances in the coastal area of South-east Bangladesh. The study further depicts that the Rakhaine children’s rights to survival, to protection, access to clean water, sanitation, food, health, sexual and reproductive health and education remain in serious threat due to disasters. It is evident that in the course of every disaster Rakhaine children had to suffer as they frequently lose the sustainability of their livelihoods, their everyday needs like nutritional intake, health care services, protection of sexual and reproductive health, shelter and educational attainment, affected in various way, which leads to more diseases, an increased risk of drowning young children, bite of the poisonous snakes etc. As the nutritional status of Rakhaine children is already poor, it is exacerbated in a disaster situation. Moreover, the prevalence of high intensity disasters in frequency and severity further deteriorated the children’s resilience and increased poverty and this situation diminished particularly life chances of children of Rakhaine community as a dependent and vulnerable group.
Under these circumstances, infants, young children, and pregnant and lactating women (PLW) experienced more vulnerability due to malnutrition and micronutrient deficiencies, especially since their nutritional requirements are relatively high, but they are less able to negotiate their fair share of food within the household. Where the nutritional status of children is already poor, it is exacerbated in a disaster situation. The study findings depict the severity of damage and loss that happened due to Sidr, Aila and other cyclonic storms and it was found that different disasters affect children more in comparison to other age groups.

The study further reveal that vulnerability of Rakhaine children in the course of disaster has several components which include initial condition, livelihood resilience, opportunities for self protection and access to social protection and social capital. For their dependent and risk prone positions, women and children are particularly prone to any form of vulnerability. Rakhaine children are often dependent on their parents, particularly on their mothers, regarding almost all the matters related to their access to nutrition, healthcare, sexual and reproductive health and life skill training.

**Educational Vulnerability of Rakhaine Children during Disasters**

Although education provision has recently improved in Bangladesh especially for the children of major ethnic community, the exclusion of Rakhaine children in the poorest families remains a pressing issue. Data are lacking for ethnic minorities such as indigenous Rakhaine children. To address this issue, we assessed indigenous children’s primary school attendance and dropout rates in Sidr and Aila affected areas during 2007 to 2010. The results revealed that during post-Sidr and Aila, only few indigenous children (18%) completed a year of primary education, and an additional 14% attended some school but dropped out. It is likely that a large percentage of indigenous Rakhaine children never experienced or completed primary education, and they probably do not attain even basic literacy skills. Focus group discussions with educational professionals, parents of Rakhaine children, and elderly people of the locality revealed that poverty, malnutrition, lack of resources of their parents, child labour, and other factors such as ignorance toward education, language problems, social exclusion, cultural alienation, and frequent natural disasters and often dislocation and out-migration account for the low rates of school attendance.

This limitation is specifically true for girls. Due to natural disasters, social stigma and economic hardship of family, majority of Rakhaine girls do not go to school beyond the primary stage. Therefore, in the Rakhaine villages of Patuakhali, the girls are married between the ages of 16-18 and this marital bond compelled most of the Rakhaine girls to discontinue their study.

**The Vulnerability of Rakhaine Children in the Context of Health, Sexual and Reproductive Health Situation**

It is evident from study observation that the indigenous people and ethnic minorities of Bangladesh bear the greatest burden of poverty and it is further aggravated due to frequent occurrence of natural disasters. Bangladesh’s Rakhaine people are no more exception and very often find themselves among the poorest of the poor.
As a consequence, the adolescence Rakhaine girls do not have access or little access to reproductive health care services, screening for HIV/AIDS and sexually transmitted diseases.

The focus group discussion revealed that many adolescent Rakhaine girls conceived as early as possible and give birth two or more child or until a male child was born to establish their position in the family. But the situation further aggravated due to frequent occurrence of natural disasters, cultural and geographical isolation, social exclusion and illiteracy makes the indigenous adolescence girls less knowledgeable about reproduction, pregnancy, disease prevention, nutrition and personal hygiene.

The research findings indicate that in general, more than two third of pregnant adolescent Rakhaine girls suffer from anemia and malnutrition and this further aggravates during the period of natural disasters. Moreover, the anemic adolescent mothers are at a higher risk of miscarriages, maternal mortality and giving birth to stillborn and underweight babies during the events of disasters.

Many indigenous Rakhaine adolescent girls have little knowledge about nutrition, nutritious foods and balanced diet due to their erroneous beliefs and traditional practice of consumption of indigenous food but during disasters they are unable to collect the natural objects of food as most of the places go under water and salinity. Therefore, according to the physician’s prediction, the adolescent girls who have inadequate nutrition do not grow well and become stunted women. Their pelvic bones are not fully mature and cephalous pelvic disproportion could occur during child birth and may result in obstructed labour.

The focus group discussion with Rakhaine adolescent girls and their mothers revealed that because of severe malnutrition and repeated illness, the normal growth spurt in as early adolescent does not occur and a slower and prolonged pubertal growth period is observed in adolescents from lower socio-economic status of indigenous girls. Early pregnancy is detrimental as if places an extra nutritional demand on the growing body and growth is permanently asserted. Even the adolescent mothers are more likely to deliver low birth weight babies if not nourished in a balanced way. But our survey findings indicate that during and after disasters, these adolescent mothers are unable to cope with and hardly get any balanced food due to temporary dislocation from their residence. Moreover, the situation hardly permits them to be fed in a balanced way as all of them are part of shelter home where there is no priority to feed the pregnant adolescent. As consequence, the lactating mother is unable to feed her infant baby and due to poor milk, the infant may not be able to gain enough weight and remained malnourished and undernourished. Again if these babies are girls they are likely to continue the cycle by being stunted in adulthood and so on, if something is not done to break this cycle.

Apart from the above vulnerability, many adolescent girls who are married and delivered children at an early age, suffer from both reproductive tract infection (RTIs) and sexually transmitted infections (STIs), and other common reproductive health problems in Bangladesh. The RTIs include all infections of the reproductive tract whether transmitted...
sexually or not. On the other hand, sexually transmitted infections include infections that are transmitted from one person to another person primarily by sexual contact. The common STIs are gonorrhea, syphilis and trichomoniasis, indigenous adolescent girls are more vulnerable to STIs and RTIs, including HIV/AIDS because of less knowledge regarding transmission of STIs and RTIs. It may be mentioned that during the occurrence of disasters, most of the adolescents suffer from the above mentioned diseases and are unable to get proper treatment due to their dislocation and inability to pay doctor’s fee or purchase the prescribed medicine.

The reproductive health of indigenous married adolescent girls become more vulnerable due to delay in seeking abortion, negative attitude of trained service providers, resorting to untrained providers, use of conventional methods, laws relating to abortions causes post abortion complication. As a result indigenous adolescent girls suffer a lot from complications like tetanus (from insertion of foreign body, sticks, rods, herbs or using unspecialized surgical instruments), hemorrhage, genital tract infections, fistula formation, perforation of uterus, chronic pelvic pain, secondary infertility, subsequent spontaneous abortion, premature labour, psychological depression etc. and the situation become worse during and after disaster period.

The impact of Cyclones on Nutritional Status of Rakhaine Children

The survey observation indicate that because of the already high prevalence of malnutrition among Rakhaine children in Bangladesh, food assistance, primarily the distribution of rice and cooking oil, following the cyclone was crucial to avoiding further deterioration in nutritional condition. The per capita caloric intake in Bangladesh is only 83% of estimated requirements; 71% of children less than six years of age have moderate to severe malnutrition when defined using a weight-for-age basis (Grant JP. The state of the world’s children 1991. New York: Oxford University Press; 1991). Some leading NGOs are currently monitoring the nutritional status of cyclone survived Rakhaine children in order to identify any deterioration in the general state of nutrition. Despite the apparent adequacy of food relief efforts, deaths during the cyclone among Rakhaine children indirectly attributed to the chronic nutritional crises that make them further vulnerable. As most of the families of Rakhaine community are poverty prone, and do not have access to agriculture and food security, the effect of decreasing per-capita food production is apparent from the prevalence rates for malnutrition. Outside of true famine situations, there is probably no other community that has such a high prevalence of malnutrition.

Rakhaine Children’s Exposure to Risks due to Natural Disasters

Focus Group Discussion with Rakhaine Adolescent Girls

How the Rakhaine children including adolescent girls were exposed to various risks due to Sidr and Aila was assessed by conducting a Focus Group Discussion with a group of girls.

Rakhaine children namely Obalan, Mamosa, Uratan, Nininan, Marsa, Mamaya, Mafusi, Jojo and some other adolescent girls of village Baliaotoli, Khepupara Upazila, Patuakhali District were consulted to assess the overall vulnerability of children especially the helplessness of girl children due to the affect of Sidr and Aila. The respondents showed
their high level depression, suicidal feelings, feelings of loneliness, helplessness, lack of security, low awareness about sexual and reproductive health, lack of proper health care services, lack of access of safe drinking water, feelings of disoriented due to temporary dislocation and staying in shelter home, lack of empowerment due to lack of income earning opportunity, unable to attain the school due to devastation of school infra-structure, traumatized due to frightening mentality out of Sidr and Aila devastation, etc.

The study findings reveal that most of the members of Rakhaine community severely injured during those cyclones were women and children. This happens because of children, particularly girl children’s close attachment with their mothers in household work. As the home managers and care givers, women, along with their children, were the last to leave their houses and take shelter in safer places.

**Recommendations and Policy implications**

**Resilience and Capacity Building**

- The only way may be, as we cannot prevent the hazards of natural disasters completely, but we can reduce disaster risk and vulnerability through increasing out resilience and capacity
- Resilience and capacity building also depends on the social, cultural and economical condition as well as political commitment of the leadership as well as local community
- Local Level Training on disaster preparedness involving local institution/ local government Weather forecast and disaster bulletin has to broadcast in easy and local language
- Development of more infrastructure development such as cyclone shelter, coastal embankment and ensure their regular maintenance
- More consultation and discussion on climate change related consequences
- Establishment of community radio station
- Initiate rural centric development activities and create rural employment that will reduce urban migration
- Increase more budgetary allocation for disaster preparedness and rehabilitation activities
- To increase coastal forestation
- Salinity tolerant crop variety development and increase research initiative on it.
- Proper initiative to reduce population growth
- Banning on the establishment of harmful and pollutant producing industries like Cement, brick field, ship breaking etc.
- Preserve rights of marginalized community people such as fishermen and tribe etc.
- Plantation those trees that can reduce disaster vulnerabilities e.g. Coconut, Palm, Betel nut, Bamboo etc.
- Stop commercialization and corporatization of natural resources,
• Political stands to be taken in strengthening local institutions.
• Collaboration & coordination between GO, NGOs, Development Partners and regional countries should be established
• Local political leaders, community people and mass people to be united to face such challenges

References
Intergovernmental Panel on Climate Change, 2002.
The term Social exclusion is of relatively recent origin. The concept of social exclusion is seen as covering a remarkably wide range of social and economic problems. In India Social Exclusion is based on caste and patriarchy. The salient features of social exclusion on the basis of caste are social stratification, social inequality hierarchy and hegemony. In present study, an attempt has been made to examine the changes in the occupational distribution of workforce and poverty relationship across different economic, social and religious groups in Indian population. Among the social groups, schedule caste has performed the least in poverty reduction, both for agricultural labourers and non-farming workers. The XI Five Year Plan (Government of India) refers to low poverty, reduction among the tribal in the 1990’s as serious problem. The poverty has reduced at low rate for the scheduled tribe and scheduled castes among the social groups and the Muslims among the religious groups. The groups with better access to assets and low poverty in the initial years have done better. By implication, this indicate that the groups with high poverty and access to assets and quality employment needs affirmative action and focused policies, particularly if the groups like schedule caste, schedule tribe and Muslim suffered from social exclusion and discrimination. Hence, special measures like increasing the hands on skill, education and expansion of employment opportunity are the only alternative for this chronically poor section.

The social system in India is mainly centered on the caste structure, its organization and caste identities. Even today, the caste system is more rigid in villages as compared to urban towns and cities. Dalits in majority of the villages are ill-treated by the so called higher and dominant castes and they are encountered with various kinds of social problems. In rural India untouchability stigma, physical isolation and social distance are very much attached with the Dalits or Harijans. A social gulf prevails between Dalits and other caste communities. The tribals still live relatively in isolation of hills and forests and they are excluded from the main stream population. A large majority of them do not have access to the natural resources like land, water and forest and they are unable to participate in the ongoing development process due to poverty, illiteracy and unawareness.

Other backward classes are constitutionally treated as economically, educationally and socially backward; where as the religious minorities are characterized with the features of numerical inferiority, linguistic, educational and economic backwardness.

*Assistant Professor, Department of Economics, Acharya Nagarjuna University, Nagarjuna Nagar, Guntur, Andhra Pradesh, India.
The economic condition of the Indian sub-continent was a self-subsistent not only in agriculture but also with the variety of traditional industries during the pre-colonial period. According to Nationalist School “Traditional Indian Society was characterized by political instability, insignificant commerce, low agricultural and non-agricultural productivity, together with or rather as a result of an unfavorable climate and geography. Indigenous traditional systems, social and cultural set-up of the Indian society at the end of the eighteenth century were the prime reasons for the backwardness (Ibid, p.30 & 36-37).

Modern literature glorifying the traditional hierarchical social structure for the judicious management of resources ignores the failure of the system in addressing the exploitation of the service providing communities at the bottom-level, particularly SCs. Describing their living conditions as better in terms of housing, food, cloth, etc. supplied by the landlord, generally of the upper caste resource-owing community, is nothing but a reflection of the internationalization of the paternalistic feudal world view (Saravanan, 2008).

The term “Social exclusion” is of relatively recent origin. The concept of social exclusion is seen as covering a remarkably wide range of social and economic problems. Even in the practical context of identifying “the excluded” in France, Rene Lenoir, as Secretarial Etat Accton Sociale of the French Government, spoke of the following as constituting the “excluded” – a tenth of the French Population: Mentally and Physically handicapped, suicidal people, aged, invalids, abused children, substance, abusers, delinquents, single parents, multi-problems and other social ‘misfits’ (Subrahmanyam, 2008).

In India social exclusion is based on caste and patriarchy. The salient features of social exclusion on the basis of caste are social stratification, social inequality, hierarchy and hegemony. As per people of India project (2002) our country has 4694 caste- communities, out of which 3654 (77.84 %) fall in the reservation categories of SC, ST and other backward classes (Silver, 1997). All these caste-communities are considered as social exclusion categories.

Higher growth in GDP (with the national income growing in the range of 6 to 8 % annum for over fifteen years now) has not accelerated the decline in poverty. The incidence of poverty among certain marginalized groups, such as ST has hardly declined. The absolute number of poor people has declined only marginally (XI Five year Plan, Vol.1, P.1), indicating a weak relationship between economic growth and poverty particularly in the decade of 1990s. The XI Plan, therefore, singled out the type of growth, rather than growth alone, as an important element of inclusive growth strategy.

Objective of the Study

The main objective of the study was to examine the change in the occupational distribution of workforce and poverty relationship across different economic, social and religious groups in Indian population.
The specific objectives of the study were:

1. To examine the change in the occupational distribution of workforce with special reference to schedule castes and schedule tribes at national level.
2. To examine poverty relationship with different economic, social and religious groups among Indian population.
3. To suggest suitable measures for up-liftment of downtrodden people in the society.

Methodology

The study is based on secondary data collected from National Sample Survey Organization (NSSO) on occupational distribution and poverty among different social groups for the period from 1983-84 to 2004-05 and the Census 2001. Comparable NSS quinquennial survey data on workforce and poverty were also available for various rounds (1971 to 2001). Statistical abstract of India, published by CSO and Economic Survey of India Published by Government of India and CMIE reports were also utilized. For measuring poverty and inequality, unit record data from quinquennial round consumption expenditure surveys (CES) conducted by the National Sample Survey Organization (NSSO) was used. The incidence of poverty in the rural and urban sector was estimated for economic, social and religious groups using simple measure of poverty, the Head Count Ratio (HCR). Simple statistical tools like Percentages and Growth Rate Techniques were used to analyze the data.

Result and Discussion

Now let us examine the change in the occupational distribution of SC, ST vis-à-vis general population in the context of workforce distribution and access to assets and quality employment.

Table 1: Occupational Distribution at all India Level

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage in Total Main Workers of SC’s</th>
<th>Percentage in Total Main Workers of ST’s</th>
<th>Percentage in Total Main Workers of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultivators</td>
<td>27.87</td>
<td>28.17</td>
<td>25.44</td>
</tr>
<tr>
<td>Agricultural labourers</td>
<td>51.75</td>
<td>48.22</td>
<td>49.06</td>
</tr>
<tr>
<td>Non-farming workers</td>
<td>20.38</td>
<td>23.61</td>
<td>25.41</td>
</tr>
</tbody>
</table>

The above table-1 reveals the changes in the occupation during 1970-71 to 2000-01. It is evident from the table that during 1971 to 1981, there was an increase in the percentage of SC workers as cultivators from 27.97 to 28.17, while percentage of SC agricultural labourers declined from 51.75 to 48.22. In case of general workers the percentage of cultivators declined from 42.9 to 41.58 per cent that of agricultural labourers also declined from 26.9 to 24.94 during the same period. Regarding the non-farming workers, it increased from 20.38 to 23.61 per cent in case of SC workers. Thus, there was some marginal improvement in the SC workers as cultivators and also as non-farming workers. This indicates some upward mobility of SC workers. This might be attributed to redistribution of waste lands and surplus lands, under 20 point programmes in 1970’s. But during 1981 to1991, the percentage of SC cultivators declined from 28.17 to 25.44, while there was an increase in the percentage of SC agricultural labourers from 28.22 to 49.06 indicating downward movement in the case of SC agricultural workers. During 1991-2001 there was an increase from 25.44 per cent to 26.78 per cent in case of cultivators, while there was a decline from 49.06 per cent to 46.15 per cent in case of agricultural labourers.

It could be seen from table-1 that in the case of workers of general population also percentage of cultivators declined from 41.58 to 38.75, while percentage of agricultural labourers increased from 24.94 to 26.15 during 1981-1991. It further declined to 31.7 in case of cultivators, while percentage of agricultural labourers almost remained same during 1991 to 2001. However, percentage of non-farming workers increased from 33.48 to 35.10 per cent and further increased to 41.8 per cent indicating the occupational shift. In case of ST there was a decline in the percentage of cultivators and also in the percentage of agricultural labourers marginally, while there was an increase in the non-agricultural activities from 9.4 per cent to 15.8 per cent during 1971 to 2001.

Thus, during 1971-2001 SC workers remained mostly as agricultural labourers although, there was some change in the composition of agricultural labourers, i.e., it was revealed from the village level studies that the percentage of attached labourers significantly declined and converted as casual labourers due to market forces unleashed by green revolution and state intervention in the form of antipoverty programmes in the post-green revolution period (Nancharaiah, 2010). Many studies on poverty established that poverty has been concentrated among agricultural labour households (Rao, 2005).

**Changes in Poverty among Social and Religious Groups**

The incidence of poverty in the rural and urban sectors is estimated for social and religious groups using simple measure of poverty, the Head Count Ratio (HCR).
Table 2: Incidence of Poverty among Social Groups in Percentages (Head Count Ratio – All India)

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
<td>Total</td>
<td></td>
<td>Rural</td>
<td>Urban</td>
<td>Total</td>
</tr>
<tr>
<td>All</td>
<td>46.5</td>
<td>42.2</td>
<td>45.6</td>
<td></td>
<td>56.9</td>
<td>32.8</td>
<td>35.8</td>
</tr>
<tr>
<td>ST</td>
<td>63.9</td>
<td>55.3</td>
<td>63.3</td>
<td></td>
<td>50.2</td>
<td>42.9</td>
<td>49.6</td>
</tr>
<tr>
<td>SC</td>
<td>59.0</td>
<td>55.8</td>
<td>58.4</td>
<td></td>
<td>48.3</td>
<td>49.7</td>
<td>48.6</td>
</tr>
<tr>
<td>Others</td>
<td>40.8</td>
<td>39.8</td>
<td>40.5</td>
<td></td>
<td>31.2</td>
<td>29.6</td>
<td>30.7</td>
</tr>
<tr>
<td>Hindus</td>
<td>47.0</td>
<td>40.3</td>
<td>45.6</td>
<td></td>
<td>36.5</td>
<td>30.6</td>
<td>35.1</td>
</tr>
<tr>
<td>Muslims</td>
<td>51.2</td>
<td>57.2</td>
<td>53.1</td>
<td></td>
<td>45.0</td>
<td>47.7</td>
<td>45.9</td>
</tr>
<tr>
<td>ORM</td>
<td>30.2</td>
<td>29.3</td>
<td>29.9</td>
<td></td>
<td>27.1</td>
<td>22.4</td>
<td>25.7</td>
</tr>
</tbody>
</table>

Source: Calculated by the author using NSSO, CES Unit Record for Relevant Rounds.

Notes:  
OBC = Other Backward Classes in Column II.
Others = Residual category comprising of those not classified as ST, SC and OBC in column II.
ORM = Other Religious Minorities that includes Christians, Sikhs, Jains and other remaining religious minorities. These have been clubbed together as sample size for many of these groups is critically small.

Table 2 reveals changes in Poverty Ratios of rural and urban. Rural poverty continue to decline during 1983-84 and 2004-05, at a per annum rate of 1.89 per cent. Among the caste groups the poverty also exhibits a typical old hierarchal order. The poverty is highest for SCs, (37 per cent) (who are placed at the bottom of caste hierarchy), followed by OBC’s (26 per cent) who come next in caste hierarchy and in the end comes higher caste (17.4 per cent) with 45 per cent the ST are the most poor among other social groups. Among the religious groups the Muslims are most poor, (33 per cent) but better than SC and ST. Thus ST, (45 per cent) SC (37 per cent) and Muslim (33 per cent) in that order are the most poor.
Table 3: Decline in Poverty Incidence during - 1983 to 2004-05 (Difference in %)

<table>
<thead>
<tr>
<th>Category</th>
<th>1983 to 2004-05</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
</tr>
<tr>
<td>All</td>
<td>18.47</td>
</tr>
<tr>
<td>ST</td>
<td>19.23</td>
</tr>
<tr>
<td>SC</td>
<td>21.85</td>
</tr>
<tr>
<td>Others</td>
<td>18.08</td>
</tr>
<tr>
<td>Hindus</td>
<td>19.04</td>
</tr>
<tr>
<td>Muslims</td>
<td>18.19</td>
</tr>
<tr>
<td>ORM</td>
<td>12.04</td>
</tr>
</tbody>
</table>

Source: Calculated by the author using NSSO, CES Unit Record for Relevant Rounds.

Notes:
- **OBC** = Other Backward Classes in Column II.
- **Others** = Residual category comprising of those not classified as ST, SC and OBC in Column II.
- **ORM** = Other Religious Minorities that includes Christians, Sikhs, Jains and other remaining Religious minorities. These have been clubbed together as sample size for many of these groups is critically small.

It is also seen in above table 3, that the social and religious groups, poverty has declined at different rate for different social and religious groups. The SC and ST experienced lower declined compared with others (among the social groups) and the Muslims (compared with Hindu and Other RM among the religious groups). It is also interesting to note that the incidence of poverty has declined during 1983 to 2005. But the incidence of poverty among SCs and STs is much higher than the incidence of poverty among general population.

Among the social groups, the ST has performed the least in poverty reduction, both for agricultural labourers and non-farming workers. The XI Five Year Plan refers to low poverty (XI Five Year Plan, Government of India) reduction among the tribal in the 1990’s as serious problems. Obviously, the poverty level in tribal agriculture is persistent and high due to low productivity and income. Therefore it is the labour intensive agricultural growth based on medium and larger farm may result in higher wage employment and prove poverty reducing for farm wage labour. For farm wage labour poverty reduction, the policy that encourages the large and medium farmers to use labour intensive methods and technology will have poverty reducing potential. Thus agricultural growth strategy with a focus on large and medium farmers for using labour intensive technology and with equal focus on small and marginal farmers will be most inclusive of the poor small and marginal farmers and poor farm wage labour. This is the spheres where policy changes are necessary, if growth in agriculture is to be poverty reducing for casual farm wage labour, who constitute most persistently and chronically poor.
Conclusions and Recommendations

The poverty has reduced at low rate for the schedule tribe and schedule castes among the social groups and the Muslims among the religious groups. The growth has been less inclusive for ST, SC and Muslim households as compared to other social groups.

The initial condition including the poverty level matters for the speed of poverty reduction. The groups with better access to assets and low poverty in the initial years have done better. By implication this indicates that the groups with high poverty and access to assets and quality employment needs affirmative action and focused policies, particularly if the groups like SC, ST and Muslim also suffered from social exclusion and discrimination.

Hence, special measures like increasing the hand on skill, education and expansion of employment opportunity is the only alternative for this chronically poor section. The state should provide the necessary micro-finance to augment the productivities of their economic assets.

References

Government of India, XI Five Year Plan, Vol. I & III.
The present paper will focus on the effect of participation in SHG on the participant’s livelihood income and also the effect of training of SHG members on their livelihood income. The sample area for the study will be SHGs from Ajmer district (Rajasthan). Poverty poses an oppressive weight on India. According to the World bank India has the largest number of poor in the World - 456 million i.e. 42 percent of the population. In absolute terms the number of poor has risen from 421 million to 456 million in the last 28 years. Finance helps the poor to catch up with the rest of the economy as it grows. Microfinance is the provision of thrift, credit and other financial services and products of very small amounts to the poor for enabling them to raise their income levels and improve their living standards. Microfinance provides ordinary people and poor access to opportunity and the ability to escape ossified social structures. Microfinance Institutions and SHGs are the major delivery models of microfinance in India. A Self Help Group is a small localized group of 10-20 persons from a homogeneous background. The members of the group are encouraged to collect regular thrift on a weekly or fortnightly or monthly basis and use the pooled resources to give interest bearing small loans to their members. The Self Help Promoting Institution (SHPI) trains the members to maintain simple accounts of the collected thrift and loans given to members. A saving bank account is opened with a bank branch and regular thrift collection and loaning to members, builds up financial discipline among the members and encourages the bank to provide larger loans to the group.

The finding of the last two decades in the world of finance says that due to its large size and population of around 1000 million, India’s GDP ranks among the top 15 economies of the world. Further it is estimated that out of these households, around 300 million people or about 60 million households are living below the poverty line and only about 20 percent have access to credit from the formal sector. Thus Micro-Finance is emerging as a powerful instrument for poverty alleviation in the new economy. MF services give low-income people an opportunity to protect their families against financial risks and invest in new or existing economic activities.

Microfinance is a critical tool in addressing the issues of financial and social exclusion. Financial exclusion is the inability of individuals, households or groups to access necessary financial services in an appropriate form. In India, micro-Finance scene is dominated by Self Help Groups (SHGs) - Banks linkage Programme, aimed at providing a cost effective mechanism for providing financial services to the ‘unreached poor’.

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Microfinance is the provision of thrift, credit and other financial services and products of very small amounts to the poor for enabling them to raise their income levels and improve their living standards. It has been recognized that microfinance helps the poor people meet their needs for small credit and other financial services. The informal and flexible services offered to low-income borrowers for meeting their modest consumption and livelihood needs have not only made microfinance movement grow at a rapid pace across the world, but in turn also have an impact on the lives of millions of poor positively. In the case of India, the banking sector witnessed large scale branch expansion after the nationalization of banks in 1969, which facilitated a shift in focus of banking from class banking to mass banking. Microfinance activities generally involve:

- Small loans, typically for working capital;
- Informal appraisal of borrowers and investments;
- Access to repeat and larger loans based on debt capacity and repayment performance;
- Streamlined loan disbursement and monitoring;
- Secure savings products.

**Micro Finance Delivery Models in India**

The non-availability of credit and banking facilities to the poor and underprivileged segments of the society has always been a major concern in India. Accordingly, both the Government and the Reserve Bank have taken several initiatives, from time to time, such as nationalization of banks, prescription of priority sector lending norms and concessional interest rate for the weaker sections. It was, however, realized that further direct efforts were required to address the credit needs of poor. In response to this requirement, the microfinance movement started in India with the introduction of SHG bank linkage programme (SBLP) in the early 1990s. At present, there are two models of microfinance delivery in India: the SHG bank linkage programme (SBLP) model and the Microfinance Institution (MFI) model. The SHG bank linkage programme (SBLP) model has emerged as the dominant model in terms of number of borrowers and loans outstanding. In terms of coverage, this model is considered to be the largest microfinance programme in the world. The Reserve Bank NABARD and SIDBI have also taken a range of initiatives to provide a momentum to the microfinance movement in India.

Microfinance has emerged as an important sector in many countries for providing financial services such as savings, credit, insurance and remittance services to the poor. Seibel (2003) throws light on the evolution of microfinance. He argues that the history of microfinance (MF) dates back to the sixteenth century in Ireland. The author concludes that MF is not a poor solution for poor countries. If properly regulated and supervised, MF institutions have great potential in poverty alleviation and development, both in rural and urban areas. Seibel (2005) documented a study aimed at tracking the inception and evolution of the SHG Banking program in India. He gives a historical perspective of rural banking in India with a comparative view of developments in Germany. He also
discusses the various stages of the evolution of the bank linkage program in India and lead role played by the National Bank for Agriculture and Rural Development (NABARD) in this movement. Helms (2006) in his paper discussed that from the past ten years, the world of microfinance has changed dramatically. The field has moved rapidly from early innovations in providing loans to help poor entrepreneurs start businesses to a bold vision of creating entire financial systems that work for the poor. In his paper he has emphasized that Microfinance has proved to be an effective tool for reducing poverty and helping poor people to improve their lives and yet a diverse range of potential clients still lack access to an array of financial services. Garg and Pandey (2006) discusses the reasons for banks’ and MFIs’ inability to fully replace moneylenders, and suggests ways to move India towards a more comprehensive financial system. This paper exposes the inefficacy of the formal financial system and builds a case for bank-moneylender linkages. The authors contend that despite one of the most widespread financial systems in India; most poor still do not have access to formal financial services, because the formal sector (including microfinance) failed to leverage the strengths of informal lending and 45% of rural lending in India is by moneylenders. Misra (2006) discusses factors and theoretical positions associated with the evolution of microfinance and its global acclaim. He opines that there is currently an overriding emphasis on microfinance in rural finance discourse. He states that microfinance is being celebrated as the new weapon in the fight against poverty and current literature on microfinance also highlights positive linkages between microfinance and achievement of the Millennium Development Goals (MDGs). In the Indian context, however, there is a missing link in terms of impact assessment of microfinance programs. Impact assessment is either left for inference through proxy measures like volume of credit, repayment rates and outreach or one-off sample impact assessment exercises. Adequate emphasis on impact assessment is integral to judging microfinance intervention. The paper proposes mainstreaming impact assessment in program evaluation for realizing the full potential of microfinance in achieving the Millennium Development Goals. Fernandez (2007) throws light on how did the Self-Help Group movement evolved over time in India. His paper traces the origins and progress of the ‘Self-Help Group (SHG) Movement’ in India from 1985 to 2006, focusing particularly on the role played by the International Fund for Agricultural Development (IFAD). The paper looks at the roles of non-government organizations (NGOs), the National Bank for Agriculture and Rural Development (NABARD), other banks, central and state governments, in the evolution of the SHG program. He discusses the first phase of the SHGs, from 1987 to 1992, when NABARD focused on supporting NGO initiatives to promote SHGs and on analyzing their potential and performance; the second phase, from 1992 onwards - the SHG-Bank linkage program; SHG contribution to various credit schemes. Jayasheela, Dinesha and Hans (2008) examined the role of microfinance in empowering people and realizing financial inclusion in India. While there are reservations about the efficacy of MFIs in handling public money, their growth and achievements have been noteworthy. Their paper states that MFIs in India want the government to empower them to mobilize savings. MFI’s have immense opportunities in microcredit given increasing demand for rural finance and the inadequacy of formal sources.
Chasnow and Johnson (2009) discussed the recent rise in equity investment in Indian microfinance and the process of obtaining equity financing and working with investors. They were of the opinion that the large growth in equity investment and high valuations of Indian MFIs is due to strong fundamentals of the Indian microfinance sector; decreasing costs; rapid expansion and low correlation between the performance of microfinance assets and the overall economy. The paper concluded suggesting that MFIs seeking to raise equity must develop a business plan; gather historic financial and operational data; estimate future growth; compile non-financial information; estimate value of the MFI and reach out to potential investors and negotiate with interested investors.

**Objective of the Study**

The main objective of the research was to study the impact of participation in SHGs on respondent’s livelihood income and effect of training on income generation.

**Hypothesis**

- **H₀**: There is no significant effect of training of SHG members on their income generation
- **Hₐ**: There is a significant effect of training of SHG members on their income generation.
- **H₀**: There is no significant effect of participation in SHG on livelihood income.
- **Hₐ**: There is a significant effect of participation in SHG on livelihood income.

**Methodology**

The present empirical study was conducted on sample of 500 SHGs from eight blocks (Arai, Kekri, Pisangan, Srinagar, Masooda, Bhinay, Silora and Jawaja) of Ajmer district in Rajasthan, who were selected by quota sampling. The primary data was collected with the help of a structured interview schedule.

**Research Design**

![Diagram of Research Design]

For the analysis of collected data both descriptive and inferential statistics have been used. In order to explore the effect of microfinance provided through SHG statistical techniques like frequency distribution, Percentage, mean, T test and correlation were used. The diagrammatic representation of the data has been present through graphs and maps.
Analysis & Results

Individual Income before Training of the Respondents

Training of SHGs leads to skilled behavior and enhances the performance of the group. To study the impact of training on individual income of the sample, data was collected before training; the percentage values are present in following table 1 & figure 1.

Table 1: Individual Income before Training of the Respondents (%)

<table>
<thead>
<tr>
<th>Individual income before training (in Rs.)</th>
<th>No. of respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1000</td>
<td>158</td>
<td>31.6</td>
</tr>
<tr>
<td>1000 – 1500</td>
<td>127</td>
<td>25.4</td>
</tr>
<tr>
<td>1500 – 3000</td>
<td>144</td>
<td>28.8</td>
</tr>
<tr>
<td>more than 3000</td>
<td>14</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>443</strong></td>
<td><strong>88.6</strong></td>
</tr>
<tr>
<td>NA (As these respondents did not receive training)</td>
<td>57</td>
<td>11.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Figure 1: Individual Income before Training of the Respondents (%)

The above table and the figure 1 clearly reveal that before training, 158 respondents had income of less than 1000 per month, 127 respondents had income between 1000-1500 per month, 144 respondents had income between 1500-3000 per month and only 14 respondents had an income of more than 3000 per month. The date proves that training of SHG leads to skilled behavior and enhances the performance of the group.
Individual Income after Training of the Respondents

In order to study the effect of training on the livelihood income of the respondents, data regarding the income of the respondents after training was collected. The details of the data are shown in the table and figure 2 given below:

Table 2: Individual Income after Training of the Respondents (%)

<table>
<thead>
<tr>
<th>Income after Training (in Rs)</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1000</td>
<td>49</td>
<td>9.8</td>
</tr>
<tr>
<td>1000 – 1500</td>
<td>117</td>
<td>23.4</td>
</tr>
<tr>
<td>1500 – 3000</td>
<td>232</td>
<td>46.4</td>
</tr>
<tr>
<td>More than 3000</td>
<td>45</td>
<td>9.0</td>
</tr>
<tr>
<td>Total (Respondents that received training)</td>
<td>443</td>
<td>88.6</td>
</tr>
<tr>
<td>NA(As they did not receive training)</td>
<td>57</td>
<td>11.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>500</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Figure 2: Individual Income after Training of the Respondents (%)

The above table & figure 2 reveal that out of 443 respondents who were recipients of training, 49 had a livelihood income of less than 1000 per month after training, 117 respondents had livelihood income between 1000-1500, 232 respondents had livelihood income between 1500-3000 and 45 respondents had livelihood income of more than 3000 per month.
To compare the respondent’s income before and after receiving training, t test was used, which has been present in the following table 3.

**Table 3: Paired Sample t test (Paired Samples Statistics)**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income after training - Income Before Training</td>
<td>632.21</td>
<td>620.304</td>
<td>29.472</td>
<td>574.29 690.13</td>
<td>21.452</td>
<td>442</td>
<td>.000</td>
</tr>
</tbody>
</table>

The result shows the P value (.000), which is less than .05. So we reject the $H_0$ and accept the $H_a$. This shows that there is a significant relationship between training and livelihood income or we can say training effects livelihood income. It shows that before training respondents had lower income but after training, there has been increase in their livelihood income considering other factors have remained constant.

**Contribution in Livelihood Income before joining SHG**

Data related to contribution in livelihood income of the respondents before joining SHG was collected shown in the below table 4.

**Table 4: Contribution in Livelihood Income before joining SHG**

<table>
<thead>
<tr>
<th>Contribution</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td>459</td>
<td>91.8</td>
</tr>
<tr>
<td>100-300</td>
<td>25</td>
<td>5.0</td>
</tr>
<tr>
<td>300-600</td>
<td>14</td>
<td>2.8</td>
</tr>
<tr>
<td>More than 600</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The above table 4 & figure 3 indicate that out of 500 respondents, 459 had contributed less than Rs 100 per month, 25 had contributed between 100-300 Rs per month, 14 had contributed between 300-600 Rs per month and only 2 respondents had contributed more than Rs 600 per month before joining SHG.

**Contribution in Livelihood Income after joining SHG**

SHGs utilize the savings mobilized to lend small loans internally among the members. The members of the group utilize this amount by investing the same in any livelihood promotion activity and thus increase their livelihood income. The data collected from 500 respondents is shown below.

**Table: 5 Contribution in Livelihood Income after joining SHG**

<table>
<thead>
<tr>
<th>Contribution</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1000</td>
<td>71</td>
<td>14.2</td>
</tr>
<tr>
<td>1000-2000</td>
<td>248</td>
<td>49.6</td>
</tr>
<tr>
<td>2000-3000</td>
<td>133</td>
<td>26.6</td>
</tr>
<tr>
<td>More than 3000</td>
<td>48</td>
<td>9.6</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Figure: 4 Contribution in Livelihood Income after joining SHG

The above table 5 and figure 4 indicate that after joining SHG, 71 respondents could contribute less than Rs 1000 per month, 248 contributed between 1000-2000, 133 contributed between 2000-3000 Rs and 48 contributed more than Rs 3000 per month in the livelihood income.

Statistical interpretation

To compare the respondent’s contribution in income before and after joining the training, t test was used, which has been present in the following table 6.

$H_0$: There is no significant effect of participation in SHG on livelihood income.

$H_a$: There is a significant effect of participation in SHG on livelihood income.

Table 6: Paired Samples Statistics

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution in livelihood</td>
<td>1985.10</td>
<td>500</td>
<td>1269.629</td>
<td>56.780</td>
</tr>
<tr>
<td>income after joining SHG</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contribution in livelihood</td>
<td>30.40</td>
<td>500</td>
<td>129.070</td>
<td>5.772</td>
</tr>
<tr>
<td>income before joining SHG</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Paired Samples Test

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>Df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Upper</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contribution in livelihood income after joining SHG</td>
<td>1954.70</td>
<td>1271.545</td>
<td>56.865</td>
<td>1842.98</td>
<td>2066.42</td>
<td>34.374</td>
<td>499</td>
</tr>
</tbody>
</table>

The result shows the P value (.000), which is less than .05. So we reject the $H_0$ and accept the $H_a$. This shows that there is a significant relationship between participation in SHG and livelihood income or we can say that participation in SHG had a positive effect on livelihood income. It shows that before joining SHG respondents had lower or no livelihood income but after they became the members of the SHG, there had been increase in their livelihood income considering other factors had remained constant.

## Conclusions

After analyzing the impact of participation in SHG on members and provision of microfinance, it was found that the SHGs had contributed immensely in the upliftment of the rural poor.

There had been an increment in the livelihood income of the SHG participants, which not only raised their standard of living but also contributed immensely in the empowerment of members especially in case of women SHG participants.

The analysis of the data obtained from the sample reveals that training and capacity building played an important role in enhancing the income of the members of the SHG.

Training of the members increased their access to markets, information on raw material and technology, skills up-gradation and a range of business development services which were equally significant in making microenterprise more profitable and sustainable.

Thus training and capacity building of the SHG participants had a positive impact on their income generation.
References


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The agonizing questions concerning the problems and issues of healthcare service development in India and their understanding towards effective, efficient, quality and equitable healthcare services to the people set the theme for this paper. There has been a remarkable improvement in health status in most countries of the world over the past few decades. Infant and child survival in developing countries has increased dramatically. However, despite these general improvements, there remain substantial inequalities in health between countries, regions, socio-economic groups, and individuals. Indeed some inequalities are widening. Socio-economic inequalities in health and disease are ever-present. They have been observed in populations throughout the world that are at varying levels of social and economic development. In this era of privatization in various sectors, healthcare privatization has affected the poor adversely. There is a foremost shift of emphasis in which health sector reform has increasingly become an alternative approach to the health service development. There is an urgent need for advancing our understanding in order to better orient policies toward improvements along this crucial dimension of health system performances. Health inequality has become the focus of increasing attention on the part of researchers and of policy makers. This paper rests on the areas of concern to bring about a change in a set of beliefs about health and illness that form the basis for health-seeking and health-promoting behaviours, the institutional arrangements within which that behaviour occurs and socio-economic, political and physical context for those beliefs and institutions in India.

The present paper discusses and differentiates the relevance of three processes in the health sector - public health, community health, and health promotion. Public health and community health share a common purpose to improve the health of the population. In order to achieve this goal, community health uses a participatory process. Health promotion, on the other hand, aims to reduce social inequalities in health through an empowerment approach and process. Nevertheless, this concept remains only on paper since, practically, health promotion professionals tend to overlook this purpose. Two opinions should influence health promoters in the struggle against social inequalities in health sector. These opinions should be based on the usefulness of the approaches for public health and community health, centering on health system and health education that may lessen social inequalities in health sector. Those responsible for health promotion must engage in planning to reduce social inequalities in health and also must ensure its effectiveness. The concept of social
exclusion implies a focus on causes of inequality. A debate on macro-micro linkages is vital to the understanding of social inequalities in health. Very little research exists centering on the relationship between social exclusion and health inequalities. Instead, research focuses on a particular dimension or groups, thus limiting the overall scope of social exclusion as a ‘state’. Other deprivations are caused such as low income, disease and ill-health. Therefore, social exclusion can be integrated into health inequality frameworks. This paper attempts to address that restructuring in healthcare activities should not only deal with the concerns in relation to structures and roles of medical care establishments, but also should take care of the issues concerning impact on health and quality of life of the people. This is an attempt to raise issues around health inequities and inequalities in the Indian and global context. It also explores how far these are common global themes in policy that may shed new light on inequalities in health, and strategies to reduce them.

**Poverty and Health Care Debate**

Privatization as a public policy succeeded in establishing its dominance around the globe. The privatization programme started in the seventies and was in full swing in the early eighties. It is essential to understand privatization in India from the gender perspective. It is suggested that privatization in India would not be in the interest of female workforce. In India the work participation rate for female is very low. It is further expected to go down during the post-privatization phase owing to underlying principles, like labour market, price mechanism, reduction in state subsidies, relatively hostile environment for working mothers and general bias against women employment.

If reformed healthcare systems are to be genuine, the new arrangement should involve the creation of a legitimate basis for the poor to claim healthcare, and a strengthening of institutional capacities to make such claims. Healthcare systems that do not offer care – that take a narrow or an abusive view of their duties – thereby contribute profoundly to people’s experience what it is to be poor (Tibandebage and Mackintosh, 1999). The failure of care is a core element of social exclusion; Kaijage and Tibaijuka (1996) placed exclusion in the failure of access to economic and cultural resources, including land and cash, education, and family, kinship, community support systems and also in the failure of government social sectors, including healthcare, to sustain and supplement such community support systems in times of crises. A growing literature on poverty and vulnerability focuses, not just on income, but in the tangible and intangible assets of the poor. However, these studies underplay the asset value of effective claims to healthcare. Moser (1998) for example defines potential assets to include health status, skills and education and household relationships and networks of mutual support. Some networks, such as pooled savings, schemes and reciprocal lending, assist access to healthcare. Relationship with the healthcare systems are not considered assets, except for credit from private practitioners.

Legitimate claims to healthcare should therefore be reconsidered as social assets for the poor, and institutional design of healthcare reform should seek to strengthen effective legitimate claims. The claim in this analysis is the duty owed to an individual that they should have a good or service (Broome, 1989; Mooney and Jan, 1997). Claims may be of
different strengths – they are not absolute in the sense that rights are often considered to be. Concepts of fairness prescribe ‘how far each person’s claim should be satisfied relative to the satisfaction of other people’s claim. Stronger claims require more satisfaction …..’ (Broome, 1989). Claims in healthcare are rooted in needs, and the formulation and agreement upon the strength of healthcare claims is necessarily an institutional process (Mooney, 1998). In unequal societies some people’s claim will be denied legitimacy, and some legitimated claims are likely to remain unfulfilled. Hence the culture and operation of the healthcare system (as a whole, public and private) is the way in which claims are established, legitimated, and denied or fulfilled by society.

The implication is that healthcare claims are relational; they are shaped by the norms and experiences governing patients’ relations to providers (Birungi, 1998).

**Negligence towards Accumulation of Health Inequality Data and Approach to Health Inequality**

In the health field, the philosophy of health for all and primary healthcare that emerged from the 1978 Alma Ata conference was quite congruent with the basic human needs development schools (WHO: 1978). In the area of economic development, the concern for poverty that emerged in the 1970s gave rise to a determined effort to produce basic information. Prominent in this effort was the establishment of the poverty line, defined as the amount of consumption needed to purchase a nutritionally adequate diet and a vigorous programme of household data analysis to produce estimates of the number of people in each country and region whose consumption placed them below that line. Nothing comparable was attempted in health. Thus the 1998 world development indicators contain no information about intra-country differences in health conditions. For example, there is information about infant mortality in the entire country population, but not about infant mortality among the poorest 20 per cent of the population or among those in the population who subsist below a country’s poverty line. One can find data about the percentage of birth attended by trained health staff; but not about the percentage of births among the poor which receive such attention, or about how big a poor-rich difference exists in this regard. Figures are provided for overall government health expenditures, but not for how the beneficiaries of those expenditures are distributed across the economic class. It is certainly true that the focus on infant, child and maternal mortality provides more of poverty orientation than reliance on some other indicator like life expectancy since, death suffered at early age or at child birth is particularly frequent among the poor.

Not all inequalities in health are equally susceptible to reduction. Working towards a healthcare system that is based on principles of equity may be easier. More fundamentally, some inequalities in risk of disease between populations may reflect profound long-term differences in the way in which societies have grown and developed. There still remains much to be understood about the way in which the health of population change is part of the broader social and economic changes that societies undergo.
The term health inequality is used to explain the variation in health status across individuals in a population. This is a use that is quite distinct from the concept of inequalities in health as used in studies of health differences between social groups. Measures of inequality of income or health are important because the same average level of income or health could correspond to vastly different distributions of these variables across individuals in a population. A concern for inequality is a concern for the distribution of attributes such as income or health across individuals. Socio-economic inequalities in health and disease are ever-present. They are as obvious today as they were 100 years ago, despite the fact that absolute poverty and deprivation are largely a thing of the past in high income countries, and that the profile of life-threatening diseases has moved decisively from communicable to non-communicable diseases (Illsley, et.al., 1997).

Healthcare Systems Contributing to Social and Economic Inequalities

Although there is much debate in developed countries about levels and trends of health inequities (Lancet editorial: 1997; Mackenbach et al: 1997; Williams: 1998) data from developing countries are limited and even when available are not fully explored (Braveman: 1998). Inequitable healthcare systems form an element of wider social inequality, and reinforce other sources of poverty, is well understood. However, this aspect of healthcare systems is curiously underplayed in the current health policy literature. The current debate in the literature focuses on the impact of healthcare systems on health outcomes and on the impact of social inequality on health outcomes. It does not pay anything like the same attention to the direct interaction between social inequality and healthcare systems themselves.

Healthcare systems could be seen as a core element of social inequalities in society in the sense that unequal legitimate claims upon a healthcare system, and unequal experiences of seeking care, are important elements of poverty and social inequality in people’s experience. At present health sector reform models tend to be prescriptive in its substance and content, which entails that they tend to disguise the associations between the reforms and inequality. Inequalities in health, both across and within populations, are a major public concern. Building on a long-standing tradition (Antonovsky, 1967), there has been a remarkable increase in interest in health inequalities and social group health differences since the early 1990s (Whitehead. 1992; Feinstein, 1993; Marmot et al., 1997; Beaglehole and Bonita, 1998). This interest has been expressed through the volume of scientific papers on the subject (Kaplan and Lynch, 1997; Acheson, 1998).

There is a vast amount of literature on studies of social group differences in health which has brought a lot of attention to health inequalities in the last decades. An attempt to summarize this would be beyond the scope of this paper. Analysis of inequalities in health which categorizes the population by location deserve exceptional note. Small geographical areas can be considered a type of social group. A study of patterns of mortality in US counties (Murray et al: 1998) has revealed remarkable differences in life expectancy at birth across geographically defined groups of population. The power of the small area analysis is that the approximate household or individual level analysis, under the assumption that
population in the same age- sex- race group within the same countries are similar. Small area analyses are very useful analytical tool which, in conjunction with individual level analysis, can help shape policy discussions.

**Health Sector Reforms and Systems**

At the national level, policies form an integral part of public health strategies to reduce inequalities, but there are policy choices to be made. Tackling health inequalities is moving up the public agenda at both international and national level. Tackling inequalities generally is clearly an ambitious policy objective (UNDP: 1996). In terms of mechanisms that may generate or contribute to inequalities in health we need to look briefly at the role of the health sector. There can be striking evidence that the introduction of effective medical interventions into society can in fact aggravate socio-economic inequalities in health outcomes. In many countries, those who are socio-economically advantaged are most likely to be the first beneficiaries of new treatments, even if in the longer term they are made available to all. This gradual diffusion of the intervention through different strata of society will leave a distinctive trace on inequalities in outcomes, which may be expected to expand before they are diminished.

In the past India has undergone dramatic shifts in its population policies and programmes. However, there is still little progress on key indicators of reproductive health and gender equity (as evidenced by declining sex ratios, limited access to safe abortions services, persistently high maternal mortality and high fertility in many states, and lack of choice within the family planning programme). Population policy debates in India have been ongoing; however, there has been very little debate on the current state of the health sector and the potential need for health sector reforms. Despite the lack of an articulated agenda of reforms, it is apparent that India is in fact experiencing extensive shifts in and reforms of its health sector. Economic restructuring opened the door to the liberalization of the health sector.

In India health sector reforms are taking place under the broad umbrella of Structural Adjustment Programmes (SAP) which is termed as the New Economic Policy (NEP). The two major aspects of the SAP are privatization and liberalization. The major problem historically and more so presently under SAP is the issue of under-funding of health services. The investment by the government in healthcare has been inadequate to meet the demands of the people (Duggal, et.al., 1995). The grants from central government to the state governments declined drastically. Central programmes or centrally sponsored programmes are the most severely affected (NIPFP, 1993). Hence, financing of the health needs to be substantially strengthened.

If the healthcare system were widely understood among healthcare policy makers as a core element and institutional expression of social inequality, then one would expect the policy literature, including the large literature on health sector reforms models, to address this problem conceptually as well as prescriptively. That is, it would analyze healthcare systems as embedded in a country’s social and cultural institutions, changes to which interact with wider social, economic and institutional change.
Conclusions

Social inequality directly shapes inequitable healthcare systems; the failure of legitimate claims to healthcare is a core element of poverty as it is experienced. It follows that commitment to redistributive healthcare, has to be actively constituted and sustained within unequal healthcare institutions. The approach to conceptualizing healthcare reforms might be summarized as follows:

1. Begin by accepting the relational nature of healthcare, and focus attention on strengthening the capacity of the poor to make claims. Establish some principled universal commitment – such as an essential package of care – as a basis for claims, and focus institutional design around ensuring that all sectors of healthcare fulfill the commitments.
2. Concentrate on improving information about healthcare in the public domain, including information about governmental facilities, and on strengthening the capacity of the public – better-off and poor – to organize around healthcare.
3. Seek to shape the private sector through negotiations and public pressure, as well as formal regulation. Influence the private sector institutional culture by blurring boundaries, using a mixture of incentives, demands and professional pressure. Publicize bad practices. Try to avoid the creation of powerful private sector lobbies against socially inclusive institutions.
4. Take discourse seriously. The public representations of healthcare system are important: Healthcare systems that shape how we learn, who we are in society, what we can expect, how we may behave. They help to create a more individualistic or a more mutual society. Such commitments have to be constantly reconstructed in a market-dominated or market-pressured system.

From what has been said, it would clearly be unfair to say that nothing at all is known about the health of the poor in developing countries and about how it compares with that of the rich within the same countries. The existing knowledge about many important issues is quite inconclusive. There appears to be a great deal of variation from country to country, for reasons that remain to be determined. As a result, it is very difficult to draw generalizations of value for the guidance of health policies. This will require not simply more and better research; but also, and even more importantly, types of research that are different from those undertaken thus far.

Health inequality has become the focus of increasing attention on the part of both researchers and of policy makers. With continued research it can lead to better evidence on the magnitude and determinants of health inequality.

Recommendations

This analytical paper brings out with some specific suggestions and main recommendations:
1. Health has to be conceptualized in an integrated manner in order to realize the goal of ‘Health for All’ in the true sense. A comprehensive approach to the Primary Healthcare Concept needs to be understood.

2. It is important to ensure quality in healthcare at all levels. NGOs can play a key role in providing both preventive and curative services.

3. Since a sizeable proportion of India’s population are poor, it is crucial to ensure sufficient resource allocation for proper functioning of the public health system.

4. There is a need for an inter-sectoral approach where all departments or ministries working on any single health issue should form a health unit for effective execution of health programmes.

5. At present, tertiary healthcare is provided by the state mainly on fee-for-service basis. Also, there is a considerable growth of the private sector in providing tertiary care. Therefore, it is important to ensure that tertiary care is provided by a reasonable mix of public and private institutions.

6. Research in alternative systems of medicines should be promoted with a view to find holistic solutions to health problems.

7. Adequate awareness of possible new communicable diseases should be generated.

8. The horizontal system of disease control programmes needs to be expanded and strengthened. Vertical approaches could be disease-based and restricted to specific locations.

9. A resource centre can be formed for documentation, assimilation and dissemination of information obtained through research.

The issues raised in this paper require to be addressed by the planners, policy makers, NGO’s, and researchers among others. Privatization and liberalization being undertaken in the country has to be viewed in the broad context of majority of the Indian people living under extreme poverty conditions, non-availability of basic amenities for the majority of the people, poor nutritional status, impoverishment due to health, poor availability of public services, presence of a dominant and unregulated, unaccountable private health sector along with strengthening of market forces and helplessness of the consumer against various odds. In India no single system can work. There is a need for a combination of social insurance, employment related insurance for the organised sector employees, voluntary insurance for other categories who can afford to pay.

References


For older people, mental health conditions are an important cause of morbidity and mortality. In addition to physical disability, dementia and major depression are the two leading contributors, accounting respectively for one quarter and one sixth of all disability adjusted life years (DALYs) in this group. Mental health practitioners have now better efficacious interventions in the form of medications for dementia and depression. Psychosocial and behavioral modalities have also shown a significant impact on these mental health conditions. In India, the decadal growth rate for 1991-2001 in the age group 0-14 years was only 6.7 per cent while that of the 60 + population was 38.4 per cent. These demographic facts and trends make the elderly in India an increasingly important segment of the population pyramid in the coming years. These important demographics of elderly have its own repercussions on the existing health system. Low-income countries like India lack the economic and human capital to contemplate widespread introduction of services of mental health professionals. The most cost-effective way to manage older people with psychiatric conditions will be through supporting, educating and advising family caregivers. The next level of care to be prioritized would be respite care, both in day centers and in residential or nursing homes. An important prerequisite to improving care for older persons is to create a climate that fosters such advances.

“It is not enough for a great nation merely to have added new years of life – Our objective must also be to add new life to those years”.

**John F Kennedy** (Message to US Congress, February 21, 1963) Aging is characterized by many changes, particularly in the occupational and financial domain, in physiology, and in health, including psychological and social domains. Such changes influence the well-being of elderly persons and tend to lessen the physical and mental capacity of elderly individuals to cope with the rigors of daily living (Prakash et al., 2007).

The aging of the population is a global phenomenon having economic, social and political repercussions. A majority, 72% will be in developing countries. Currently, one out of every 10 persons is above 60 years of age. Today, about 10% of the population over age 60 is already age 80 or older; this likely to rise to 25 % before the year 2050. The health professionals have to play a bigger role in implementing President Kennedy’s suggestion that new life be added to later years (Prakash, 2002).


Ageing and India

In India, urbanization, modernization and globalization have significant impact on economic structure, erosion of societal values and the weakening of joint family systems. The younger generation is searching for new identities and redefined social roles within and outside the family. Like Western countries, the traditional sense of duty and obligation of the younger generation towards their older generation is being eroded. The older generation is caught between the decline in traditional values and the absence of an adequate social security system (Bhat & Dhruvarajan, 2001).

India, like many other developing countries in the world, is presently witnessing rapid ageing of its population. The Indian aged population is currently the second largest in the world. Almost eight out of 10 older people in India live in rural areas. About 7.6% of India’s population is over 60 years and is expected to reach 18.84% in 2025. Life Expectancy at birth for males has shown a steady rise from 42 years in 1951–60 to 58 years in 1986-90; it is projected to be 67 years in 2011-16 (Jaiprakash, 1999).

In India, the decadal growth rate for 1991-2001 in the age group 0-14 years was only 6.7% while that of the 60 + population was 38.4% (Jaiprakash, 1999). These demographic facts and trends make the elderly in India an increasingly important segment of the population pyramid in the coming years. These important demographics of elderly have its own repercussions on the existing health system.

Ageing and Mental Health

Mental health of older persons is influenced not just by ageing changes in the body and brain, but by socio-economic and psychological factors (Prakash, 2002). Isolation from the society and a feeling of loneliness and hopelessness are the important agonizing problems of the old age. Many think in terms of "time left to live" rather than time from birth. Moreover, conflicts are likely to arise when the sick, tired mind and body can not cope with psychological, emotional and physical stress. Lack of social interaction caused by loss of physical capabilities (e.g. mobility, hearing, sight, mental functioning, intelligence, memory), and by retirement from work is most likely to reinforce these feeling and may lead to further social withdrawal and segregation (Lazarus & Weinberg, 1981).

Concurrent physical illnesses increase the vulnerability to mental health illnesses. Though a positive mental outwork is essential to healthy aging, many issues faced in old age create serious challenges for elderly. Older adults and their families usually deny the existence of mental health problems. As a result, elderly patients may seek medical care for nonspecific somatic complaints such as headache, insomnia, dizziness or other vague physical symptoms, instead of requesting seeking psychiatric care (Prakash, 2002).

The aged population bears a very significant burden and array of symptomatic mental illness (Lish et al, 1995). Growing numbers of elderly in countries of the developing world presage an increase in those affected by firstly, organic, age-related mental diseases such as dementia. Secondly, a simultaneous rise in the burden of non-organic mental disorders like depression in elderly populations is likely because stressors in many countries are affecting
the mental health of the elderly directly and/or indirectly by altering the ability of families to provide care for them (Levkoff et al., 1995).

Magnitude/Burden of Problem

For older people, mental health conditions are an important cause of morbidity and mortality. Thus, it is not surprising that with one in five individuals over age 65 are suffering from mental disorders, and the number of older adults with psychiatric disorders is expected to double in the next 30 years (Jeste et al., 1999; Bartels et al., 2003). In addition to physical disability, dementia and major depression are the two leading contributors, accounting respectively for one quarter and one sixth of all disability adjusted life years (DALYs) in this group.

Depression in old age is reported to occur in 2–5%, and depressive symptoms occur in as much as 50% of persons aged 65 and over in community (Blazer et al., 1988). Depression has been found in 17 to 37% of elderly patients treated in primary care settings and about 30% of these have major depression (Alexopoulos, 2000). Depressive disorders are inadequately diagnosed more so in the elderly with medical problems (Cullum et al., 2006). The rates of depressive disorders amongst medically hospitalized elderly found to be 10 times greater (Koenig and Blazer, 1992). The confounding relationship between a typical phenomenology of depression in the elderly and the co-occurrence of physical illness influences both diagnosis and treatment, presenting a unique clinical and therapeutic challenge (Prakash et al., 2009a).

Depression is an often-missed diagnosis especially in the medical elderly patients. In one of the study, Prakash and his colleagues reported 23% of patients having depressive symptoms and 18% having a definite depressive disorder among geriatric clinic attendees. Surprisingly, none of the geriatric physicians even from a tertiary clinic setting had made a diagnosis of depression (Prakash et al., 2009a).

Dementia is a major neuropsychiatric disorder primarily affecting geriatric age group Alzheimer’s disease (AD), the most common cause of dementia in the elderly, is a progressive neurodegenerative illness characterized by a spectrum of clinical features and neuropathologic findings. The last several decades have marked an unprecedented new era of scientific progress in the field of AD, where the pace and breadth have surpassed the previous 100 years of investigation. As a result of this research progress, it is now possible to investigate AD biochemically, pathologically, and clinically. It is an age-associated phenomenon influenced by nutrition, vascular factors and genetic background (Prasad et al., 2009).

In a report by Ferri et al (2005), it is estimated that 24.3 million people in the world were suffering from dementia in 2001, with an estimated 4.6 million new cases every year. This is equivalent to one new case every 7 seconds. The number of people affected by dementia is projected to double approximately every 20 years to 42.3 million in 2020, and to 81.1 million by 2040. The prevalence of dementia in India has been shown to vary from 0.84% to 3.5% (Chandra et al 1998; Shaji et al 2005; Vas et al, 2001) in elderly population over 60 years.
Health Resources for Elderly

As a society we have slowly begun to acknowledge this ongoing change in demographics, yet we have done little to prepare for it. The following section briefly discusses how many health care providers are available to treat the mental health needs of the Indian elderly population and what resources are currently available to continue training.

Health Infrastructure

India is one of the pioneer countries in health services planning. Improvement in the health status of the population has been one of the major thrust areas for social development programmes in the country. However, only a small percentage of the total annual budget is spent on health (Khandelwal et al. 2004). India has a number of public policy and judicial enactments, which may impact on mental health. These have tried to address the issues of stigma attached to the mental illnesses and the rights of mentally ill people in society. Low-income countries like India lack the economic and human capital to contemplate widespread introduction of services of mental health professionals, though India is well placed as far as trained manpower in general health services is concerned.

Apparently, there are only around 4000 psychiatrists in India to serve the five crore mentally ill population currently. Approximately 50 of them list "geriatric or gerontologic psychiatry" as one of their three primary interests. India is having 289 institutions providing undergraduate medical training (196 MCI recognized, 77 MCI permitted, and 16 in the "danger zone"). Training opportunities for various kinds of mental health personnel are gradually increasing in various academic institutions in the country. The postgraduate training in psychiatry includes Doctor of Medicine (MD) (83 centers, 159 seats), Diploma in Psychological Medicine (DPM) (46 centers, 107 seats), and Diplomate of National Board (22 centers, 36 seats) (Mohandas, 2009).

Mental health professionals are mostly based in urban areas. Mental health care for the elderly population is also provided by primary care physicians. Their role in this field must not be ignored. However, studies have shown that many of these providers are unprepared to deal with geriatric mental disorders (Prakash et al., 2007). Most physicians receive little training in mental disorders of elderly persons, and consequently they do not provide optimal treatment to their patients. Considering this reality, development of mental health services has been linked with general health services and primary health care.

Private medical care has expanded in recent years, offering the latest medical treatment facilities to those who can afford it. Land and other facilities are provided at less than market rates. Recently, there has been a major initiative in the growth of private psychiatric services to fill a vacuum that the public mental health services have been slow to address (Khandelwal et al. 2004).

A number of non-governmental organizations have also initiated activities related to rehabilitation programmes, human rights of mentally ill people, and school mental health programmes. Non-governmental organizations need to be encouraged and assisted through
grants, training and orientation of their personnel and various concessions and relief to provide ambulatory services, day-care and health care to complement the efforts of the state.

Despite all these efforts and progress, a lot has still to be done towards all aspects of mental health care in India in respect of training, research, and provision of clinical services to promote mental health in all sections of society including elderly. Mental health practitioners have now better efficacious interventions in the form of medications for dementia and depression. Psychosocial and behavioral modalities have also shown a significant impact on these mental health conditions.

The most cost-effective way to manage older people with psychiatric conditions will be through supporting, educating and advising family caregivers. The next level of care to be prioritized would be respite care, both in day centers and in residential or nursing homes. An important prerequisite to improving care for older persons is to create a climate that fosters such advances.

**Government Policies**

The Ministry of Social Justice and Empowerment (MoSJE) has launched in the year 1999, a National Policy on Older Persons (NPOP). The NPOP extends comprehensive support for financial security, health care, shelter, welfare and other needs of the elderly. It seeks to provide protection against abuse and exploitation, make available opportunities for development of the potential of older persons by enlisting their participation and providing services to improve their quality of life.

The Government has also constituted a National Council for Older Persons (NCOP) to advise and aid the Government on policies and programmes for older persons and also to provide feedback to the Government in this regard. The areas of concern which have been emphasized include: - uniform age of > 60 years for extending facilities/ benefits to senior citizens; Financial security to the elderly population by proposing tax benefits and higher interest rates for senior citizens; promotion of long term savings in both rural and urban areas; increased coverage and revision of old age pension schemes for the destitute elderly; and prompt settlement of pension, provident fund, gratuity and other retirement benefits.

Under NCOP, it is also decided to strengthen health care and nutritional needs of the elderly populations by strengthening of primary health care system to enable it to meet the health care needs of older persons; training and orientation to medical and para-medical personnel in health care of the elderly; promotion of the concept of healthy ageing; assistance to societies for production and distribution of material on geriatric care; and provision of separate queues and reservation of beds for elderly patients.

Other issues covered by the Council are food security and shelter coverage under the Antyodaya Scheme to be increased with emphasis on provisions for the benefit of older persons especially the destitute and marginalized sections; earmarking ten percent of houses/ house sites for allotment to older persons; and barrier-free environment for the disabled and elderly persons etc. the council also look after the education, training and information
needs of older persons; identification of the most vulnerable among the older persons and working for their welfare; realizing the crucial role by the media in highlighting the situation of older persons and emphasizing their continued role in society; and protection of life and property of the elderly population. An Inter-Ministerial Committee is responsible for the implementation of the action points described above.

**Need of Hour**

**Need for health care professionals**

Our society is generally ill prepared to deal with the number of older persons with mental disorders, and this situation will only worsen. It has been estimated that currently India needs 10,000 psychiatrists and out of which, 10% cater services to elderly. These estimates are derived by authors taking account of demographics, training paths, training capacity, and other factors. For other general mental health care workers, no studies with estimates could be found. Also, given the large number of nursing home residents with chronic mental illnesses, including dementia, it is clear that paraprofessionals must also receive appropriate training to meet changing needs. The current Revised District Mental Health Programme is working this regards.

Again, one must not overlook primary care physicians. A large majority of older people seek mental health care services from their primary care physicians for disorders such as depression and dementia. Research findings have indicated that primary care physicians often fail to adequately detect and treat mental illnesses in older patients (Prakash et al., 2007; 2009a). There is an urgent need of training primary care physicians about geriatric mental disorders (Prakash et al., 2009b) either through DMHP or National Rural Health Mission (NHRM) or National Urban Health Mission (NUHM). There should be a separate programme to cater the needs of this vulnerable population.

**Strategic Planning**

Multiple strategies are necessary for ensuring that we are able to provide adequate mental health care to the elderly population in India.

Firstly, some level of core training in the provision of mental health care to older patients must be in place for all disciplines—primary care, psychiatry, psychology, nursing, and social work. Training in assessment and diagnosis should be required in all such programs. In M.B.B.S. curriculum, there should be an adequate emphasis on training on mental disorders. This level of training can be provided through basic training programs to new personnel entering the professions and through continuing education for existing professionals. Primary care practitioners, psychiatrists, and psychologists should receive some training in appropriate intervention strategies and referral. The running DMHP should look this issue on urgent basis.

Second, specialty training in geriatric mental health should be available in each of these professions. Such training can take place through a number of mechanisms, including both didactic and practical training. Specialists will provide services directly to patients and
also will take a large degree of responsibility for training other providers.

Lastly, a larger cohort of academic geriatricians must be developed to serve as leaders in research and training. The current professional bodies like Indian Psychiatric Society (IPS) and Indian Association of Geriatric Mental Health (IAGMH) should take active initiative in this regards.

**Recommendations**

Clearly, an urgent demand exists to train individuals to meet the needs of the growing population of older adults for our country. Multiple strategies must be implemented to facilitate understanding and training. We present several specific recommendations for addressing these needs.

- Educate the general public about the common mental disorders of late life through awareness programmes and use of mass media. Better awareness is a necessary precondition for appropriate help-seeking in this population. This approach will lead people to seek appropriate and effective interventions for treatable disorders, encourage health care providers to become more educated about treating common disorders, and increase the number of advocates for additional research on mental disorders of late life.

- Expand the core curriculum on aging and late-life mental disorders in professional programs i.e. M.B.B.S. (medical graduation), M.S.W. (social work graduation), Psychology and Nursing graduations. This approach will ensure that all health care providers have had some, albeit limited, education in the field of geriatric mental health.

- Encourage professional organizations to offer certification in disciplines related to aging to highlight the increased knowledge of specialists within their field. For example- Indra Gandhi Open National University (IGNOU) is offering certificate course in geriatric health and care.

- Increase central, state, and private research funding for late-life mental disorders, especially in epidemiological studies and developing new interventions. This strategy will lead people to seek research careers in late-life mental disorders, increase the base of academic faculty available to provide training in geriatric mental health, and increase scientific findings that may lead to new interventions or prevention of late-life mental disorders.

- Establish "centres of excellence" in geriatric mental health to provide multidisciplinary training environments.

**References**


Living Pattern of Voluntary Retired Employees

M. Trimurthi Rao*

In India most of the Public and Private Sector Undertakings are implementing Voluntary Retirement Scheme (VRS) and it is sometimes compulsory for the basic survival of the organizations. As a result, thousands of workers are losing their jobs and overnight becoming rootless socially, psychologically and economically. There are instances in which after opting for VRS, some people have been murdered by their children due to refusal to give the VRS fund, some have been driven out from homes, and some have died being ill treated, and uncared by their children and family members. The present study examines various problems and challenges faced by VRS opted employees. It also includes the views and suggestions of the respondents’ aftermath of voluntary retirement, their current state of mind and suggestions given by them to those employees who are about to take voluntary retirement. Moreover, since VRS has social, economic and psychological impacts.

The word ‘retirement’ implies leaving or withdrawing from a specific act or employment. In the context of Industrial Relations it implies termination of employer-employee relationship at the conclusion of pre-agreed terms/conditions or on attaining age of superannuation. The term ‘voluntary retirement’ on the other hand relates to a situation when a worker, for one reason or other, resigns from his job and thereby terminates the employer-employee relationship prior to the maturity of terms and conditions of employment (Sinha, 1994).

Voluntary Retirement Scheme (VRS) as compensation package for exit policy is not new in Indian context, which emerged immediately after declaration of new economic reforms of the Indian economy. Data reveals that most of the public and private sector industrial enterprises implemented this scheme; however, there is very poor response to it. Till 1991 it was only a part of the personnel policy appearing in the personnel manual of the industrial organizations. Effectively, it remains a non-implemented personnel policy in most of the industrial organizations in India. Reinforcement of VRS by the manufacturing industries in India after 1991 is by a way of circumstantial compulsion due to economic liberalization in the country i.e., the scheme gained momentum only after 1991 with economic restructuring programme initiated by the government (Dwivedi, 2002).

Going for VRS by an organization would always be an important decision with respect to the bread and butter, life and living, socio-economic and cultural well being of the employees. Rajan and Dhunna (2000) stated that to improve the organizational effectiveness and competitiveness VRS should be implemented. The employees who avail

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VR Scheme should be helped with placement services for getting jobs elsewhere. Tripathy (2001) emphasized the downsizing as a long-term strategy, not as a short-term business goal. For this, downsizing must be approached from a strategic perspective rather than reactive. Guha (1996) explained various important aspects like VRS package, its utilization and its impact on the economic and social life of retired employees of public and private sector enterprises in the states of West Bengal, Bihar, Orissa, Maharashtra, Madhya Pradesh, Delhi, Uttar Pradesh, Andhra Pradesh and Karnataka. Datta (2001) attempted to examine the survival strategies adopted by the workers after opting for VRS.

A large number of Indian researches on VRS have indicated that VRS is sometimes compulsory for the survival of the organization and looked upon as human technique which eases out the surplus manpower without much hardship to labour under the circumstances.

Faced with the diabolic situation of neither being able to retrench surplus workers nor being able to close a loss making or sick units, the employer looked at ‘golden handshake/voluntary retirement as the most suitable method for coming out of this tricky situation. Accordingly, most of the units in public and private sector enterprises have introduced individual Voluntary Retirement Schemes (VRS) to attract workers to seek voluntary termination of employer-employee relationship (Stiftung, 1994).

VRS is one of the strategies introduced in the early 1980s in Central Public Sector Enterprises (CPSE) to reduce the surplus or redundant workforce. It is envisaged in the New Economic Policy that VRS can provide minimum sustenance security to the retired individual and his family. Trade Unions play crucial role in introducing VRS in the organized sectors. The scheme cannot be implemented without, at least, the tacit approval of the representative union.

Due to this paramount size in PSEs, the wages and personnel cost adversely affected the profitability of the PSEs. Swaminathan (1994), rightly stated that, there was a surplus of three million PSEs workers blaming them for consuming Rs.12,000 crores in wages every year without any productive end. Under these circumstances, top priority was accorded in the reform programme to reduce the excess manpower in public sector undertakings through introduction of ‘Voluntary Retirement Scheme’ (VRS) popularly known as ‘Golden Handshake’. This has now become a basic component of the labour adjustment strategy of both public and private sectors undertakings to weed out inefficiencies and make the industry more competitive and cost-effective under the new economic setup (Muraleedhran, 1996).

The liberalization policy of the Government of India has led to structural adjustments in many of the industries, which renders a part of the existing labour force either surplus or unsuitable for the newly introduced technologies. Thousands of workers have so far voluntarily left their jobs by accepting lump sum amount or monthly pension or both. This study inquires the status of the respondents during the post VR life.

For the present study two organizations viz., The Singareni Collieries Company Limited (SCCL) and Hyderabad Industries Limited (HIL) have been selected. The SCCL is one of the oldest public sector enterprises in Coal Industry in India, carrying on the coal
mining activities in the Godavari valley in South India. SCCL became Andhra Pradesh State owned public sector unit in the year 1961. The Government of Andhra Pradesh and Government of India, finance the share capital of the SCCL in the ratio of 51:49 respectively. From its original workforce of 1,20,000 during the decade of seventies, it has reduced to 85,600 by March 2010.

Hyderabad Industries Limited is one of the Birla Group of Companies in the private sector. It was incorporated in 1946 under the name, Hyderabad Asbestos Cement Products Limited. The present management has taken over the company in 1956 under the Birla Group; the name was changed to Hyderabad Industries Limited in 1958 to reflect the diversified activities of the company. With the advent of new economic policy and its concomitant liberalization, the unit intends to improve its performance by reducing the cost of production and competitiveness in the market. Towards this end, it trimmed its workforce to 1900 by March 2010 from its original strength 6,024 in March 1998 through VRS.

**Objective of the Study**

The study aims to understand the empirical data on socio-economic status of VR employees. The main objective of the study is to understand the living pattern of VR employees and their socio-economic conditions during the post VR period.

**Methodology**

Case study method and survey method were used in present study. All the facets of the VRS, life style and status of VR opted employees during post VR life were sought to be covered in the study. Voluntarily retired employees (workmen, staff and executives) from the both selected units SCCL (211) and HIL (99), total 310 respondents were selected for the study. The sample was drawn following the principle of stratified random sampling method and prepared an interview schedule for collection of data from VR employees. Statistical techniques like averages, percentage and rank correlation method were followed for the data analysis.

**Analysis and Results**

**Planning for Post - Voluntary Retirement Activities**

The success of VRS lies in proper utilization of VRS compensation availed by the voluntarily retired employees. It determines the social and economic status of VR employees. The social and economic status of employees in post VR period is a crucial dimension. It deserves the attention of government, organization and society as their noninvolvement in productive activity influences the present unemployment situation in the country. The government has initiated certain measures for assisting VR employees. These measures can be fully utilised by VR employees only with a proper plan about post voluntary retirement activities.
Table 1 presents the percentage of respondents’ planning of activities for Post-Voluntary Retirement

**Table 1: Planning for Post-Voluntary Retirement Activities**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Alternatives</th>
<th>Respondents</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Workmen</td>
<td>Staff</td>
<td>Executives</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td>123 (66.13)</td>
<td>72 (81.82)</td>
<td>33 (91.67)</td>
<td>228 (73.55)</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>43 (23.12)</td>
<td>13 (14.78)</td>
<td>3 (8.33)</td>
<td>59 (19.03)</td>
</tr>
<tr>
<td>3</td>
<td>No Opinion</td>
<td>20 (10.75)</td>
<td>3 (3.40)</td>
<td>---</td>
<td>23 (7.42)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>186 (100)</td>
<td>88 (100)</td>
<td>36 (100)</td>
<td>310 (100)</td>
</tr>
</tbody>
</table>

*Note: Figures in parentheses indicate percentages of vertical totals.*

Out of the total respondents 73.55 per cent had planned about post VR activities. While 19.03 per cent had not planned anything for the post VR activities and 7.42 per cent of the respondents did not state their opinion about the issue rose.

The need for planning post-voluntary retirement activities had been identified by many respondents. Among 270 respondents who had planned for post VR activities only 42.58 per cent proposed to get into new employment, while 39.36 per cent were interested and planned for self-employment and about 18 per cent of the respondents were interested in other activities i.e. social, political, spiritual etc.

**Income after Voluntary Retirement**

Monthly income determines the economic condition of an individual or family. The constituents of monthly income in the post VR period include the income received in the form of pension, income from re-employment/ business and the income of other family members if any.

The monthly income of 13.22 per cent of respondents was in the range of Rs.3001 to 4000. It is followed by 12.58 per cent of respondents’ monthly income in the range of Rs.6001 to 7000, whereas 7.43 per cent of total respondents’ monthly salary was in the range of Rs.9000 to 10,000. Category wise income profile of the respondents shown that 30.55 per cent of executives earn monthly in the range of Rs.9001 to 10000. Twenty five per cent of Staff respondents’ income range was in between Rs.6001 and 7000. On the other hand the monthly income of 31.18 per cent of workmen category was between Rs.2001 and Rs.3000. The cause of low-income levels of staff and workmen was attributed to utilization of VR compensation for clearing loans or fulfilling family responsibility in contrast to Executives who had invested VR compensation in securities.
Post-VR Employment Status

Assessment of Post VR employment status of respondents was essential to find out the impact of VRS. Hence, the need to collect data on the parameters which determined Post VR employment status of respondents. Age, family size, formal education, health and awareness of the schemes, employment market and plan for VR activities were the parameters influencing status of respondents after retirement in regard to employment. National Renewal Fund (NRF) was also helpful to VR employees by providing counseling and retraining activities.

Table 2 presents the percentage of employment status of the respondents after VR.

**Table 2: Post VR Employment Status of the Respondents**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Status/ Position after VR</th>
<th>Respondents</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Workmen</td>
<td>Staff</td>
</tr>
<tr>
<td>1</td>
<td>Wage-employment</td>
<td>51 (27.42)</td>
<td>34 (38.64)</td>
</tr>
<tr>
<td>2</td>
<td>Self-employment</td>
<td>59 (31.72)</td>
<td>27 (30.68)</td>
</tr>
<tr>
<td>3</td>
<td>Un-employment</td>
<td>76 (40.86)</td>
<td>27 (30.68)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>186 (100)</td>
<td>88 (100)</td>
</tr>
</tbody>
</table>

*Note: Figures in parentheses indicate percentages of vertical totals.*

Table 2 reveals that 34.52 per cent respondents were jobless after the VR, and 33.87 per cent were involved with their self-employment activities, while 31.61 per cent of the respondents were settled in various jobs or in the wage-employment actively.

According to the category wise employment status of respondents, 36.12 per cent of executives, 38.64 per cent of staff and 27.42 per cent of workmen respondents got re-employment. When the investigators engaged in discussion with 107 respondents who were not settled in employment, some of them stated that they intentionally did not engage themselves in any economic activity, as they desired to lead a peaceful life, while others in spite of making best efforts had not got a job due to lack of new skills required.

**Reasons for Un-employment**

Employment of VR employees in any economic activity was vital for the success of the VR Scheme. Table 3 presents percentages of multiple reasons for unemployment after VR of the respondents.
Table 3: Percentages of Reasons for Unemployment

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Reasons for Un-employment</th>
<th>Respondents</th>
<th>Number (n=107)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Workmen</td>
<td>Staff</td>
</tr>
<tr>
<td>1</td>
<td>Non availability of jobs</td>
<td>61</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>Advanced Age</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>Low paid jobs</td>
<td>47</td>
<td>18</td>
</tr>
<tr>
<td>4</td>
<td>Poor working conditions</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>Distance to be traveled</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>Lack of required skills</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Insecurity in job</td>
<td>57</td>
<td>17</td>
</tr>
<tr>
<td>8</td>
<td>Insufficient qualifications</td>
<td>58</td>
<td>10</td>
</tr>
<tr>
<td>9</td>
<td>Illness</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>10</td>
<td>Not interested to work</td>
<td>36</td>
<td>15</td>
</tr>
<tr>
<td>11</td>
<td>To enjoy free life</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>Other reasons</td>
<td>32</td>
<td>11</td>
</tr>
</tbody>
</table>

Note: Figures in parentheses indicate percentages of vertical totals.

The results of rank correlation of coefficients are presented in the table- 3a.

Table 3a shows the coefficients of rank correlation to the reasons for unemployment after Voluntary Retirement by the respondents:

Table 3a: Coefficients of Rank Correlation

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Workmen</th>
<th>Staff</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workmen</td>
<td>----</td>
<td>0.48 @ (1.77)</td>
<td>N.C</td>
</tr>
<tr>
<td>Staff</td>
<td>0.48 @ (1.77)</td>
<td>----</td>
<td>N.C</td>
</tr>
<tr>
<td>Executives</td>
<td>N.C</td>
<td>N.C</td>
<td>----</td>
</tr>
</tbody>
</table>

Values in the parentheses are ‘t’ values
*Significant at 10 per cent, **Significant at 5 per cent, ***Significant at 1 per cent (highly significant)
@ Not significant, N.C: Not Computed

Ranks were given to the reasons by the respondents according to their predominance. Out of the 107 respondents 80.37 per cent were unemployed due to non-availability of jobs.
It was followed by 69.15 per cent of the respondents, who felt that insecurity in jobs was an important reason for unemployment. Table 3 shows that 64.48 per cent of respondents could not get re-employment as they were offered very low pay compared with what they were drawing earlier and an equal percent of respondents remained unemployment because of insufficient qualifications, while 48.60 per cent of the respondents mentioned that they were not interested to work. Poor working conditions was the reason given by 38.31 per cent of the respondents for being unemployed. The reasons i.e. advanced age, distance to be travel, lack of requisite skills, desire to enjoy free life and some other miscellaneous reasons were responsible for the unemployment of VR employees.

According to the results presented in the table- 3, there was a weak correlation (0.48) between workmen and staff, ranks awarded for reasons for unemployment after voluntary retirement. However, it was found to be statistically insignificant. There was no correlation between executives and staff and between executives and workmen.

Regarding the reasons for unemployment after voluntary retirement the respondents had given different opinions for unemployment. We can identify that there was no relation between these three categories and ranks awarded by workmen, staff and executives regarding unemployment aspect.

Respondents’ Life after Voluntary Retirement

The impact of VR obtains was not only felt on their monthly income but also on lifestyle and meaningfulness of life. Out of 310 respondents, 53.55 per cent have felt that life after VR has become meaningful to them, which could be attributed to availability of leisure to practice hobby or build relationship with friends and family members. Out of the remaining respondents, 27.74 per cent had felt that life was not satisfactory after VRS due to unemployment, depression and anxiety of future life. Only a fraction (18.71%) stated that they had not experienced any change in lifestyle after VR.

Family Relationship after VR

It is clear from the above mentioned data, that majority of the respondents had found a change in the family life after VR as they were not enjoying the same position in the family as they had enjoyed earlier.

Table 4 presents the percentage of changes in the Family Relationship after VR.
Table 4: Percentage of Changes in the Family Relationship after Voluntary Retirement

<table>
<thead>
<tr>
<th>Reaction of the family members</th>
<th>Command over family affairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Changed</td>
</tr>
<tr>
<td>Workmen</td>
<td>59 (31.72)</td>
</tr>
<tr>
<td>Staff</td>
<td>22 (25.00)</td>
</tr>
<tr>
<td>Executives</td>
<td>6 (16.66)</td>
</tr>
<tr>
<td>Total</td>
<td>87 (28.06)</td>
</tr>
</tbody>
</table>

Note: Figures in parentheses indicate percentages of horizontal totals.

Table 4 reveals 47.42 per cent had not experienced any change in family relationship. According to category wise analysis 63.89 per cent of executives did not experienced any change in family relationship, as they had already accumulated properties and planned for post retirement period. 57.95 per cent of Staff and 39.25 per cent of Workmen had noticed a perceptible change owing to fall in income. In case of staff, 47.73 per cent had found a change in command over family.

Living Pattern of Voluntary Retired Employees

After opting for VRS, people were busy in manifold activities for whiling away their time, earning their livelihood and releasing their boredom by sitting at home. All employees opting for VRS were not interested in re-employment; some of them were interested in business and non-economic activities, social work, political or spiritual activities etc. The respondents had mentioned more than one option for living pattern after voluntary retirement.

Percentage of living pattern of Voluntary Retirement employees are present in table 5.
### Table 5: Percentage of Living pattern of Voluntary Retired Employees

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Living pattern</th>
<th>No. of Respondents</th>
<th>Number (n=310)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Workmen</td>
<td>Staff</td>
</tr>
<tr>
<td>1</td>
<td>Reading and writing</td>
<td>55</td>
<td>44</td>
</tr>
<tr>
<td>2</td>
<td>Domestic work</td>
<td>67</td>
<td>36</td>
</tr>
<tr>
<td>3</td>
<td>Busy with Job</td>
<td>51</td>
<td>34</td>
</tr>
<tr>
<td>4</td>
<td>Self employment</td>
<td>59</td>
<td>27</td>
</tr>
<tr>
<td>5</td>
<td>Involved in Social work</td>
<td>45</td>
<td>16</td>
</tr>
<tr>
<td>6</td>
<td>Busy in Religious Activities</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Involved in Politics</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Spiritual and Meditation</td>
<td>37</td>
<td>27</td>
</tr>
<tr>
<td>9</td>
<td>Other activities</td>
<td>56</td>
<td>23</td>
</tr>
</tbody>
</table>

*Note: Figures in parentheses indicate percentages to vertical totals.*

Table 5 explains the involvement of VR opt ants in various activities. Out of 310 respondents interviewed, 31.29 per cent of them were in new jobs, remaining respondents were interested in multiple options.

Table 5a shows the coefficients of rank correlation to the Living pattern of Voluntary Retired Employees

### Table 5a: Coefficients of Rank Correlation

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Workmen</th>
<th>Staff</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workmen</td>
<td>----</td>
<td>0.675 ** (2.42)</td>
<td>0.658 * (2.32)</td>
</tr>
<tr>
<td>Staff</td>
<td>0.675 ** (2.42)</td>
<td>----</td>
<td>0.677 ** (2.44)</td>
</tr>
<tr>
<td>Executives</td>
<td>0.658 * (2.32)</td>
<td>0.677 ** (2.44)</td>
<td>----</td>
</tr>
</tbody>
</table>

*Values in the parentheses are ‘t’ values*

*Significant at 10 per cent, **Significant at 5 per cent,***Significant at 1 per cent (highly significant) @ Not significant
It is clear from the table-5 that the majority (38.71%) of the respondents were involved in domestic work to help their family members. It was followed by 38.38 percent who spent their time in reading and writing. 33.87 per cent of the respondents were engaged in self-employment, 25.80 per cent were interested in social work and establishing voluntary service, societies to look after the needs of abandoned children, establishment of old age homes by becoming volunteer and rendering services in trusts catering to the needs of downtrodden sections of society. 23.54 per cent of respondents were engaged in offering prayers to God, bhajanas, religious decisions, service to poor and disabled section of society religious activities such as voluntary services on important festive events. Small fractions (5.80%) of respondents were involved in politics.

Table- 5a shows the coefficients of rank correlation to living pattern of respondents after Voluntary Retirement, the results revealed that there was a moderate positive significant correlation between Workmen and Staff (0.675) and between Staff and Executives (0.677). Ranks were awarded for responses given by the respondents for their living pattern after voluntary retirement. However, there was moderate positive association between Workmen and Executives (0.658).

Discussion

A large number of researches on VRS have been done in India which indicate that VRS is sometimes compulsory for the survival of the organization and looked upon as human technique which eases out the surplus manpower without much hardship to labour under the circumstances.

The main findings of the study were that social and economic status of respondents in post VR period is determined by proper plan for post VR activities.

The present study gives a clear idea about respondents’ plan for post VR activities. Most of the respondents have expressed about the need to plan for post VR activities. Majority of them were interested in self-employment and others were interested in social, political and spiritual activities (Arora, 1998; Aswathappa, 2001; Dwivedi, 2002; Guha, 1996; ; Mehrotra, 2001; Rath and Patro, 2005; Sinha, 1995; Verma, 2000).

The study reveals that employment status of the respondents had been enquired and majority of them were engaged in self-employment, remaining were successful in getting re-employment and very few have not taken up any economic activity (Das and Shukla, 1998; Datta, 2001; Muraleedharan, 1996; Rajendra, 2001; Ranjan and Dhunna, 2000).

The feelings of respondents regarding life after VR were studied and found that most of the respondents felt that life after VR has become meaningful to them, whereas some of them felt that life has lost its charm due to unemployment and consequent feeling of despair depression about future prospects (Datta, 2001; Jagannathan, 2002; Sharma,1994).

Majority of the respondents expressed that they did not experience any change in family relationship as they must have already accumulated properties and planned for post retirement period. Most of the respondents felt that the decision to opt for VRS is a right decision considering the problems and pressures prevailing at the time of VR and in line
with structural changes which are taking place in the Indian industries i.e., downsizing of work force, amendments in Industrial Disputes Act, 1947 and hire and fire policy etc. and attractive VR Compensation is also one of the main reasons (Aswathappa, 1997; Dey and Ray 2003; Dwivedi, 2002; Mehrotra, 2001; Muraleedharan, 1996; Stiftung, 1994).

Suggestions

Suggestions are offered to help the employees, employers, government, and policy makers implementing VRS effectively:

α) If downsizing of manpower is inevitable, VRS must be properly planned and managed. It is unfair if the workers who have given large part of their life to the company and if they are thrown to the streets and are made to face the agony and travails of unemployment.

β) The organizations must make necessary preparations before implementation of the scheme.

χ) Before the actual implementation of VRS, the workers must be imparted necessary training to acquire new skills relevant for their redeployment.

δ) Counseling is the crucial aspect which needs the attention of the management, the Government nominated agencies such as Confederation of Indian Industries (CII), National Small Industries Corporation Limited (NSICL), and National Productivity Council (NPC) NGOs etc. They should all collaborate and render effective counseling to employees opting for VRS. Some of the aspects on which they need counseling include the avenues for redeployment/re-employment and self-employment.

ε) VR compensation and benefits, instead of being paid at one time compensation can be paid in the form of monthly pension to ensure the worker and his family, regular source of income to meet their daily needs.

ϕ) NGOs may be involved in counseling the VR optees to provide them the necessary emotional support and guidance in planning for the utilization of their leisure time.

γ) The objective must be to help the VR employees to feel that they continue to enjoy the love, affection and esteem of family members, friends and relatives and also to bring them cheer, enjoyment and peace in the fag end of their life.

References


Knowledge, Attitude and Perception about Reproductive Health in Jharkhand

P. C. Deogaria*

Keywords:
Reproductive health, Knowledge, Attitude, Perception

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Health is a fundamental right of people and improved health status of people not only leads to individual and social happiness but also significantly contributes to the economic development of a country. Reproductive health is a component of the physical and emotional health of well being of the individuals, families and that of the social and economic development of communities and nations. The concept of reproductive health awareness may be defined as a scientifically correct knowledge and information about reproductive health. It includes information and knowledge of factors that promote or harm the reproductive health. The present study reveals the youth’s knowledge, attitude and perception about selected reproductive health indicators using both qualitative and quantitative tools. It also attempts to analyze the knowledge, attitude and perception about reproductive health in Jharkhand.

Reproductive health is at the core of the people’s lives and wellbeing. Emerging mainly from the International Conference on Population and Development (ICPD) held at Cairo in 1994, it encompasses a wide range of health concerns. It has been defined as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes’ (United Nations, 1996). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide it, when and how often to do so. A strong focus on reproductive health is justified on the ground of human rights, equality and social justice. There are strong public health arguments too, since reproductive ill-health contributes significantly to the global burden of disease and we have at our disposal cost-effective ways of preventing, or at least managing, much of this ill-health. Reproductive health is in general related to youth and now and then, it has been emphasized that the future of any society lies with the youth and that they have the ability to transform the society and its socio-economic and political structure. United Nations (UN) as well as World Health Organization (WHO) defines youth as the population in the age group of 15-24 years.

In India, reproductive health problems are related to 18% youth population. Their reproductive health profile reveals a bleak for India as well as Jharkhand. It has been observed that in spite of continued efforts by the government to persuade people to get married after reaching the legal age, more than two-fifth of the women aged 20-24 years have been found married by 18 years of age and 6% aged 15-19 years have already experienced pregnancy or motherhood. Regarding use of reproductive health services, more than 24%
of the currently married women aged 15-24 years have not received any ante-natal care during pregnancy and more than 47% have experienced an unsafe delivery. Contraceptive use among the currently married women aged 15-44 has been 54%. In addition, a quarter of the women have an unmet need for contraception as well (DLHS-RCH-3, 2007-2008).

Social scientists have studied the different aspects of reproductive health. However, a study related to knowledge, attitude and perception of reproductive health has some similarities. A number of earlier Indian studies assessing young people’s knowledge basically in the areas of puberty, menstruation and reproduction view that the knowledge level is not adequate (Ahuja and Tiwari, 1995; Awasti et. al., 1980; Bhende, 1994; Gupta et. al., 1979; IIPS and PC, 2007; Murthy, 1993; Patnaik, 2003; Ram et. al., 2006; Rasheed et. al., 1978; Sharma and Sharma, 1995; Todankar, 2001; Verma et. al., 1995). The contraceptive awareness among the youth was found poor (IIPS and PC, 2007; IIPS, 2006; Rajagopal and Philip, 1995 and Rakesh, 1992). Similarly, another study among the newly married men and women in Gujarat revealed that half of the women were ignorant about the sexual life after marriage (Khan et. al., 2004).

Regarding attitude of the young people towards sex and related issues, Rakesh (1992) revealed that more than 80 percent of the college girls in Delhi had negative attitude towards sex before marriage and a majority of them were in favour of the control of sexual desire. Some other studies have also confirmed the negative attitude towards sex (Bhende, 1994; Goparaju, 1993 and Patnaik, 2003). Moreover, societies that dictated different attitudes towards males and females in respect of sexuality and where talking about sex with young people continued to be a stigma, had further contributed to the permissive behavior (Hardee et. al., 2004 and Miller and Whitaker, 2000).

Present paper analyses the knowledge, attitude and perception of the youth about reproductive health issues in Jharkhand.

**Methodology**

The study was based on primary data collected on youth sample selected by stratified random sampling method from Ranchi, Palamu, Hazaribagh, West Singhbhum, and Dumka districts of Jharkhand. Out of 5 selected districts, 1-2 blocks were randomly selected for the study. At the second stage, 20 villages of more than 300 households were selected randomly (10 each for male and female). Out of 500 sample, 250 married female aged 15-24 years and 250 married male aged 20-29 years were selected. Data was collected by using both qualitative and quantitative tools.

At first, the study portrays the comprehensive knowledge about reproductive health, comprehensive knowledge about abortion and knowledge about various contraceptive methods. This was followed by the discussion on comprehensive knowledge about RTI/STI and HIV/AIDS.

**Analysis & Findings**

**Knowledge about Reproductive Health**

Present section of the study attempts to understand the knowledge about selected reproductive health matters of the youth sample, the results are given below:
Knowledge about Pregnancy and Abortion

Table 1 reveals the youth’s comprehensive knowledge about pregnancy and abortion by selected background characteristics. Analysis shows that about half of the youth in the study (485 of young men and 50% of young women) had a comprehensive knowledge about pregnancy. Analyzing the knowledge level separately for young men and women, it is apparent that a little higher than a-quarter of the young men aged 20-24 years had comprehensive knowledge (26%), while the same figure was a little higher than one-third (35%) and nearly three-fifths (56%), respectively, among those aged 25-27 years and 28-29 years. More than half of the young men engaged in business/service sector had knowledge (55%), compared to nearly two-fifth of those engaged in cultivation/labour (42%). Education and exposure to mass media had been thought of as increasing the knowledge level, and the data in the same table seems to confirm this. As may be seen, 77% of those young men with an average/good inter-spousal communication on reproductive issues (39%). Besides this, 60% of the young men from general caste had comprehensive knowledge (26%), while the same figure was a little higher than one-third of those from scheduled caste. Household wealth index reveals a higher percentage of knowledge among those young men from households with a high wealth index than their counterparts from households with a medium or low wealth index. Exploring comprehensive knowledge about pregnancy among the young women, table 1 depicts an almost similar picture to that of the young men.

1 Includes (1) correct knowledge of two ways of pregnancy occurrence out of three possible ways viz. a woman can get pregnant on the very first time she has sexual intercourse; a woman is most likely get pregnant if she has sexual intercourse half way between her periods, and a woman who is exclusively breastfeeding her baby can become pregnant; and (2) knowledge that abortion can occur after kissing or hugging.

2 Includes (1) knowledge that abortion is legal; (2) aware of availability of abortion services in government and private hospitals; and (3) knowledge that abortion can be done safely within three months of conception.

3 Includes (1) identification of two major ways of RTI/STI transmission out of three major ways (i.e. sex with multiple partners, unsafe sex with infected person, and unhygienic living style); (2) rejection of two most common local misconceptions about RTI/STI out of three misconceptions (i.e. RTI/STI is a disease mainly in women, people suffering from RTI/STI should not disclose it to others, and persons suffering from RTI/STI should be avoided); and (3) awareness that RTI/STI is a curable disease.

4 Includes (1) identification of two major ways of preventing HIV/AIDS (condom use, and sex with only one uninfected partner); and (2) rejection of four most common local misconceptions about HIV/AIDS transmission such as (a) people can get HIV/AIDS from mosquito bites, (b) people can get HIV/AIDS by sharing food/utensils with a person who has AIDS, (c) people can get HIV/AIDS by sharing clothes with a person who has AIDS, and (d) people can get HIV/AIDS by hugging someone who has AIDS.
Table 1: Comprehensive Knowledge about Pregnancy and Abortion by Selected Background Characteristics

<table>
<thead>
<tr>
<th>Background Characteristics</th>
<th>Comprehensive knowledge about pregnancy and abortion</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td></td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Age</td>
<td>Percent</td>
</tr>
<tr>
<td>15-19 years¹/20-24 years²</td>
<td>26.3</td>
</tr>
<tr>
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<td>21.1</td>
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<td>19</td>
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<td>17.4</td>
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<tr>
<td></td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>23</td>
</tr>
<tr>
<td>20-22 years¹/25-27 years²</td>
<td>35.2</td>
</tr>
<tr>
<td></td>
<td>14.1</td>
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<td>51.3</td>
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</tr>
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<td></td>
<td>80</td>
</tr>
<tr>
<td>23-24 years¹/28-29 years²</td>
<td>55.6</td>
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<td>6-9 years</td>
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<td>Cultivation/labour</td>
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<tr>
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<td>19</td>
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<td>55.6</td>
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</tr>
</tbody>
</table>

¹ Age of women. ² Age of men. ³ Includes non-literate.

* Those who do not come under SC, ST or OBC category
Table 1 further reveals that less than a quarter of the youth sample had comprehensive knowledge about abortion (24% young men and 22% young women). Twenty-one percent of the young men aged 20-24 years and 14% of those aged 25-27 years had comprehensive knowledge about abortion, while it was 28% among aged 28-29 years. Not surprisingly, knowledge level was remarkably high among those young men with 10 or more years of schooling (54%) compared to less than six years of schooling (2%). Again, a higher percentage of the young men engaged in business/service sector (39%) knew about it than engaged in cultivation/labour (14%). The possible explanation may be that these young men were more educated and exposed to mass media besides their working environment, which contributed positively to their knowledge level.

Data further reveal that knowledge level was relatively better among those young men, who had partial exposure to mass media (27%) than those with a full exposure (21%). Further, higher percentage of the young men with an average/good inter-spousal communication on reproductive issues, those belonging to general caste and those from households with a high wealth index had comprehensive knowledge compared to the young men, respectively, with a poor inter-spousal communication on reproductive issues, belonging to scheduled caste and households with a low wealth index.

On the other hand, analysis reveals that comprehensive knowledge about abortion was 9%, 28% and 21%, respectively among the young women aged 15-19 years, 20-22 years and 23-24 years.

The comprehensive knowledge was further found to be better among young women with 10 or more years of schooling, with full exposure to mass media, with an average/good inter-spousal communication on reproductive issues and from households with a high wealth index than their respective counterparts.

Again, 61% of those engaged in business/service sector were better informed, while the same figure was 21% among the housewives. However, none of the young women engaged in cultivation/labour had comprehensive knowledge about abortion.

**Knowledge about Contraception**

The data in table 2 shows the percentage of youth according to their knowledge of any contraceptive method by specific methods. The data reveals that irrespective of sex; majority of sample had knowledge of any method of contraception (98% each). The figure is the same so far as knowledge of any modern method of contraception was concerned. More than 90% of both young men and women knew about oral contraceptive pills. There was again not much difference between both, so far as the knowledge of emergency contraceptive pill was concerned, which was 18 percent and 17 percent respectively, among the young men and women. However, looking at the knowledge about condom, young men seemed to be ahead of the young women, as 94 percent of the young men knew about condom as against 81 percent of the young women. Again, 57% of the young men and 56% of the young women know IUD as a method of contraception.
Regarding the permanent methods, female sterilization seems to be more popular among youth, as more than 80% of youth from both sample knew about female sterilization. On the other hand, 63% of the young men and 49% of the young women knew about male sterilization. In addition to this, 28% of the young men and 21% of the young women knew about any of the traditional methods of contraception.

Table 2: Percentage of Youth according to their Knowledge of any Contraceptive Method by Specific Methods

<table>
<thead>
<tr>
<th>Methods</th>
<th>Knowledge of contraceptive methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>Any method</td>
<td>98.4</td>
</tr>
<tr>
<td>Any modern method</td>
<td>98.4</td>
</tr>
<tr>
<td>Oral pill</td>
<td>90.4</td>
</tr>
<tr>
<td>Emergency contraceptive pill</td>
<td>17.6</td>
</tr>
<tr>
<td>Condom</td>
<td>94.0</td>
</tr>
<tr>
<td>IUD</td>
<td>57.2</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>80.8</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>63.2</td>
</tr>
<tr>
<td>Any traditional method</td>
<td>27.6</td>
</tr>
<tr>
<td>Rhythm/safe period</td>
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</tr>
<tr>
<td>Withdrawal</td>
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</tr>
<tr>
<td>Other method¹</td>
<td>3.6</td>
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<tr>
<td><strong>Number of youth</strong></td>
<td><strong>250</strong></td>
</tr>
</tbody>
</table>

¹ Includes both modern and traditional methods that are not listed separately

Data in table 3 provides youth’s knowledge of all modern spacing contraceptive methods¹ by selected background characteristics. Data reveals that more than half of the young people interviewed (55% young men and 52% young women) had knowledge about all the modern spacing methods of contraception.

⁵ All modern spacing methods of contraception includes oral pill, IUD and condom
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<thead>
<tr>
<th>Background characteristics</th>
<th>Knowledge about all modern spacing contraceptive methods</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 years$^1$/20-24 years$^2$</td>
<td>36.8</td>
<td>19</td>
</tr>
<tr>
<td>20-22 years$^1$/25-27 years$^2$</td>
<td>42.3</td>
<td>71</td>
</tr>
<tr>
<td>23-24 years$^1$/28-29 years$^2$</td>
<td>63.1</td>
<td>160</td>
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<tr>
<td><strong>Education</strong></td>
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<td></td>
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<tr>
<td>0-5 years$^@$</td>
<td>13.3</td>
<td>60</td>
</tr>
<tr>
<td>6-9 years</td>
<td>52.1</td>
<td>121</td>
</tr>
<tr>
<td>10 or more years</td>
<td>97.1</td>
<td>69</td>
</tr>
<tr>
<td><strong>Present occupation</strong></td>
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<td></td>
</tr>
<tr>
<td>Household work only</td>
<td>90.0</td>
<td>10</td>
</tr>
<tr>
<td>Cultivation/labour</td>
<td>41.1</td>
<td>151</td>
</tr>
<tr>
<td>Business/service sector</td>
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<td>89</td>
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<tr>
<td><strong>Mass media exposure</strong></td>
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<tr>
<td>No exposure</td>
<td>16.7</td>
<td>18</td>
</tr>
<tr>
<td>Partial exposure</td>
<td>54.5</td>
<td>189</td>
</tr>
<tr>
<td>Full exposure</td>
<td>74.4</td>
<td>43</td>
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<tr>
<td><strong>Inter-spousal communication on reproductive issues</strong></td>
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</tr>
<tr>
<td>Poor</td>
<td>41.8</td>
<td>79</td>
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<tr>
<td>Average/good</td>
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<tr>
<td><strong>Caste</strong></td>
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<td>Scheduled caste</td>
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<td>General caste$^#$</td>
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<tr>
<td><strong>Household wealth index</strong></td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>55.2</strong></td>
<td><strong>250</strong></td>
</tr>
</tbody>
</table>

$^1$ Age of women. $^2$ Age of men. $^@$ Includes non-literates. $^#$ Those who do not come under SC, ST or OBC category
Analyzing knowledge level among the young men, 63% of those aged 28-29 years knew about all the modern spacing methods. The corresponding figure was 42% and 37%, respectively, among those aged 25-27 years and 20-24 years. Again, 97% of the young men with 10 or more years of schooling knew about all the modern spacing methods, while the same figure was 13 percent among those with less than six years of schooling. Further, nine out of every ten young men engaged exclusively in household works knew about these methods (based on 10 observations), which was three out of every four among those employed in business/service sector and about two out of every five among those engaged in cultivation/labour.

Sources of Knowledge about Reproductive Health

Data in figure 1 reveals the percentage of youth according to their sources of knowledge about sexual and reproductive health matters, before marriage.

Same sex friends/neighbors followed by various electronic media (radio/television/Internet) and print media (newspaper/books/magazines/posters) were the main sources of knowledge for the young male, respectively, 75%, 47% and 31%. Twenty four percent had learnt about it from female friends/neighbors.

Further, 2% had learnt it from the family members or any formal source like teacher/school/health care provider. Besides it, about 16% of the young male had reported other sources of knowledge (mostly blue/pornographic films) while a similar number of them had never received any such knowledge, before marriage.

Analyzing the sources of knowledge among the young female, the same figure elucidates that like young male, it was the same sex friends (59%), electronic media (48%) and print media (37%) that top the list as sources of knowledge about sexual matters, before marriage. Again, 28% of the young female responded that parents/other family members were as one of their sources. Six percent of them had revealed a formal source like teacher/school/health care providers while another 18% had not received any such knowledge, before marriage.

Figure 1: Percentage of Youth According to their Source of Knowledge about Reproductive Health Matters Before Marriage
Attitude towards Reproductive Health

Attitude towards reproductive health needs are called reproductive health attitudes. Reproductive health attitude should not be equated with reproductive health behavior. Favorable reproductive health attitudes facilitates self care activities and responsible reproductive behavior maintain reproductive health avoid related diseases (Hassan, 2008).

Attitude towards Pre-marital and Extramarital Sex

Sexual relationships before marriage and/or outside the wedlock are not alien to almost any society in the world. However, what matters is the perception of the society and the youth themselves about it. Qualitative data reveals that the societies as well as the boys themselves somehow approve their pre-marital relationships in order to prove their masculinity and ability to satisfy their prospective spouses. Young women, on the other hand, are invariably expected to be virgin until marriage, as their chastity is associated with family prestige in the community.

The information in figure 2 shows that almost three-fourth of the young men (74%) had an ideal\(^6\) attitude towards pre-marital sex. Similarly, a majority of the young women (82%) also had an ideal attitude towards pre-marital sex. At the outset, it was only 18% of the young women compared to 26% of the young men, who approved of pre-marital sex to some extent.

Exploring, youths’ attitude towards extra-marital sex in the study area, it seems to be comparatively less prevalent and less admired, as monogamy still is the most preferred form of marriage. However, the perceived gender role, especially of the young men sometimes leads them to explore their masculinity by involving themselves in sexual relations outside the marital union. The reasons cited for the involvement in such activities are - love for the partner, peer pressure, ability to prove sexual power besides being a man in true sense.

People should not indulge in sex before marriage
People should not indulge in extramarital relation

---

\(^6\) People should not indulge in sex before marriage
\(^7\) People should not indulge in extramarital relation
Figure 3 reveals that irrespective of sex, more than 90 % of the youth have an 'ideal' attitude towards extramarital sex.

Conclusions

The study reveals that the youth sample were unaware about the reproductive health issues. Nearly half of the young male and female sample had not comprehensive knowledge about pregnancy.

The variables like education, exposure to mass media, and inter-spousal communication on reproductive issues had emerged as important determinants of comprehensive knowledge of pregnancy for the young female sample. Similarly, it was the education and household wealth index that significantly affected young male’s knowledge about pregnancy.

Analysis further reveals that irrespective of sex, more than three-fifth of the youth had no comprehensive knowledge about abortion. Again, regardless of sex, the attributes such as education, inter-spousal communication on reproductive issues and caste of the youth seemed to affect comprehensive knowledge of abortion.

It was observed that nearly half of both young male and female had no knowledge about all modern spacing methods of contraception. Exploring the determinants of knowledge of all modern spacing methods, variables like education, inter-spousal communication on reproductive issues, caste and household wealth index had been found significant effect on the young males. However, in case of young females, factors such as age, education, exposure to mass media, inter-spousal communication and caste seem to affect knowledge of all modern spacing methods of reproductive health.

The study reveals that a low percentage of youth had comprehensive knowledge about RTI/STI, which was really a matter of concerned.

Regression analysis shows that irrespective of sex, higher educated youth were more likely to have knowledge as compared to lower educated sample of youth.

Again, the probability of knowledge about RTI/STI was significantly high among the young female with high decision-making power as compared to low/medium decision-making power.
Analysis of comprehensive knowledge about HIV/AIDS showed that merely 40% of the young male and 30% of the young female had the knowledge. Educational status was found the significant factor affecting knowledge about HIV/AIDS.

It can be concluded that the knowledge of various reproductive health indicators was inadequate in the study area; along with gender based differences in knowledge level. Additionally, various electronic (radio/television/Internet) and print media (newspaper/books/magazines/posters) followed by same sex friends/neighbors had been observed as the main sources of knowledge about sexual and reproductive health for the youth sample, before marriage.

The analysis of youth’s perception about commonly prevailing sexual and reproductive health problems reveals that male and female both had reproductive problems. Additionally, more than two-fifths of the young female had preferred to delay their first pregnancy, if the decision about pregnancy was left to the couple alone.

The study brings out that in addition to the biological factors education, religion, age, wealth index and some other socio-cultural factors played vital role in reproductive health. Education had a powerful impact on awareness, attitude and practice of reproductive health. Religion also influenced the reproductive health significantly. However, age had mild effect on reproductive health awareness.

The study further reveals that since young boys and girls were treated differently and were provided different learning environments, they tend to develop differential needs, desires, skills, temperaments, roles etc. They eventually grow into different types of people—male and female, often adhering to the culturally appropriate ways of thinking. They hardly questioned why they had different or ended up the way they were. Further, there prevails ambiguity as far as the sexuality of both sexes was concerned. Nevertheless, youth in general were expected to adhere to the roles ascribed to them based on their biological construct and any deviation from it was not encouraged, more so for young female.

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Domestic Violence against Women: A Comparative Study of Two Indian States - Tamil Nadu and Uttar Pradesh

Shyam Kartik Mishra*

This study reveals that culture led women favouring perception of men and women in Uttar Pradesh strengthen the conversion factor to transform even small opportunities into a big functioning in the form of protecting women against domestic violence. Thus, to reduce domestic violence, along with modern socio-economic growth, there is also need to overthrow iniquitous but entrenched practices and societal arrangement that are often accepted as part and parcel of an assumed ‘natural order’. Educational, cultural and political movements and well designed related programmes may have roles to play in social reforms that may lead to attitudinal and perceptual transformation in favour of women. More over, an in-depth examination of the widespread acceptance of spousal violence among women of Tamil Nadu would help to understand the prevalent cultural and social norms that govern conjugal relationship in Tamil society.

Keywords: Domestic violence, Modern socio-economic growth, Societal norms and values,

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Violence against married women in India appears to have deep roots in social history and fiction writings that vividly describe the violent behaviour of their husbands. But systematic efforts to study the magnitude of the violence, its determinants and consequences can be traced only over the last two decades. Serious concerns came to be shown in social science writings only since the decade of 1990s. In fact, now domestic violence is recognized all over the world as a violence of basic human rights. Domestic violence is more devastating for victims than violence outside the home, as it might leave victims without a safe place to live, no one to trust, and severe anxieties towards safety of their children (Robeyns, 2006). No wonder, domestic violence attracted increasing attention of researchers in various social sciences. Since incidences of domestic violence often have strong economic underpinnings, economists legitimately are equally equipped to investigate this frightening problem at length.

Violence against women was defined by the United Nations Commission on the status of women as “any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women” (Economic and social Council, 1992). Thus, the depreciation may include wife-beating, rape, sexual abuse and dowry related murder or honour killing which are the most endemic and wide spread forms of violence prevalent in India. NFHS-3 defines domestic violence to include violence (against women) by spouses as well as by other members of the household.

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Most of the researchers in social sciences on domestic violence in India are related to impact of women’s employment and education on gender based violence. Community based research on the prevalence, pattern and determinants of domestic violence is scarce, but urgently needed if the pragmatic political action is to be spurred (Heise, Pitanguay and German 1994).

Survey based studies have indicated that one-third to three-fourth women in India face physical, sexual or emotional violence from their partners or other men known to them (Mahajan 1990; Jejeebhoy 1998; Karlekar 1998; Visaria 2000). Violence against women varies largely among the states in India. Emotional or physical or sexual violence ranges from as low as 6.9 percent in Himachal Pradesh to as high as 60.8 percent in Bihar (NFHS-3). Surprisingly, the state like Tamil Nadu has almost equal level of spousal violence to that of Uttar-Pradesh (nearly 45.0 percent), despite a huge differentials in the level of indicators of their socio-economic development.

It is evident that violence against women in India is a widely accepted form of behavior, viewed as ‘a women’s due and her husband’s right’. Three in four women consider wife beating a justifiable form of behavior (Jejeebhoy, 1998).

Some studies have examined determinants of domestic violence empirically points to women’s lack of autonomy as a major cause of violence. Levinson (1989) noted that economic inequality between men and women, a pattern of using force to resolve conflict, male authority and control of decision making in the home, and divorce restrictions for women are prominent determinants of prevailing domestic violence against women. Bloch and Rao (1995) have observed in their study in Indian context that higher the dowries lower the probability of wife being beaten. Jejeebhoy (1998) has tried many determinants of domestic violence against women in diverse settings of the states of Tamil Nadu and Uttar Pradesh. To her, in egalitarian setting of Tamil Nadu, primary education enables women to protect themselves from physical violence and intimidation whereas in highly patriarchal setting of Uttar Pradesh it takes attainment of a secondary education to provide this protection to women. Rao, 1997 and Krishnan, 2005 reported that alcohol consumption by husband is significantly associated with domestic violence irrespective of caste and economic status of the household. Visaria (2008) drawing on NFHS-3 data observes that empowerment has no clear relationship to prevalence of violence and says “this belies the expectation that women who participate in household decisions, and therefore have egalitarian gender-role attitudes, are less likely to experience of violence.”

The paper explores comparative roles of economic growth, societal norms, and values led living arrangement in determining the level of domestic violence in Tamil Nadu and Uttar Pradesh.
Methodology and Data Sources

Two sets of variables have been used to measure modern economic growth and cultural values led living arrangements. First set includes those variables which flourish with modern growth, e.g. per capita Net State Domestic Product (NSDP), per capita credit deposit ratio, percentage of households living in the highest and lowest quintiles of wealth, percentage of main workers to total population, quantitative and qualitative aspects of housing facility and habit of alcohol drinking. Modern growth led living arrangements and its impact on women’s status has been examined thereafter. On the contrary, second set includes those variables which are highly influenced by societal values/norms and deprivations of modern economic growth leading to different living arrangements. These variables in this study include pattern of distribution of agricultural land to the households, average monthly income from different sizes of land holding, arrangement of employment and wages (rate) to females, yield from the agricultural land etc.

Modern economic growth yields several benefits to the women in form of more opportunity of all sorts of employment like self, regular and casual employment to its female workforce. It also provides greater exposure to newspaper, T.V. and radio to women. Facilities of education, maternal care, health and nutrition-measured by female infant mortality rate and female life expectancy at birth, and consumption of milk and fruits may also be extended to more women by faster modern growth. More economic opportunities may keep men and women excessively busy compelling them to leave certain decisions-like purchases for daily or major household needs, visit to natal family or doctor for being taken by women, keeping female disfavoring societal values/norms led men’s and women’s perception intact. Whether societal values/norms favor or disfavor women may truly reflect in perceptions of men and women towards women’s right, to say the least.

Perceptions of men and women regarding hitting and beating of wife and right of wife to refuse sex with husband in certain cases have been studied by NFHS-3. It collected data on percentage of women and men who agree that a husband is justified in hitting or beating his wife in seven specific cases- she goes out without telling him, she neglects the house or children, she argues with him, she refuses to have sexual intercourse with him, she does not cook properly, he suspects she is unfaithful, she shows disrespect for in-laws. Justifiability in perception is greatly influenced by inherited societal values/norms that considers hitting or beating of wife in all these cases ‘a right of men and duty of women’. Likewise, right of wife to refuse sex with husband in certain cases may be justified on the ground of conjugal relation based on equality and basic human right. These cases may be - when wife knows that husband has sexually transmitted disease, husband has sex with other women and wife is tired or not in the mood. NFHS-3 has published data on perception of men and women pertaining to all these aspects which again is impacted by societal values.

NFHS-3 has brought out data on perception of men on two more important aspects which strengthen women’s esteem as an outcome of specific societal values. First, men’s attitude towards husband right when his wife refuses sex with him in form of - whether husband should get angry and reprimand her, he should refuse her financial support, use
force to have sex with his wife or have sex with another women. Secondly, NFHS-3 has collected data also on men’s perception about five important decisions which should be taken by wife alone or jointly with her husband. These decisions pertain to major household purchases, purchases for daily household needs, visits to her family or relatives, what to do with money wife earns and how many children to have. Societal norms/ values regarding gender role greatly influence these decisions as well.

In similar way, culturally regulated gender perception may also have its bearing on possession on money that women can decide to use on their own, gender differentials in wages and sharing of available food and nutrition between male and female members of the household. The data on these issues have been collected from NFHS-3, Report of National Commission for Enterprises in Unorganized Sector (NCEUS) and Report of National Sample Survey Organization (NSSO).

**Analysis and Findings**

The facts in this paper have been presented in percentage form to make them comparable without using any sophisticated analytical technique. This is owing to dearth of individual level data required for this purpose. However, the paper indicates towards need and nature of required data for making detailed study of culture bound domestic violence which possibly can not be mitigated just by modern economic growth.

**Status of Economic Development and Sources of Livelihood**

This section deals with level of economic development, standard of living, source of livelihood and living arrangements in Tamil Nadu and Uttar Pradesh. From modern indicators of economic development viewpoint, Tamil Nadu is far ahead vis-à-vis Uttar Pradesh. However, Uttar Pradesh is able to make better living arrangements to its people residing in rural area and at lower rung of the socio-economic ladder in comparison to Tamil Nadu. This bare fact is exhibited in table 1.

Indicators one to six in the table show that Tamil Nadu is economically much more developed with solid industrial base offering more and better employment opportunities to its people vis-à-vis Uttar Pradesh. Items seventh and eighth in the list indicate better housing facilities in TN. Items 10 to 16 in the table describes significance of agriculture in the economy of Uttar Pradesh. The table also shows that role, structure and nature of agriculture sector differ in Uttar Pradesh economy vis-à-vis that of Tamil Nadu. The table elucidates that larger percentage of rural households in TN are landless in comparison to UP. On the contrary, 82.1 percent rural household in Uttar Pradesh are either Marginal or Small farmers as against 73.9 percent of that in Tamil Nadu. Table also shows that agriculture provides wage employment to much larger proportion of rural inhabitants in UP vis-à-vis that in TN. So is the case with female rural work force.

The table interestingly explores that the yield per hectare of land and per capita production of food grains are higher in Uttar Pradesh despite higher level of mechanization and modernization of agriculture in Tamil Nadu. It may be an outcome of larger gross
irrigated area as percentage of gross cropped area in UP vis-à-vis that in TN. These all results into higher monthly income per farmer household from small sizes of land holding in Uttar Pradesh in comparison to that in Tamil Nadu.

Thus, the table presents two diverse spectrum of living arrangement and source of livelihood in Tamil Nadu and Uttar Pradesh. Average income, market dependent consumption level and living standard are much higher in Tamil Nadu than those in Uttar Pradesh. On the other hand, distribution of agricultural land is more egalitarian and small size of holdings yields relatively more income in Uttar Pradesh vis-à-vis that in Tamil Nadu. This may lead to better living arrangements to rural inhabitants in U. P. than that in Tamil Nadu.

**Socio-Economic Status of Women**

Higher level of indicators of modern economic development in TN provides leverage to betterment of women’s status. Women in Tamil Nadu enjoy higher opportunities with regards to employment, education, exposure to mass media, health and nutrition and also autonomy and decision making power. This reality is revealed in table 2.

The table exhibits that percentage of women currently employed is higher and not currently employed is lower in Tamil Nadu vis-à-vis that in Uttar Pradesh. Likewise, percentage of women not educated is lower and that with education up to 9th standard or with 10 or more years of education is higher in Tamil Nadu than that in Uttar Pradesh. Percentage of women with exposure to mass media like newspaper, T.V., radio and that with available maternal care facilities, and also with available food and nutrition facilities is higher in Tamil Nadu in comparison to those in Uttar Pradesh. Economic Development promotes market activities that draw upon the time of both male and female. Consequently, females in new living arrangement are left to share or to accomplish on their own certain functions with consent of male members of the household. It is revealed by the table that decision making power and autonomy of the women increase with enhancement in market led activities and level of female education. This all take place without any spectacular change in perception of gender sensitization or perception of men and women that favour women which is deeply rooted in specific cultural norms.

**Level of and Gender Disparity in perceptions**

This section deals with different source of livelihood led living arrangements and probably cultural heritage led achievements to women with regards to health, access to money, wage rate and their perception of self esteem. It also describes comparative picture of gender disparity in TN and UP in all these spheres. This is shown in Table 3.

The table shows that percentage of both men and women having perceptions favourable to women is larger in Uttar Pradesh vis-à-vis Tamil Nadu. Percentage of both women and men who agree with at least one specified reason that husband is justified in hitting or beating wife is higher in Tamil Nadu vis-à-vis that in Uttar Pradesh. Being it nearly 18.5 percentage point higher in case of Tamil women against their counterpart in UP, exhibits far greater self esteem of women in Uttar Pradesh. This women’s self esteem is well supported
by men in Uttar Pradesh, being 7.8 percentage point less men agreeing to justify hitting and beating in comparison to that in Tamil Nadu.

Table also shows that traditional perception of men’s control over women’s sexuality is far weaker for both men and women in Uttar Pradesh vis-à-vis that in Tamil Nadu. Percentage of men perceiving wife’s right in case of certain household decisions including withholding from sex with husband is higher in Uttar Pradesh in comparison to that in Tamil Nadu.

More than double (in percentage) of women in Uttar Pradesh have money that they themselves can decide how to use, higher ratio of female-male wage rate for all social class categories and higher proportion of females with normal Body Mass Index and also less percentage of women with anemia in Uttar Pradesh in comparison to those in Tamil Nadu reveal the ground reality of higher achievement of women as an impact of perception of women’s self esteem and women favouring perception of men.

Caste led Differentials in Perceptions and Domestic Violence

Religion and caste wise differentials in composition of population differentiate cultural norms and values. India is a country of rich cultural heritage and diversity. U.P. and T. N. have Hindu population between 80 to 90 percent. Both the states have nearly one fourth Scheduled Caste and Scheduled Tribe population. Major difference in two states is with regards to percentage of Other Backward Caste (OBC) and General Caste population. In T.N. three fourth population belong to OBC whereas it is only about one - half in U.P. Share of General Caste is about one – fourth in U.P. as against merely 2.4 percent in T.N.

Caste led differentials in social norms, perceptions, attitude and level of domestic violence is exhibited in table 4. The table shows that among the seven specified cases, wherein men and women both agree that hitting and beating of wife is justified, showing disrespect to in-laws stands at first rank in both OBC and General Caste. It is purely a culture led binding upon women. Percentage of agreeing men and women both is higher by 7 percentage point for OBC vis-à-vis that for General caste. Neglecting house and children stands at second rank for being agreed as a cause for hitting and beating of wife. In this case also, proportion of agreeing men and women is higher by about 9 percentage point for OBC than that for General Caste. Men and women agreeing with any of the seven cases is large enough in both the caste categories but it is higher by 10 percentage point for OBC in comparison to that for General Caste.

Female disfavouring perceptions in larger proportion of men and women in OBC lead to higher percentage of women experiencing violence against them. It is higher by about 8 percentage point in OBC vis-à-vis that in General Caste.

However, nearly two third of the women ever having experience of violence against them have never sought any help to stop it. Proportion of women ever sought help from any source is less than one-fourth. Percentage of women ever sought help is lower and never sought help is higher in General Caste vis-à-vis that in OBC. This is also impact of caste based cultural norms and values.
Conclusion and Finding

This study determines sources of livelihood and thereby related living arrangement which also includes conjugal relationship and perceptions inculcated in men and women in a household.

Development led living arrangement appears to be favourable to women in some cases like employment, education, health and nutrition facilities but not in all cases.

Underdevelopment and cultural norms led perception of men and women may yield different sorts of living arrangement that may also favour women despite their lower level of socio-economic development. Thus, level of domestic violence is influenced by both types of living arrangements.

This study exhibits that female favouring perceptions of men and women and achievement to women led by these perceptions seem to have resulted almost equal level of domestic violence against women both in TN and UP despite the latter being economically far behind.

The findings here are in contrast to Jejeebhoy’s study (1998) that UP needs relatively higher level of education vis-à-vis Tamil Nadu to protect women from similar amount of domestic violence against them.

This study rather reveals that culture led women favouring perception of men and women in UP strengthen the conversion factor (Robeynes, 2006) to transform even small opportunities into a big functioning in the form of protecting women against domestic violence.

An in-depth examination of the widespread acceptance of spousal violence among women of TN would help understand the prevalent cultural and social norms that govern conjugal relationship in Tamil society.

Thus, to reduce domestic violence, along with modern socio-economic growth, there is also need to “over turn iniquitous but entrenched practices and societal arrangement that are often accepted as part and parcel of an assumed ‘natural order’ ” (Amartya Sen, 2005).

Educational, cultural and political movements and well designed related programmes may have roles to play in social reforms that may lead to attitudinal and perceptional transformation in favour of women.

References


The concept 'Modernity' emerged as a socio-psychological explanation of development in social science literature. 'Modernity' includes scientific discoveries and innovations, higher level of education, urbanization, industrialization, contemporary against ancient, new against old.
Table 1: Economic Development and Sources of Livelihood in T.N. and U.P.

<table>
<thead>
<tr>
<th>Economic Development and Sources of Livelihood</th>
<th>T.N.</th>
<th>U.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percapita NSDP at current prices (in Rs. 2006-07)</td>
<td>40,757</td>
<td>16,060</td>
</tr>
<tr>
<td>2. Per capita Credit Deposit Ratio</td>
<td>112.3</td>
<td>45.1</td>
</tr>
<tr>
<td>3. Percapita Value added in industries (in Rs. 2004-05)</td>
<td>3,350</td>
<td>800</td>
</tr>
<tr>
<td>4. Percentage of main workers to total population</td>
<td>38.1</td>
<td>23.7</td>
</tr>
<tr>
<td>5. Percentage of HH in the lowest two quintiles</td>
<td>26.2</td>
<td>50.2</td>
</tr>
<tr>
<td>6. Percentage of HH in the highest two quintiles</td>
<td>43.9</td>
<td>30.4</td>
</tr>
<tr>
<td>7. Percentage of HH living in pucca houses</td>
<td>69.9</td>
<td>28.8</td>
</tr>
<tr>
<td>8. Mean number of persons per room used for sleeping</td>
<td>2.9</td>
<td>3.8</td>
</tr>
<tr>
<td>9. Percentage of men who drink alcohol</td>
<td>41.5</td>
<td>25.3</td>
</tr>
<tr>
<td>10. Percentage of HH with size of land possessed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Landless</td>
<td>22.6</td>
<td>10.1</td>
</tr>
<tr>
<td>Marginal</td>
<td>66.6</td>
<td>69.6</td>
</tr>
<tr>
<td>Small</td>
<td>7.3</td>
<td>12.5</td>
</tr>
<tr>
<td>Semi-medium</td>
<td>2.5</td>
<td>5.8</td>
</tr>
<tr>
<td>11. Average monthly income per farmer HH (in Rs.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marginal</td>
<td>281</td>
<td>389</td>
</tr>
<tr>
<td>Small</td>
<td>978</td>
<td>1746</td>
</tr>
<tr>
<td>Semi-medium</td>
<td>2450</td>
<td>2999</td>
</tr>
<tr>
<td>12. Gross irrigated area as percentage of gross cropped area</td>
<td>52.4</td>
<td>72.8</td>
</tr>
<tr>
<td>13. Per hectare food grains yield (in Kgs. 2005-06)</td>
<td>1763</td>
<td>2072</td>
</tr>
<tr>
<td>14. Percapita food grains production (in Kgs. 2004-05)</td>
<td>94.8</td>
<td>206.4</td>
</tr>
<tr>
<td>15. Percentage of agricultural workers to total workers</td>
<td>49.3</td>
<td>65.9</td>
</tr>
<tr>
<td>16. Percentage share of female agricultural workers in female rural workforce</td>
<td>73.8</td>
<td>86.5</td>
</tr>
</tbody>
</table>

### Table-2: Socio-Economic Status of Women in T. N. and U.P.

<table>
<thead>
<tr>
<th>Socio-Economic Status of Women</th>
<th>T.N.</th>
<th>U.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(1) Employment Status (in percent):</strong> Currently employed</td>
<td>48.2</td>
<td>28.1</td>
</tr>
<tr>
<td>Not currently employed</td>
<td>3.6</td>
<td>6.0</td>
</tr>
<tr>
<td>Not employed in 12 months preceding survey</td>
<td>50.2</td>
<td>65.8</td>
</tr>
<tr>
<td><strong>Nature of Employment (Usual Principal Status)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self employed</td>
<td>12.7</td>
<td>6.3</td>
</tr>
<tr>
<td>Regular wage/ salaried</td>
<td>6.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Casual labour</td>
<td>13.7</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32.5</td>
<td>9.0</td>
</tr>
<tr>
<td><strong>(2) Exposure to Mass Media (in percent)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not regularly exposed to any media</td>
<td>11.2</td>
<td>47.5</td>
</tr>
<tr>
<td>Reads, news paper at least once a week</td>
<td>27.5</td>
<td>14.3</td>
</tr>
<tr>
<td>Watches television at least once a week</td>
<td>81.4</td>
<td>40.1</td>
</tr>
<tr>
<td>Listens to radio at least once a week</td>
<td>46.8</td>
<td>29.7</td>
</tr>
<tr>
<td><strong>(3) Status of Education (in percent)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not educated</td>
<td>27.7</td>
<td>53.5</td>
</tr>
<tr>
<td>9 years of complete education</td>
<td>46.4</td>
<td>28.1</td>
</tr>
<tr>
<td>10 or more years of complete education</td>
<td>31.9</td>
<td>18.3</td>
</tr>
<tr>
<td><strong>(4) Status of Health, Nutrition and Autonomy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(a) Maternal Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage who received all recommended types of antenatal care</td>
<td>34.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Percentage of deliveries assisted by health personnel</td>
<td>90.6</td>
<td>27.2</td>
</tr>
<tr>
<td>Percentage of deliveries with a post natal checkup</td>
<td>91.3</td>
<td>14.9</td>
</tr>
<tr>
<td>Percentage of household that do not generally use government’s health facilities</td>
<td>47.0</td>
<td>84.7</td>
</tr>
<tr>
<td><strong>(b) Health and Nutrition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female’s Infant Mortality Rate (per 1000 live births, 2006)</td>
<td>33.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Female’s Life Expectancy at Birth (in years, 2005-06)</td>
<td>67.4</td>
<td>59.5</td>
</tr>
<tr>
<td>Percentage of women consuming milk or curd at least once a week</td>
<td>65.8</td>
<td>52.0</td>
</tr>
<tr>
<td>Percentage of women consuming fruits at least once a week</td>
<td>59.6</td>
<td>24.1</td>
</tr>
<tr>
<td><strong>(c) Autonomy and Decision Making Power</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of married women who takes decision about own health care</td>
<td>63.3</td>
<td>52.9</td>
</tr>
<tr>
<td>Percentage of currently married women making major household purchases</td>
<td>77.8</td>
<td>55.6</td>
</tr>
<tr>
<td>Percentage of currently married women making purchases for daily household needs</td>
<td>76.7</td>
<td>50.3</td>
</tr>
<tr>
<td>Percentage of married women who have autonomy to visit her family or relatives</td>
<td>48.8</td>
<td>33.7</td>
</tr>
<tr>
<td>Percentage of currently married women who participate in all the above four decisions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table-3: Level of /and Gender Disparity in Perceptions, Access to Money and Achievement in Health and Nutrition in T. N. and U. P.

<table>
<thead>
<tr>
<th>Socio-Economic achievements to women</th>
<th>Tamil Nadu</th>
<th>Uttar Pradesh</th>
<th>Gender Disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>1. Women favouring perceptions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Percentage who agree with at least one specified reason that husband is justified in hitting or beating wife</td>
<td>65.5</td>
<td>52.0</td>
<td>47.0</td>
</tr>
<tr>
<td>(b) Percentage of men who say that wives should have final say alone or jointly with their husband in all of the five decisions</td>
<td>-</td>
<td>44.7</td>
<td>-</td>
</tr>
<tr>
<td>(c) Percentage who agree that a wife is justified in refusing sex with her husband in all the four specified cases</td>
<td>62.8</td>
<td>73.2</td>
<td>74.9</td>
</tr>
<tr>
<td>(d) Percentage of men who agree with the right to none of the four behavior when a wife refuses to have sex with her husband</td>
<td>-</td>
<td>79.0</td>
<td>-</td>
</tr>
<tr>
<td>2. Access to money &amp; wage rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Percentage of women who have money that they can decide how to use</td>
<td>25.4</td>
<td>-</td>
<td>59.9</td>
</tr>
<tr>
<td>(b) Wage Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average wage/salary earnings (in Rs. per day) received by casual labour of prime age</td>
<td>39.07</td>
<td>77.18</td>
<td>44.22</td>
</tr>
<tr>
<td>Women’s wages as percentage of men’s wages</td>
<td>(M)</td>
<td>-</td>
<td>(W)</td>
</tr>
<tr>
<td>All Classes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Health and Nutrition Achievement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Percentage with Anemia:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild (W-M, for gender disparity)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Anemia</td>
<td>37.4</td>
<td>9.2</td>
<td>35.1</td>
</tr>
<tr>
<td>(b) Percentage with normal BMI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>© Percentage consuming pulses or beans at least once a week</td>
<td>53.2</td>
<td>16.5</td>
<td>49.9</td>
</tr>
<tr>
<td></td>
<td>50.6</td>
<td>58.4</td>
<td>54.8</td>
</tr>
<tr>
<td></td>
<td>57.9</td>
<td>56.9</td>
<td>94.5</td>
</tr>
</tbody>
</table>
Table 4: Caste wise Perceptions, Attitudes & Level of Domestic Violence against Women

<table>
<thead>
<tr>
<th>Socio-Demographic Characteristics</th>
<th>Other Backward Caste</th>
<th>General Caste</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage share in total Population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>74.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>49.7</td>
<td>24.1</td>
</tr>
<tr>
<td>Percentage of men who drink alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.8</td>
<td>24.1</td>
<td></td>
</tr>
<tr>
<td>Percentage of women aged 15-49 ever having experience of physical violence since age 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.1</td>
<td>26.8</td>
<td></td>
</tr>
<tr>
<td>Percentage of women aged 15-49 ever having experience of physical/emotional/sexual spousal violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40.4</td>
<td>32.3</td>
<td></td>
</tr>
<tr>
<td>Percentage of men/ women who agree that hitting and beating is justified if:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Men’s Response)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>She shows disrespect to her in-laws</td>
<td>39.0</td>
<td>32.2</td>
</tr>
<tr>
<td>She neglects house or children</td>
<td>32.4</td>
<td>22.6</td>
</tr>
<tr>
<td>In any of the seven specified cases</td>
<td>54.4</td>
<td>43.1</td>
</tr>
<tr>
<td>(Women’s Response)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>She shows disrespect to her in-laws</td>
<td>42.3</td>
<td>35.5</td>
</tr>
<tr>
<td>She neglects house or children</td>
<td>37.3</td>
<td>28.8</td>
</tr>
<tr>
<td>In any of the seven specified cases</td>
<td>57.7</td>
<td>47.0</td>
</tr>
<tr>
<td>Percentage of women aged 15-49 who often experience violence and sought help to stop violence:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never sought help</td>
<td>65.0</td>
<td>69.2</td>
</tr>
<tr>
<td>Ever Sought help from any source</td>
<td>24.6</td>
<td>20.9</td>
</tr>
</tbody>
</table>

Source: Different tables of NFHS 3 report.
A Selected Bibliography on Religious Identity and Prejudice

Renu Dewan*


Census of India 2001. The First Report on Religion Data, Registrar General & Census Commissioner, New Delhi, India, 2004

Census Commissioner, India. Brief Analysis. Released on Website www.censusindia.net, September 6, 2004


*Associate Professor of Psychology, Ranchi University, Ranchi (Jhakhand), India.
e-mail : renudewan2001@yahoo.com


Hewstone N. T. M. and A. Voci. Intergroup Contact between Hindus and Muslims in India,
Its Role in reducing Perceived Threats Intergroup Anxiety and Intergroup Bias.


This present book entitled “Health Matters: India’s Health Services, Who Benefits” published in 2009, is a jointly edited volume by Archana Sinha and T.A. John on wide ranging aspects of health services prevalent, mainly in the northern states of India. There have been books written on health concerns, especially, of diseases covering the types of sickness, preventive and curative measures for all age groups, but of women and children in particular. The volume in question is different from this conventional approach to health matters in that it is based on the systems and policies of healthcare services both in private and public sectors. Almost all the authors focus on the health service access to women and children under difficult circumstances.

The principal problems addressed by most authors are centred on the government policies, service systems, and multiple intervening factors both in urban and rural sectors. As the country’s population is enormously huge with 1.21 billion according to census 2011 provisional records, it is inevitable for the private sectors to come in the healthcare programmes. As such the bottlenecks that arise in the government service sectors could be removed by public private partnership approach. It is to be remarked that among the essential services health is not given much importance compared to food, shelter and clothing, by the government albeit a large number of population suffering because of deficient services. The whole discussions by different authors are focused on the inadequacy of government sectors for healthcare services add to it the scarcity of doctors and nurses in the rural areas. Consequently, the rural poor as stakeholders are the most deprived. Even among them women and children are the most impacted groups because they are more exposed and susceptible to different kinds of food and water borne diseases, malnutrition and sexual exploitations. The authors try to show that how the poor health conditions of women are directly related to poverty in rural India.

The authors have also shown lot of social sensitivity towards poor and the marginalized section of the rural people, but much more towards elderly women and children who have turned dependent population. The study delves into deeper socio-economic problems of aged people who need acceptance for themselves in family, community, society because they are no more earning members. On the other hand the sensitivity of the authors reflects the futuristic views of the younger generation and they argue in their discourse about the right based approach to healthcare for children.

Privatization of healthcare services as a result of liberalization of global economy and in India from 1990s onwards has become the real crux of the disparity problem among the stakeholders. Healthcare expenditure shot up to the sky and the scholars attributed

* Executive Director, Indian Social Institute, New Delhi

The cause of it to privatization. It has produced dramatic shift in economic policies and programmes in the country. As a result in the health sector, the changed scenario has left no
choice for the public but to turn to the private sector, since the public sector is so inadequately equipped. Implications of privatization, of course, can be seen on the poor and the marginalized. This phenomenon needs to be taken seriously for examination as introspection. This again is an area where the authors have not gone deeply enough in their analysis.

The systemic orientation of health service contains both the private and public sectors with their consequences and implications. The policy of the government is to restrict government health services to preventive care and leave the private sectors to take care of the other health services. Under this policy there are mushrooms of private health centres but mainly motivated for profit. As a result the question arises as to who benefit from such centres. The healthcare is under the State programme, and this healthcare has three main elements: preventive, treatment and rehabilitation. Under the preventive measures the government is obliged to provide other related services of good and clean environment, safe drinking water supply, vaccination and other health advice and family and social welfare services. It is expected of the private and voluntary organizations by their role to take care of providing, curative measures and rehabilitative medical services. At the same time such services are being more and more privatised, therefore, costlier to exclude the already marginalised and poor.

Some articles also looked into the whole problem from the Millennium Development Goals perspective. Health is crucial for healthy economic growth of a country, because only healthy people can be economically productive. Healthy people produce healthy economy and healthy economy makes a wealthy nation. This is why heath is one of the major indicators of human development index.

Ethical dimension of human values, especially, that of the Muslim women is well covered in one article. Improved technology covering female reproductive system is questionable if not repugnant, to the Muslim community so also is the question of sex determination technology resulting in dismal sex ration today. Apart from being an ethical question it also implies gender sensitivity and women’s empowerment.

The people covered are again almost all the communities of the higher class, the marginalised rural poor, women and children, Scheduled Castes, Scheduled Tribes and minorities. Among them there is a segment of population like the elderly, dependant and the crippled who are often forgotten.

Greater numbers of articles are based on empirical studies and reports in selected north Indian states. The data generation on various aspects of health care is commendably rich and useful for further studies. At first glance the topics look repeated, but a more careful and attentive reading of the text gives a reader the whole spectrum of modern health and healthcare related problems. Lots of new data are generated through the empirical studies from the fields and secondary sources.

The authors have discussed various aspects of topics under the wider canvas of health. As contributors of this volume they have analysed the present healthcare scenario and also raised some relevant issues and concerns, and have come up with recommendations on greater accessibility and affordability of healthcare, especially, for those living at the social and economic margins of society.

It is expected that the policy makers, planners, programme managers, researchers, academicians and students find it as an essential reading in their work and profession. It is much more so because the issues raised here are based on practical concerns and implications of the health sector reforms of our country.
The book is divided into 6 chapters: 1 Development of religious identity. 2 Communalism in India. 3 Prejudice and group identity. 4 Methodology. 5 Analysis of Data by ANOVA and ‘t’ ratios. 6 Main findings & Bibliography.

The book presents a longitudinal study on the development of religious identity and prejudice among Hindu children in Ranchi District of Jharkhand. The main objective of the present study was to find out the pattern of the development of religious recognition, religious preference prejudice and religious information in high and low caste Hindu children of prejudice and non-prejudice parents.

The sample for the study was 20 high cast and 20 low caste children of prejudice and non-prejudice parents. Each of the caste groups had 10 children of prejudiced and 10 children of non-prejudiced parents.

Tools used for data collection:

A. Personal Data Questionnaire: It has 10 items about name, age, sex, grade, education, place of residence, religion, caste, parental education, occupation and income etc.
B. Prejudice Scale: It consists religious prejudice, caste prejudice, gender prejudice. It consists of 45 items.
C. Religious Recognition Test: It consists of 11 sets of pictures of objects, symbols and events associated with Hinduism, Islam, Sikhism and Christianity. Thus the religious recognition test has 44 pictures.
D. Religious Preference-Precipice Tests: It has 40 pictures related to above mentioned four religions.
E. Religious Information Test: It consists of 55 items to measure children’s religious information about Hinduism, Islam, Sikhism, Christianity and other religions like Buddhism, Jainism, and Zoroastrianism. This covers 5 themes such as: (i) Religious founder’s personalities, (ii) Saints, (iii) Socio-cultural Political figures, (iv) religious places and (v) Religious books.

The tests applied in the study were constructed and developed in the Post Graduate Department of Psychology, Ranchi University under the guidance of Late Prof.(Dr.) Amar Kumar Singh.

Keeping in view the four aims of the research, the main findings were summarized under four categories, which include (1) Effect of parental prejudice on the development of religious recognition, religious preference prejudice and religious information. (2) Effect of caste-status on the development of religious recognition, religious preference prejudice and religious preference prejudice and religious information. (3) Effect of Age on the development of religious recognition, religious preference prejudice and religious information. (4) The interaction effect of parental prejudice, caste-status and age on the development of religious recognition, religious preference prejudice and religious information.

Parental prejudice does not seem to influence religious recognition of Hindu children for own and other religions at their early age. This however, produced significant effect on children’s recognition for the Hindu, Sikh and the Christian religions at the age of 8 years. At higher age levels,
both high and low caste children of prejudiced parents than those of non-prejudiced parents tend to have significantly better religious recognition for Hinduism, Sikhism and Christianity. Parental prejudice of both high and low caste children did not seem to produce significant different impact on the development of ethnocentrism and prejudice. Children of prejudiced parents in both high and low caste groups were significantly more ethnocentric and prejudiced against the Muslims than those of non-prejudiced parents. Children of prejudiced parents and non-prejudiced parents in both caste groups were more prejudiced against the Christians. No significant effect of parental prejudice was found on religious information. Children of high caste prejudiced parents had significantly better religious information scores than children of non-prejudiced parents about their own religion. While children of low caste prejudiced parents had no significant effect on their religious information about Hinduism, but it had influenced Christianity.

As compared to low caste and high caste children of prejudiced parents had significantly better religious recognition scores for Hindu items. Castes –status of non-prejudiced parents had influenced their religious recognition scores for the Hindu and Sikh. Caste-status did not produce any significant impact on children’s preference for own religion and prejudice against Islam, Sikhism and Christianity. Castes –status has failed to produce any significant effect on religious information about Islam and Christianity.

The religious recognition was increased with development of children’s age. The religious recognition for own religion was higher than that of other religions. The development of religious recognition for Islam, Sikhism and Christianity is faster than the development of religious recognition for own religion (Hinduism). Initially children had same preference for their own and other religions. But with development of age, preference for own religion was increased and for others was decreases. Age of children was tends to influence significantly the development of religious information about their own religion. The religious information about all religions was significantly higher at the age 8 years.

The second order interaction effect of parental prejudice and caste-status on religious recognition for Hindu, Muslim, Sikh and Christian items were found statistically insignificant. The second order interaction effect of caste-status and age on religious recognition for Muslim and the Christian items were found statistically significant.

The study reveals that the development of prejudice against Sikhs was same in children of both prejudiced and non-prejudiced parents but prejudice against Muslims and Christian was higher in children of prejudiced parents than in children of non-prejudiced parents. There was no difference between children of prejudiced and non-prejudiced parents on their religious recognition for Muslim items. But children of prejudiced parents than those of non-prejudiced parents were found to have better religious recognition for the Hindu, Sikh and Christian items at the age of 8 years.

Children of both prejudiced and non-prejudiced parents tend to had no information or, very little information not only about some basic facts of other religions but also about their own religion.

The study has thrown light on the pattern of religious preference –prejudice and religious information starting from 5 1/2 to 8 years. The study has thrown light on the pattern of religious identity and prejudice in Indian children which provides a base for comparison with the pattern of development in children of other cultures. It provides relevant information about the impact of parental prejudice, caste-status and age on the development of religious recognition, ethnocentric attitudes, prejudice and religious information in Hindu children in relation to Hinduism, Islam, Sikhism and Christianity.

The author has mentioned the limitation of the study and suggested for the further researches. The book carries previous research studies related to the subject. The book has added value due to good numbers of previous researches and scientific bibliography.
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