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FOOD TRANSITION AMONG TRIBAL AND GLOBALIZATION WITH REFERENCE TO ARUNACHAL PRADESH

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ABSTRACT: With the advent of globalization, one of the most visible impacts of it can be seen in food practice of indigenous tribes; tremendously transition of traditional food taking place. The changes have its own merit and demerit aspect. Firstly, it has improved the food security of the tribal people on the other hand, due to food transition and lifestyle new health problem has been experiencing by the tribal people. Further, traditional food such as smoked meat aggravates the chronic diseases. The result shows that 42.8 percent of the respondents consume smoke meat 2or 3 times in weeks and 54.4 percent of the respondents take traditional dish almost daily, which is exceeding the recommended quantity.

Keywords: Traditional food, Transition food, Health Status, Arunachal Pradesh, Tribes

1. INTRODUCTION

The traditional diet upon which tribal of Arunachal Pradesh survived for millennia was based on a wide range of nutrient-rich foods obtained from the local environment, including cultivation, hunting, and trapping of fish, birds, and seasonal roots, stems, tubers, wild berries and edible weed thus man eats what his forefathers ate or what his environment offers (Hoff, 2010). Traditional food habit is fundamental part of every culture. Indeed, food comprises an intrinsic part of our culture profile in other words food can be seen as a conveyor of culture. It encompasses everything that is important to human; food marks social variations and enhances social relations. It signifies very different things from region to region and culture to culture. The food habit and culture is dynamic process yet static (Marvin, 2000). With the advent of modernity and exposure to globalization, within the span of 30 years, indigenous tribes have undergone tremendous changes in their socio-culture life, compelled to forsake their ordinary way of life and socially absorb to the Western culture (Martin, 2011). This adjustment in way of life has understood as an enthusiastic sustenance depicted as decreasing in traditional food habit to depending more on imported food or ready-to-eat food (Mead, 2010). Transition of food habit from organic to inorganic food, which are considerable packs with artificial confectionary and fat-and sugar-rich food (Sharma, 2010).

Tribal people have been experiencing increasing rate of diabetic, obesity, kidney problem, hypertension, and chronic non-communicable diseases among these tribal people. ICMR (Indian Council of Medical Research), 2016 reports that Arunachal Pradesh has the most elevated

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number of patients with liver cancer, also known as hepatic cancer, cancer that originate in the liver in the country and the second highest stomach cancer cases in the world after China, under nationwide cancer-tracking program. Traditionally, Northeastern states are reported a highest incidence of cancer as compared to the rest of the country however, the most recent information uncovers that the cancer occurring in the Northeast among the highest in the world (Hindu, 2016). As per National Cancer Registry Programe 2014, reports on age-adjusted incidence rate (AAR), 271/100,000 males in Aizawl district in Mizoram State and 249.0 among females in Papumpare district of Arunachal Pradesh state. As per statistic report from Regional cancer center, among females, 7 of 17 cancer centers had over 20% of cancers associated with the use of tobacco. Most of the patients generally present themselves to the hospital for diagnosis and treatment when the disease has spread regionally or in an advanced stage. It has been found that a large number of people get infected with Hepatitis-B due to ignorance which finally causes liver cancer, 20% of those suffering from hepatitis were likely to develop liver cancer in later stages. Further, consumption of alcohol has also led to increased liver cancer cases (Borooah Cancer Institute, Guwahati), approx. 7% of the population die yearly by tuberculosis. Goiter is another major problem in the State. The 14.9% of the population still deprived of iodine . As the result of high prevalence of chronic disease rates and also due to the remoteness of the communities in the territory, State Healthcare system is under constant pressure due to the high cost of health service delivery and difficulty in investigation.

2. Brief Background

Arunachal Pradesh is the Easternmost state of India, divided into twenty districts. The state shares international border with China on the North, Tibet, and Bhutan on West, through Patkai range separate India from Burma and on the south it shares the border with Nagaland and Assam. As per the census report of 2011, the state has a total population of 13.84 lakhs, spread across nearly 83,743 sq. km area with 65% of inhabitants is Schedule tribe. There are 26 major tribes and more than 100 sub-tribes, some of the important tribes are Nishi, Apatani, Adi, Galo, Monpa etc. For the purpose of a study, Apatani, Nishi, Adi tribes have been selected to explore the traditional food transition as they tribes shared the similar food habit, culture, and lifestyle.

3. Methods

A cross-sectional survey was conducted among three communities of Arunachal Pradesh namely Apatani, Nishi, Adi tribes in Itanagar in during October and December 2014 in Papumpare district (Itanagar). The respondents were randomly selected based on tribes and cultural background, the respondents below 20 years of age and pregnant/ lactating women were excluded from the study, as they have different nutrition requirement. The individual in the family unit who was fundamentally in charge of cooking and shopping was chosen for the interview to capture the sorts of foods eaten within the population on regular basis. Dietary data was collected using a culturally appropriate, validated FFQ (Food Frequency Question) developed specifically for the study population. Data on demographics, socioeconomic status collected. The FFQ contained 52 food items (6 types of meat, fish, and poultry 25 vegetables;

7 snacks; 8 fruits; 3 pieces of bread and 5 cereals; 2 dairies; 4 beverages; 3 alcoholic drinks; 2 sugar and sweetener product), of which 15 were traditional foods. Participants were asked to report the frequency of consumption over a 30-day period by choosing from five categories, which ranged from 'daily' to 'never.' The analysis was done utilizing SAS statistical software, version 9.2 (SAS Version 9.2, SAS Institute Inc., Cary, NC). According to the nutrition value of food item, it was classified under food group for the convenience of analysis.

4. Results

In total, 180 adults from Papumpare district (90 women and 90 men) participated in the study. Respondents ranged in age from 20 to above 50 years of age, with a mean (SD) age of 45 (14.0) years for men and 35 (12.2) years for women. It was found that 75.6 per cent respondents eat leafy vegetables daily, while 35 per cent of the respondents take non-veg on a daily basis, 54.4 percent once or twice in a week. **Cereal:** It is an importance source of nutrition, it contains fiber and other essential micronutrients; only 8 per cent of the respondents eats cereal food on daily basis in a form of snack, break or other byproduct of cereal and 40 per cent respondent rarely eat cereal product. **Fruits:** The consumption of fruit is only 2.2 per cent respondent on daily basis although 28.9 per cent respondents takes fruit weekly, this indicates that 68.9 per cent respondents takes only seasonal fruit when it is available in cheap price, data reflects the variation in purchasing power or either it could be aware of nutrition among those respondents. **Milk:** As per data only 9.4 percent, respondents take milk or milk product daily, 31.7 per cent weekly, 21.7 per cent monthly, 25.6 per cent rarely and 11.7 per cent respondents have never used any milk product. **Pulse:** Only 8.9 per cent respondents eat pulses on daily, 16.7 per cent weekly, 51.7 per cent monthly and 22.7 per cent of respondents eats rarely. The data reflects that majority of the respondents, eats pulse either seasonally or rarely. **Beverage:** As per the data, it shows that 22.2 per cent respondents take beverages on a daily basis in the form of tea, coffee, rice beer or soft drinks, 42.2 per cent takes once or twice in a week, 18.3 per cent in a month and only 16.7 per cent takes rarely. **Rodent:** The data shows 43.3 per cent respondents eat rodent at least once or twice in a year, 7.8 per cent eat once or twice in a month, 46.7 per cent respondents had never eaten rodents. **Traditional dish:** Traditional dish one of the most popular dishes of Apatanis, gaining popularity among other tribes too. 1.1 per cent respondents claimed to eat pike or pila on the regular basis, 42.8 per cent respondents eats pike pila once or twice in a week, 46.1 eats once or twice in a month and 8.9 per cent eats rarely. This data highlights that 88.9 per cent respondents use pila or tapyo (sodium carbonate).

5. Discussion

The present study provides information on the transition of traditional food among the tribal group of Arunachal Pradesh. There are numerous factors may have contributed to the traditional food transition, probably due to change in occupation, for instance, indigenous peoples in recent years; association in the wage economy, a decrease in community food sharing systems, the pollution and increasing contamination by organochlorines and heavy metals, and reduced animal populations or changing migration patterns due to climate change and declining in hunting interest (Kuhnlein, 2001).The outcome of the data analysis shows that more than 50 percent of the respondents consumed meat at least two or three times in week, these trend reflects the direct influenced of globalization towards food behavior,

because in traditional society, the meat available for the family are usually received from social ceremony or from ritual sacrifice at home, as per the tradition, no livestock is allowed to killed for meal without incantation by priest, moreover people preserved livestock for ritual sacrifice. In social events, Pepsi, coke, and other energy drinks have created a niche in the traditional feast; it is served to a non-alcoholic guest, Pure traditional pure rice-beer which is nutritious and health drink is replace by beer cane, other alcoholic drinks. Rice beer is the main beverage used in traditional social and religion event hence, the tendency for consuming rice beer is higher in compared to other beverages, also it is commercialized for economic purpose makes the easy availability of rice beer even on the usual ordinary day. The subsequently increasing in alcohol consumption leads to increase alcohol-related health problem among all the tribes. With the liberalization of trade and industrialization (establishment of World Trade Organization in the 1980s) has spread the universal brand names of popular beverages and fast food contributed to the global epidemic of obesity by replacing traditional diet with fats and calorie-rich foods (Guindon, 2004). New food habits are developed based on food marketing strategies rather than traditional practices that persuade people to change their choices as result of some particular marketing concept created by advertisers. Commercial promotion of food contributes to psychological satisfaction and physiological well-being utilizing symbolic meaning of food rather than the nutritional values (Abrahamson ,1979), the changing food trends led to many health problems and diseases (Marwa 2012); due to the effect of fast food which contains huge processed fats and salt. Even the vegetables and vegetables are found to contain genetically modified organism (GMO) which is not natural; is harmful to health. The globalization has not only influenced the attitude and behavior towards to traditional food habits but also changed the value of traditional food. In developing countries such as India, there is emergence of global epidemic of non-communicable disease such as lung cancer, cardiovascular disease, diabetics and tobacco-related ailment, injuries and violent, liver cirrhosis etc. are the attribution of globalization. Although the traditional food is still preserved and eaten at least once in a day; for breakfast, for lunch or for dinner while modern food is enjoyed at leisure time or on especial occasion like birthday or gathering. Simultaneously, the improving economic power also enhanced the traditional food quality and quantity. For instance, people eat traditional food but add more sugar, more fat, more oil in traditional food preparation, sometimes even put cheese are the reason the increasing diseases like obesity, heart problem, and cancer. Changing food pattern from traditional one with more vegetable, which is more fibers to more fat and sugar contained food (Indrawaty, 2008).

Most commonly tribal consume high frequency of smoked. The studies linked eating smoke meat or barbecued meat, fried or roasted in high temperatures to esophageal cancer. These methods leave a coating of a high level of the chemical which may cause cancer. Some of these chemicals are polycyclic aromatic hydrocarbons, heterocyclic amines, and tar. Food expert says that when salty or fatty meat exposed to the smoke of wood or coal absorbs a large amount of tar, which may content carcinogen. National Cancer Institute, USA conducted laboratory test in the cancer study. This report has compelled to retrospect the tribal food habit and food processing. The cancers cases are also prevalent China, Japan, and other northeastern states that food habit or consumed high amount smoked in their diet. Further, cultural food practice of rice beer

consumption increased the chances of cancer in the patient. Despite rich nutritious diet; traditional food habits consist of edible leafy, leafy vegetables, herbs, and berries, people are suffering from nutrition deficiency. Yet state continue to suffer from diet-related disease, Cancer highest in country 249 per one lakh (Hindu, 2016), 62.5% of the population are anemia. One aspect of nutritional deficiency is a frequent intake of traditional dishes such as Pike Pila and Tap, an indigenous version of sodium bicarbonate; neutralized the nutrition and micronutrients of the other food items due to its alkaline properties. Although Na2COH is also used as medicine in treating acidity, however, the excess intake of this substance may be hazardous and lead to health implication from mild to severe symptoms. Many of respondents knew that excess intakes of a traditional dish may be harmful because after eating traditional dishes. The present study has highlighted transition of traditional food habit among tribal population in Arunachal Pradesh, the impact of this changes resulted to various diet-related diseases. In order to combat the health problem of the state, nutritional intervention should be implemented at community-based, culturally appropriate, multi-institutional chronic disease prevention program that has worked at the individual, household, community and institutional level to improve diet, and increase physical activity among town dweller (Sharma, 2010).

6. Conclusions

The current phenomena of health status and food transition is the attributes of globalization in traditional food system, globalization through plethora of opportunities and choice, no doubt it reduced hunger, food crisis and malnourished, made the life more comfortable and easier life as compared to olden days especially in among indigenous tribes, however, it also brought various turmoil in indigenous social culture, as the cultural food value and traditional is being felt threaten as it the globalized food system is gradually replacing the traditional system.

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PLIGHT OF WOMEN WORKERS IN UNORGANIZED SECTOR OF BASTAR DISTRICT OF CHHATTISGARH

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ABSTRACT: India has all along followed a proactive policy in the matter of labour Policy. India has evolved in response to specific needs of situation to suit requirements of planned economic development and social justice and a two-fold objective namely maintaining industrial peace and promoting the welfare of labour. The unorganized sector of the economy is primarily labour intensive but less rewarding to the workers in compensation to their efforts put in production. The characteristics of the unorganized labour are specified by the Second Commission on Labour (2002) as self employed persons involved in jobs, agriculture workers, migrant labours, casual and contract workers and home-based artisans. The nature of the employment relationship is the key determinant factor of unorganized labour.

The unorganized labour accounted for more than percent of the total workforce according to census 2001. The majority of women workers come under this category and is employed in the rural areas. Among the rural women workers, 87 percent are employed in agriculture as labourers and cultivators. In urban areas, 80 percent are employed in household industries, petty traders, domestic servants and workers in the cottage industries. Though women constitute a significant part of workforce, they lag behind men and they are neglected section of the society. Moreover, it is an established fact that women bear a disproportionately heavy burden of work than men as they have to contribute more time in the care economy that is the domestic work. The unorganized is most vulnerable, ignored and diverse. Women in unorganized sector constitute a sizable number so it is important to study their problems and prospects. The present study is based on the primary data conducted in Baster district of Chhattisgarh which examine the socio-economic conditions and various problems of unorganized women workers.

Keywords: Women workers, Unorganized sector, Chhattisgarh, Labour, Tribes

1. INTRODUCTION

The Constitution of India guarantees equality of opportunity in employment and directs the state to secure equal rights for livelihood, equal pay for equal work as well as just and human conditions of work for all. Despite the concerned efforts of the state, the economic status of women is lagging far behind their male counterparts. Women work the most; paradoxically they earn the least in life. The additional social responsibility shouldered by them, their subordinate status in society,

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patriarchal family set up, socio- economic backwardness, proneness for occupation in the unorganized sector with low productivity and marginalization in employment opportunities account for their poor or low earning capacity. A majority of women work in unorganized sectors for low wages due to low level skills, illiteracy, ignorance and surplus labour and thus face high level of exploitation. This hampers their bargaining power for higher wages and any opportunities for further development.

The term unorganized sector was first used by Hart in 1971 who described the unorganized sector as that part of urban labour force, which falls outside the organized labour market. In the unorganized sector, work situations are not in official record and working conditions are not protected by law. So the problems of female workers in unorganized sector are not properly known. It has been pointed out by Hart that one of the major problems is that working conditions are worst.

That optimistic vision of economic transition did not match what was actually happening in the world. In the late 1960s and 1970s, a large section of the population in the developing countries was suffering from poverty and working outside the organized sector in activities that were later broadly termed as "unorganized". Due to population growth and urban migration, the active labour force was growing at a much faster rate than availability of jobs in the organized sector. The focus of development policies was gradually shifting from pure economic to growth with equity and the eradication of poverty. Interest was, thus generated in sectors outside the organized economy that was providing a livelihood to a large section of the poor. Hence, the concept of the unorganized sector was born. In defining the unorganized sector, self- employed with or without family labour and microenterprises with less than five workers, is also included.

In analyzing the contribution of the unorganized sector, emphasis is placed on the pervasive importance of the link between organized and unorganized activities that are not confined to particular occupations or even economic activities.

2. Problems of Women Workers in Unorganized Sectors

A large number of women from rural areas migrate to cities and towns all over India. Most of these women and girls are illiterate and unskilled. They work in inhuman conditions in cities as their living standard is extremely poor. A large number of these women are being exploited by middlemen, contractors, construction companies and other type of employers. Many of these women and girls work as housemaids, construction area and brick kiln, where their working hours extend up to 14 hour a day. A large number of migrant women become victims of financial and sexual exploitation. Gradually, many women and girls lose contact with kith and kins back home and become alienated from their culture and roots.

It is a recognized fact that there is still no society in the world in which women workers enjoy the same opportunities as men. The women unorganized sector are facing so many problems. According to the 2001 census about 96 percent of women workers in India are in unorganized sector. The rise of female participating in unorganized sector is due to the compulsion and employer's preferences for female employee. Their ignorance, illiteracy and poverty have added fuel to their woes all the more. Women are considered the human resource of choice for the unorganized sector because they lack education and training and are amenable to accept lower

wages for equal work due to gender casting.

The unorganized sector is characterized by the several factors such as wage discrimination, no limit for minimum wages, long hours of work, lack of job security, lack of legislative cover, lack of minimum facilities at work place, heavy physical work and ill treatment, physical exploitation by the employers. A proper study shall bring out the problems of women workers in unorganized sector and their attitude towards employment. The present study is an attempt in this direction.

3. Scope of the Study

The study is an attempt to understand the women workers attitude towards their employment conditions in unorganized sector.

4. Objectives

The study has been undertaken with the following main objectives:

1. To study the socio economic conditions of women workers in unorganized sector.
2. To analyze the problem faced by women workers of the study area.
3. To suggest measures for overcoming the problems of women workers in unorganized sector.

5. Methodology

The present study is empirical one. Survey method was employed to collect the data from women workers. A well conceived and structural interview schedule was prepared for collecting the primary data. To study the plight of women workers of unorganized sectors, 120 samples were selected through the convenient sampling method. Fieldwork for the present study was carried out personally by the research. Secondary data has been collected from the articles, journals and the books.

6. Socio-economic Background of the Women Workers

Table 1: Age-wise Classification of the Women Workers

Age in years	*No. of women workers*	*Percentage*
Below 20	18	15
20-30	48	40
30-40	34	28.3
Above 40	20	16.7
Total	120	100

The Table 1 reveals the age group of the women respondents. It is clear from the table that the majority of women workers (40%) belong to the age group of 20 to 30 years, 28.3 percent workers belong to the age group of 30 to 40 years, 16.7 percent workers are above the 40 years and the remaining 15 percentage women workers are below 20 years.

Table 2: Education –wise Classification of Women Workers

Educational level	*No. of women workers*	*Percentage*
Illiterate	76	63.3
Primary school	32	26.7
Middle school	10	8.3
High school	02	1.7
Total	120	100

It is evident from Table 2 that the majority of the respondents (63.3%) are illiterate while 32 have primary school education, 10 respondents (8.3%) have middle school education and 2 respondents have high school education only. Thus, it is clear that the educational status of the most of the respondents is very poor.

Table 3: Marital Status of Women Workers

Marital status	*No. of women workers*	*Percentage*
Married	97	80.8
Unmarried	23	19.2
Total	120	100

Table 3 reveals that 80.8 percent of women worker are married while only 10.2 percent respondents are unmarried.

Table 4: No. of Children of Women Workers

No. of children	*No. of women workers*	*Percentage*
1 to 2	13	13.4
3 to 4	53	54.6
More than 4	26	26.8
No children	05	5.2
Total	97	100

*Only 97 women workers (97/120) are married.

Majority of the women workers (54.6%) have 3 to 4 children, 26.8 percent have more than 4 children, 13.4 percent respondents have 1 to 2 children and 5.2 women worker have no children.

Table 5: No. of Earning Members in the Family of Women Workers

Earning members (including the respondent)	*No. of women workers*	*Percentage*
One	06	5
Two	25	20.8
Three	57	47.5
More than three	32	26.7
	120	100

It is found that (47.5 %) of the women worker have three earning members in their family, 26.7 percent workers have more than three earning members in their family, 20.8 percent of respondents have two earning members while only 5 percent women workers have 1 earning member in their family. The male members of their families were mostly drivers, carpenters, construction workers and scavengers.

Table 6: Family Income of Women Workers (per month)

Income (in rupees)	*No. of women workers*	*Percentage*
Below 2500	13	10.8
2500-4000	33	27.5
4000-5500	62	51.7
Above 5500	12	10
Total		100

It is clearly evident from Table (6) that 51.7 percent women workers have a family income of Rs 4000 to Rs 5500, 27.5 percent workers have a family income of Rs 2500 to 4000, 10.8 percent workers have a family income below Rupees 2500 and only 10 percent women workers have family income above 5500 Rupees. The women workers in unorganized sectors felt that they find it highly difficult to run their family with such a meager income. Some of them are single earners in their family who entirely depend on the income from unorganized sector.

Table 7: Caste-wise Classification of Women Workers

Age in years	*No. of women workers*	*Percentage*
Schedule Tribe	99	82.5
Schedule Caste	13	10.8
Other Backward Class	08	6.7
Total	120	100

Baster, the land of tribes and about 70% of the total population of Bastar comprises tribals, which is 26.76% of the total tribal population of Chhattisgarh. It is clear from the table 1.7 that majority (82.5 %) of women workers belong to schedule tribe, only 10.8 percent of women workers belong to schedule caste while 6.7 percent respondents are from other backward class.

7. Problems of Women Workers

Table 8: Duration of the Employment of Women Workers (in months)

Duration of employment	*No. of women workers*	*Percentage*
Less than 3 months	15	12.5
3 to 6 months	36	30
6 to 9 months	42	35
More than 9 months	27	22.5
Total		100

It is clearly evident from the Table 8 that 35 percent women workers get employment from 6 to 9 months, 30 percent workers can get the work from 3 to 6 months, 22.5 percent women workers can get employment more than 9 months and 12. 5 percent women workers can get the employment less than 3 months.

Table 9: Type of Residence of the Women Workers

Type of residence	*No. of women workers*	*Percentage*
Own house	11	9.2
Rented House	109	90.8
Total	120	100

Table 9 shows that 90. 8 percent women workers reside in rented house and only 9.2 percent women workers reside in their own house. The house rent takes away a considerable portion of their income and leaves a little residual income to meet other necessities.

Table 10: Numbers of Hours Worked by the Women Workers

Working Hours	*No. of women workers*	*Percentage*
9 hours	36	30
9-10 hours	58	48.3
More than 10 hours	26	21.7
Total	120	100

Table 10 highlights the working hours of women workers. 48.3 percent women workers have to work 9 to 10 hours, 30 percents workers have to work up to 9 hours while 21.7 workers have to work more than 10 hours. According to unorganized sector worker's Bill, 2002, the working hours are defined as 9 hours a day. It further says that every worker shall be entitled a weekly holiday, casual or sick leave and 15 days earned leave in a year. However in most of the workers in unorganized sector are to work for more hours.

Table 11: Monthly Income of Women Workers

Monthly Income	*No. of women workers*	*Percentage*
Below 2500	24	20
2500-3000	81	67.5
3500-4000	11	9.2
Above 4000	04	3.3
Total	120	100

Table 11 shows that 67.5 percent of the women workers earn Rupees 2500-3000 per month, 20 percent of women workers earn below Rupees 2500, 9.2 percent workers earn between 3500 to 4000 Rupees per month while only 3.3 percent women workers earn above Rupees 4000 per month. In fact, most of the workers stated that they seldom get their wages timely. One of the severe problems that is being faced by the workers of unorganized sector is that they are not given wages what they deserve.

Table 12: Expenditure Pattern of the Women Workers (Per Month)

Expenditure	*Percentage of monthly income*
House rent	28.6
Grocery	41.9
Clothing	2
Loan repayment	10
Education	9.5
Health	2
Savings	0.8
Repair of house	1
Festival	2
Miscellaneous	2.2
Total	100

*The expenditure of each women worker is converted into percentages and averages are taken for each expenditure.

Table 12 shows that women workers spend 41.9 percent of their monthly income on grocery items, 28.6 percent of their income for paying the house rent, 10 percent on loan repayment, 9.5 percent on education, 2 percent on their income spend on health and clothing and festival, 1 percent on the repair of their house and save only 0.8 percent (average) of their income.

Table 13: Occupational Diseases of Domestic Workers

Disease	*No. of women workers*	*Percentage*
Back pain/body pain	21	17.5
Skin Diseases	5	4.1
Anemia	37	30.8
Bronchitis	18	15
Indigestion	14	11.7
Other diseases	11	9.2
No Disease	14	11.7
Total	120	100

Occupational diseases pose a serious problem to the women workers. The polluted environment and unhygienic work place are affecting not just the flora and fauna, but also workers of the unorganized sectors. Majority of women workers suffer from anemia, back pain, body pain and various diseases. The women workers in unorganized sector generally do not eat rich food. Though they work hard, they eat only one or two times a day. This affects their health to a great extent.

Table 14: Working Condition of Women Workers

Working condition	*No. of women workers*	*Percentage*
Less Hygiene Prevails	35	29.2
Old machines	37	30.8
Insecurity	48	40
Total	120	100

Table 14 shows the various factors that affecting the working conditions. 40 percent women believe that insecurity is the reason, (30.8 %) women workers believe that old machines are affecting the working condition while 29.3 percent women said that less hygiene prevails.

Table 15: Harassment of Women Workers

Harassment of women workers	*No. of women workers*	*No. of women workers*
Sexual Harassment	42	41.7
Financial Harassment	28	23.3
Caste harassment	50	35
Total	120	100

Table 15 reveals the various kinds of harassment and exploitation faced by women workers in unorganized sector. 41.7 percent women workers are sexually harassed while 23. 3 percent women workers feel that they face the financial harassment and 35 percent respondents said that they are exploited on the basis of their caste.

Table 16: Problem of Women Workers (Level of Satisfaction)

Problems	*Satisfied*	*%*	*Not Satisfied*	*%*	*Total*	*Percentage*
Job security	32	26.7	88	73.3	120	100
Work duration	36	30	84	70	120	100
Wages	23	19.2	97	80.8	120	100
Leave facility	26	21.7	94	78.3	120	100
Medical facility	28	23.3	92	76.7	120	100

It is clearly evident from Table 16 that majority (73.3%) of women workers are not as far as job security is concerned. The worker could not entirely rely on their monthly income. They fear that they would be terminated at any time without notice.

Long duration of work is a crucial problem for 70 percent of women workers as shown in Table 2.9. Majority of women workers said that they have no stipulated working hours. Irrespective of day or night, they have to discharge any type of work assigned to them. In fact long duration of work spoils the health of the workers.

The unorganized women workers are paid very low wages. According to the study 97 percent of women workers are not satisfied with their income. Furthermore there is no leave facility if they are on leave their employers deduct the wages of that day.

As shown in Table 16 that 78.3 percent women workers don't get leave facility. Sometimes the workers are either terminated or get deduction of their wages even if they take leave for genuine reasons. Besides whenever the workers return after taking casual leave, the employer assigns lot of work to them. Hence, lack of leave facility is the biggest problem before them.

The women workers in unorganized sector pay the medical expenses (if any) from their own pockets. Only few employers reimburse such expenses. Though some of them get treatment in Government hospital but they are not satisfied. In case of life threatening diseases the workers borrow money from the employers, relatives to get treated in private hospitals. Hence huge debt

accumulates before they recovered from the disease. As such lack of medical facility seems to be a great problem for 76.7 percent workers.

8. Suggestions

The empowerment of women is the major concern of the present day. The efforts of the government to improve the condition of women workers are praiseworthy but due to corrupt practices of the functionaries, the beneficiaries are not capable to utilize the programmes meant for their betterment. In order to improve the condition of unorganized women workers some of the suggestions are recommended.

1. Women workers should be educated and make them aware about their rights and legislative provisions.
2. Effective steps should be taken to reflect the duty of the government and society to protect the rights of women workers in unorganized sectors.
3. The legislations, which prevent all forms of discriminations and guarantee equal job opportunities, should be strictly enacted and implemented.
4. Women workers must be motivated to utilize the existing programmes of their welfare.
5. Necessary amendments are required to be made in labour laws.
6. Women workers leaders must be included in the policy formulation and other decision making processes relating to their welfare.
7. To ensure full employment to the women workers the government must come forward with certain job oriented training and skill programmes to generate local self employment.
8. The workers have to work for very long hours. This need to be regulated and not to exceed 8 hours per day. The government must take some sincere attempts to regulate working hours of the women in unorganized sectors.
9. To fight against harassment and exploitation the women workers must be encouraged to form groups.
10. There should be proper regulation of unorganized sector industries, which ensure job security, healthy work environment and at least minimum wages, maternity and child care benefits.

9. Conclusion

Even though, the unorganized sector has been the most vulnerable and ignored sector in India, it holds an inevitable place in Indian economy. Thus, there is no exaggeration in saying that the backbone of Indian workforce is the unorganized sector. The unorganized women workers development should be viewed as an issue in social development to be seen as an essential component in every dimension of development. In order to get empowerment the government and the social workers may contribute significant role in making women workers capable, self reliant and well organized. It is worthwhile to create the awakening among unorganized women so that they can come up by taking care themselves. There is urgent need to givw top priority to the issues and problems of the workers of unorganized sector.

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Public Private Partnership: A developing trend in the health care sector in India.

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ABSTRACT: Public private partnership is a developing trend in which services are delivered by the private sector, both non-profit and for profit organization, while the responsibility of the funding and additional necessities may be provided by the government. The PPP has made its entry to the health care sector since last two decades. The Public Private Partnership in health sector has made successful stories in India at the same time there are debates related to its accountability and transferability. The Indian government is now largely looking in to the PPP model to solve larger problems in health care delivery. This is because of the large number of population struggling for survival and basic health needs. The challenges in health sector leads to the PPP, where the public and private sector merges in a harmonized way to meet the demand of quality of health services. The area in which PPP now operates in health care includes private management in public health delivery, adoption of primary health care centers, clinical services, health insurance programmes, non-clinical services etc. The study throws light on the emergence of PPP in the Indian health sector and the various models where it is successfully implemented. The study focuses on the implications of partnership models and the benefits and limitations of them. The data is collected from thorough literature review of articles of journals, books, study reports, unpublished works and news papers. The study focuses on various PPP models operating across the country. The PPP models have lead to the delivery of accessible, reliable and better quality services to the poor. Efficient supervision and high quality managerial and budgetary support from the government can lead to implementation of successful partnerships which can ensure the modern health care to the deprived people.

Keywords: Public Private Partnership, , Health care reforms, Health care service delivery

1. INTRODUCTION

Health system of a state is its vital part where each state gives immense care and budgetary support. While taking a close look into the history, it is evident that states across the world were always concerned about the health of its masses and made timely interventions whenever necessary. The twenty first century witnessed the critical face of public health. The state finds a better alternative in private, non-profit, for-profit and voluntary organizations to provide better health care services. The difficulty to reach the people in rural areas with the same range of services that of the urban areas also had to be addressed. Hence the new initiative i.e., Public Private Partnership (PPP) got wider acceptability and larger scope. The efficiency of private sector

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in reaching the grass root level of the population is taken in to consideration and entrusted with carrying out accountable services.

Public Private Partnership is thus a developing trend in the global health sector. The world bank has announced that it will encourage partnership as a part of its comprehensive development framework. Non government organizations have established new relationship with private for profit firms and with international agencies (Reich, 2001). There are wide responses from International agencies to assure health care in poor countries. Non –governmental organizations also have gained acceptance and respect in last two decades. It is visible that government of India has partnerships with NGO'S, CBO's and other voluntary organizations for major National health programmes. But why this trend of Public Private Partnership is getting this wider response from all over the world? The major reason is globalization. Globalization makes modern technologies spread across world market, where the poor countries lagging behind will make a sharp and contrast which gains attention (Bennet, 1991). The increased acceptance of NGO's has also helped taking the public health issues around the world to international policy agenda.

Both the state and the private partners are not capable enough to single handedly sort out the public health issues. The state cannot provide same quality services to every corner which lead to the larger dependence on private sector. This uneven dependence may lead to the out of pocket expenses. State has budget constraints and limitations to reach whole mass whereby it has to take the help of private sector for its ability to reach the grass root level and efficiency in handling health care.

Various definitions are given to PPP by various authors and agencies,

"Public Private Partnership means to bring together a set of actors for the common goal of improving the health of the population based on the mutually agreeable roles and principle'' (WHO, 1999).

"A partnership means that both party has agreed to work together in implementing a programme and that each party has a clear role and say in how that implementation happens" (Balgescu and Young, 2005)

"A partnership is a relationship based upon agreements, reflecting mutual responsibilities in furtherance of shared interests." (Mitchell, 2002)

"Collaborative efforts between public and Private sectors with clearly identified partnership structures shared objectives and specified performance indicators for delivery of a set of services in stipulated time period" (MoHFW, GoI ,2005)

In this study the Public Private Partnership refer to the merging of public and private sector where the public partner will be the Central/State / Local government and the private partner will be a Non- profit, privately owned business or corporate working together for providing agreed services.

2. Emergence of PPP in Indian health sector

In 1978, the World Health Organization (WHO) and the United Nations Children Education Fund (UNICEF) studied a history of global health rights in Alma Ata, USSR. In the Alma Ata Declaration, 134 countries were geared up to the goal of "Health for All'' by the year 2000" and then till 2020. They affirmed WHO's broad definition of health as "a state of complete physical, mental, and social

well being". To approach health for all, the world's nations, together with WHO, UNICEF, and major funding organizations, pledged to work towards meeting people's basic health needs through a comprehensive, remarkably progressive approach called "primary health care''. The declaration strongly advocated the need for a broader strategy that not only provides the basic health services but also take care of the social ,economic and political causes of the poor health, which lead to a participatory strategy which was called people centered development

The Bhore committee report in 1946 is a proof that India was always considerate to the health of the masses. India had its majority of masses living in rural area , so the emphasis was placed on the development of infrastructure techniques and manpower for service delivery mainly in rural area. The private sector role in the PPP model was important because of its proximity to the rural masses. Many Projects have been implemented in India in the PHC segment in different states with different levels of perspectives. The National Rural Health Mission (NRHM: 2005-2012) from the Government of India planned to set up PPPs at different levels of health care as key partners to success in implementation. NRHM has contemplated that involving the private sector as part of the Reproductive Child Health (RCH) initiative will provide more effective health care delivery system. The number of private sector institutions and dependence on them has been increasing over the years; the private sector now provides more than curative care comparing to earlier times. Another reason for implementing PPP is out of pocket expenses. The unsatisfactory health facilities lead to more dependency on private sector which ultimately leads to high out of pocket health expenditure at 86.4 during 2010 as estimated by the World Bank in 2012. (Holla et al,2013)

India has, since independence, developed a huge health care infrastructure in both public and private sector .Apart from the for-profit private sector for health care, the non-governmental organization (NGO) and voluntary sector have also been providing health care to the community. More recently, PPPs have been attempted to involve the private sector in delivery of national health programs like Revised National Tuberculosis Control Programme (RNTCP),National AIDS Control Programme (NACP) and in drug development. In the health sector, it is visible that the PPP takes out the best features of the two merging authorities. Various state governments in India have been experimenting partnerships with the private sector to reach the poor and underserved sections of the population. PPPs are increasingly seen as an important mechanism for improving health care. Located in rural and urban areas, the health services studied included mobile services, general curative care, maternal and child health services, community health financing activities, health promotion activities etc.

There are various partnership models working in Indian health sector, some may be identical and some may have unique features and style. The table below is an overview of the various projects in India implemented through PPP model. The table throws light on the nature of partnership, state which carries out the programme, partners included, services provided and the state, benefits and limitations of the project.

Table 1:- Synthesis of contracting models in India

Partnership model	State/ Case	Public Partners	Private Partners	Services Provided	Benefits of the Programme	Challenges	Recommendations
Contracting	SMS Hospital Rajasthan	Public Hospital	Private Company	Drugs at low cost and Radiological diagnosis (CT &MRI scan)	Free for all BPL patients. above 70 year and freedom fighters	Identification of authentic BPL beneficiaries	Maintenance of authenticated and reliable BPL holders list
	Bhagajatin Hospital, Kolkata West Bengal	Public Hospital	Private individuals, private company	Non-clinical services like dietary, kitchen cleaning scavenging and laundry	BPL patients supplied free diet.50% charges for others	Lack of monitoring agency for quality assurance of food	Quality assurance of foods and services verifying authority
	Mobile Health services in Sunder bans, West Bengal	State government West Bengal	NGO	Providing mobile (boat based) health services	52% remote villages covered, increased Patient attendance, Anti natal monitoring	Cover all the remote villages of Sunder bans, quality assurance	Extending the services to reach all the parts of Sunderbans timely Monitoring of services

(Source: Adapted from Raman and Bjorkman2009, Pai and Tripathy2012)

Table 1 represents the contracting model partnerships in India. Contracting in and out is one of the dominant tools for engaging the private sector in health sector reforms across all types of public health systems throughout the world (Raman and Bjorkman 2009). The private providers receive a grant or budget amount from the government for delivering certain services that the latter used to deliver itself. There will be written agreements on the set of services to be given, quality, quantity and duration of service. The SMS hospital partners with a private company to provide drugs and radiological services at low cost. The services are accessible round the clock to the people from poor economic background. The Bhagajatin Hospital situated in Kolkata is another example of providing non-clinical services through partnership, whereas Mobile health services in Sunderbans makes a new effort by providing health services to the remotest area with the means of boat based clinics. By analyzing the three models it is evident that these initiatives closely aim at the poor and deprived people who can't access the quality health services.

Table 2: Synthesis of multiple-nurtured PPP models

Technology Demonstration Project (Collaborative Partnership)	Utharanchal Mobile Hospital and Research Centre Blimtal Utharanchal	Autonomous government agency, Govt of Utharakhand	Non-Profit Research Institute	Mobile health vans delivering diagnostic and health care services.	Free services BPL card holders OPD consultation Radiological Diagnostics and pathological tests	Identification authentic BPL beneficiaries, assessing quality of services	Maintenance of authenticated and reliable BPL holders list, timely monitoring
	Karnataka Integrated Telemedicine and Tele health Project Karnataka	Public sector hospital, Autonomous GOI agency	Private hospital	Tele consultation and in patient services for cardiac patients and other specialist care.	Free diagnosis medicines and treatment to heart patients Yeshaswini card holders	People fear of user charges, problems regarding connectivity and machines	Improve Information Education and Communication services
Community based Health Insurance schemes	Yeshaswini Health Insurance Scheme Karnataka	Government of Karnataka	Private and corporate Hospitals.	Health Insurance to the members of farmers corporative	Targeting farmers	Reaching the entire farmer community	Extending the services and Improving Information Education and Communication services
Hospital autonomy	Rogi Kalyan Samiti Hospital Bhopal Madhya Pradesh	District hospital	Private Individuals	Decentralized management of hospital to improve the quality of care	All service free for BPL patients, defense personnel and differently able people.	Identification authentic BPL beneficiaries.	Maintenance of authenticated and reliable BPL holders list.
Public –Private mix	Mahavir Trust Hospital Hyderabad	GOI	Private hospital, private doctors and Nursing homes	Surveillance and treatment of Tuberculosis patient	Entire programme covered under RNTCP free of charge	Long term sustainability is a concern	Provide incentives to private practitioners, proper linkages with monitoring hospital

(Source: Adapted from Raman and Bjorkman, 2009. Pai and Tripathy,2012)

Table 2 gives a picture of other innovative PPP models operating successfully in various states. The collaborative partnership indicates more than one partnership with the government like autonomous institutions or semi-government Institutions. Utharanchal Mobile Hospital and Research Centre is a model in which TIFAC (Technology Information Forecasting and Assessment council partners with Birla Institute of Scientific Research (BISR). Whereas Karnataka Integrated Telemedicine and Tele health Project has a prominent Hospital Narayana Hrudayalaya to provide online health care services to the poor in underserved areas. The people in remote areas can connect with any district hospitals which linked with super specialty hospital where they get uninterrupted online services.

Yeshaswini is a community based health insurance scheme in which targets the poor people. The Karuna Trust with the help of National Health Insurance Company and the Government of Karnataka undertook the project to improve access to and utilization of health service to prevent impoverishment of the rural poor due to hospitalization and health related issues and to establish insurance coverage for out- patient care by the people themselves. Rogi Kalyan Samiti is an example where the individuals from the community put efforts for the management of a public hospital to deliver quality health services. Mahavir Trust Hospital in Hyderabad has joined hands with the government to implement RNTCP (Revised National Tuberculosis Control Programme).

3. Findings and Discussions

The PPP in health sector has a major role in bridging the funding gap and enriching the programme with other necessary resources. Efficiency in implementation has lead to the opening of PPP models in various service sectors. The entry of Private sector into health sector has lead to the removal of hostile attitude towards private sector. The myth that private sector aims only profit motive has been broken.

Even though "contracting" is the dominant modal in public private partnership, the study tried to closely look on to the other PPP models existing across the country. In all most all the partnerships the principal public partner is the Ministry of health and family welfare (GOI) either directly or through nominal bodies. The private partner varies from private individuals, doctors to large corporate entities. The service of these partnerships also varies from super specialties services to community care, health education and non-clinical services. Most of these partnerships are meant to help the rural population, who are deprived of the basic health needs . The partnerships addressing urban slums are also studied.

The literature suggests the cases of PPP have to be yielding benefits to masses compared to the previous health care conditions. PPP's are supposed to ensure quality and accessibility of health services to poor and vulnerable session. However verification of the authenticity of poor patient is a matter of concern. Mostly the 'ration card 'issued by the government certifies a person to be poor or rich. But the BPL /APL divisions has always been a matter of controversy across the state. The case of destitute and migrants without certification is also a question. Sometimes people are subjected to the interpretation by hospital authority or get a citation from local authority which can create a negative attitude towards these programmes.

Most of the PPP ventures are free of user fee or maintaining a less fee for meeting the operational expenses which is an act to be accessible for every person and preventing out of pocket expenditure on health. The matter of user fee must be written down in the contracts to avoid later confusions. But the consistency in providing quality services by the private sector is something to be taken care. Prior experience and area of interest of the private firm must be well studied before starting a partnership. to ensure the quality. Technical and managerial abilities of the private firm should be analyzed effectively. There should be a performance indicator to assess timely results and quality of services. The risk sharing factors should be also equal while starting a partnership to ensure the smooth functioning. The mutual roles and responsibilities of both parties should be laid

down and understood previously. The risks also should be understood and addressed to prevent partnership from being affected in long run. A trust –oriented selection is recommended while selecting partners.

'Red tapism' is a bigger threat which curtails the growth of PPP in Indian health sector. The procedural requirements to get the timely grand in aids sanctioned will lead to chaos in the ongoing programme and eventually lead to the closure of the project. It may also lead a negative impact among private entities to get involved with PPP projects.

Last but not least, the stake holder's interests should be taken in to consideration. Some projects are lagging behind in addressing major problems of people. Hence before acting on assumptions a good research should be carried out to assess the stake holder needs for building up a successful PPP.

4. Conclusion

PPP is getting wider attention day by day and new projects are under planning and about to be implemented in various fields. Health sector partnerships are gaining more attention from the masses across the country. The new ideas like, Corporate Social Responsibility has lead to the better involvement of private sector in addressing the health needs of the society. The PPP projects have lead to the diminishing figure of private sector merely as "profit motive sector". The Public sector should adopt more welcoming and liberal terms and conditions for the building up of more and more health partnerships. There should be policy changes for creating better atmosphere for PPP. The call for focused researches on the partnership models in health is necessary. This will throw light to the gaps in these projects and helps in bridging them for public good.

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Challenges Faced by Parents of Children with Learning Disability

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ABSTRACT: Learning Disability is a neurological disorder and it affects an individual in such way that their brain works differently from others. Hence the processing that occurs in an individual's brain functions differently in people with Learning Disability. This can cause serious challenge to the individual and family physically, socially and emotionally. The study is of descriptive in nature and describes the various challenges faced by the parents of children with Learning Disability in all these aspects. The study is conducted among 65 parents of children with Learning Disability in Trivandrum.

Keywords: Disability, Learning Disability, Neurological disorder, Children with Disabilities, Parents Challenges

1. INTRODUCTION

"No other disabling condition affects so many people and yet has such a low public profile and low level of understanding as LD", Washington Summit 1994 (Reid L, et al., 1994).

Learning Disability is a neurological processing problem which affects an individual. It can be identified when the child starts his or her school life and now tends to be a challenge not only to an individual or family but for entire nation's development as the number seems to increase and without proper attention as such children may not be able to gain their fruitful future. The primary persons to understand and deliver proper attention and care are the parents and hence the challenges they face are also not minor.

A child with a difficulty in learning encounters many problems owing to the lack of understanding of the problem he or she faces. Owing to the many abilities and disabilities the child shows, parents are also confused about the accurate problem. Many parents suffer from a feeling of inadequacy when they discover that their child is disabled and many a times in case of Learning Disability, the parents do not discover or tend to fully understand the peculiar nature of the child's disability. In a society which places much importance and value on intelligence and which have a little toleration for any deviation from the cultural values Learning Disability is a big problem and it poses multi-dimensional challenges to parents. Parents do not tend to understand the fact that their child has Learning Disability and it is mainly because of the lack of awareness as they are often confused about the child's abilities and disabilities. Some of the challenges faced by parents are the shadows of some unidentified causes.

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Indian statistics show that at least 10% of the school going children in India suffers from Learning Disabilities (Times of India, Jan27 2012). This proves the importance of awareness about the problem for better facilities for such students. In the present situation many schools are not complying to the needs of such children. The number being increasing day by day it is essential for grooming a society that understands Learning Disability in reality.

2. Review of Literature

2.1 Definitions of Learning Disability

World Federation of Neurology

"A disorder manifested by difficulty in learning to read despite conventional instructions, adequate intelligence and socio-cultural opportunity. It is dependent upon fundamental cognitive disabilities which are frequently of constitutional origin"

The National Joint Committee on Learning Disabilities

"A heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading ,writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to Central Nervous System Dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g. sensory impairment, mental retardation, social and emotional disturbance) or environmental influences (e.g. cultural differences, insufficient/inappropriate instruction, psychogenic factors)it is not the direct result of those conditions or influences"

National Institute of Learning Disability

A Learning Disability is an area of weakness or inefficiency in brain function that significantly hinders our ability to learn or to function in life. It is a pattern of neurological dysfunction in the brain that causes a person to have difficulty correctly receiving information coming into the brain(perception), correctly processing that information once it is received (cognition/ thinking) or satisfactorily responding to the information once it has been processed(written and verbal expression, visual-motor coordination, memory etc.)

National Institute of Neurological Disorders and Stroke

Learning Disabilities are disorders that affect the ability to understand or use spoken or written language, do mathematical calculations, coordinate movements, or direct attention. Although Learning Disabilities occur in very young children, the disabilities are not usually recognized until the child reaches school age.

2.2 Types of Learning Disabilities

Dyslexia- It is the most common type of Learning Disability. Children with Dyslexia have a problem with language.

Dyscalculia- Children with Dyscalculia has a problem with mathematical operations.

Dysgraphia- Characterized by an inability to write properly.

Dyspraxia- problem in motor activities which leads to difficulty in learning.

2.3 Causes of Learning Disability

Learning Disability is caused by variety of reasons, none of which can be clearly outlined. Hereditary causes are an important factor. Other causes are Consumption of Alcohol or drugs by mother during pregnancy may affect the neurological development of the baby. Problems during

birth may also be responsible. Premature birth and nutritional deprivation are said to be other causes.

2.4 Family and Parental Problems

Roper (1999) states parents often think that it is better to struggle with the learning problems privately than to be branded with the stigma of being labeled as "Learning Disabled" as it may pose a great problem to children and adults and such attitude tempts the parents to delay seeking help for their child. Jeremy Turk(1996) stated that having a child with severe Learning Disability produces a number of challenges for the family: medical. Cognitive, Psychodynamic, educational and social. Jacques(2003) suggest the challenges faced in a family in the presence of a child with intellectual disability. They may often complain about the loss of a normal child. Morgan(1988), Kazak & Marvin (1984) says that siblings of a child with disability could feel that they are assigned more responsibility and receive less attention than siblings of normal children and this may lead to sibling rivalry.

2.5 Parental Coping Strategies

Corinne Smith and Lisa Strick (1999) speak of six strategies that parents can adopt for the academic success of their Learning Disabled Child.

- "Recognizing a learning problem that won't be out grown
- Designing an effective educational programme that targets a student's strengths.
- Negotiating effectively for what the child needs at school.
- Avoiding dead end practices that rob students of motivation and self esteem.
- Managing problem behaviors at home.
- Planning ahead for college and career."

3. Methodology

The study was conducted in four centers in Trivandrum ICCONS (Institute for Communicative and Cognitive Neuro Sciences), Vani Hearing Aid Centre, St. Mary's HSS, Pattom, Government Girls HSS, Pattom. The study is descriptive in nature as the researcher tries to describe the challenges faced by parents of children with Learning Disability in various aspects. Simple Random Sampling was used to select the sample and a well structured Questionnaire was administered to get the research findings. The primary source of data collection was the parents of children with Learning Disability in these centers. Data analysis was conducted using SPSS.

4. Analysis and Interpretations

4.1 Socio Economic Background of the families of Children with Learning Disability

63 % of the respondents belonged to Nuclear family and 53 % belonged to middle income group of annual income. It was found that with regard to age of diagnosis of the Learning Disability 96% of the respondents had identified their child's disability before 10 years where 50% of them had identified it in 2-5 years. Many psychologists recommend waiting until children are atleast 6years old before evaluating intelligence for more valid and reliable scores (Ann Logsdon 2010). But in this study 50 % of the parents diagnosed their child's disability before 6 years and it can be interpreted as Kerala society's uniqueness focusing more on child's education.

4.2 Cause of Learning Disability and its awareness among parents.

Majority of the respondents 76.7 % of the respondents were unaware of the cause of their child's Learning Disability. Other reasons stated were X-Ray exposure during pregnancy, bleeding during pregnancy, premature birth, Malnutrition, Mothers alcohol uses and Hereditary causes. The use of drugs and alcohol during pregnancy and complications such as low birth weight, lack of oxygen and premature or prolonged labor can cause brain damage and learning difficulties. Incidents after birth such as head injuries, nutritional deprivation or exposure to toxic substances just after birth can cause or contribute to Learning Disabilities (Brown,2003; Smith 2005). With regard to complication during child birth 43% had some complications while the other 43% did not have any complications at all during child birth. (Smith 2005) says that problems during birth may also be responsible for Learning Disability. In difficult deliveries the child may have to be delivered by forceps. This may damage the brain of the new born leading to learning difficulties. Premature Birth can also be a cause for Learning Disability.

4.3 Psycho socio and economic challenges faced by parents of children with Learning Disability.

Depression was felt by 36.7% of the parents on knowing the fact of their child's disability while 46 % of them accepted the reality which can prove to be good for their children. Jacques (2003) suggest that family reactions to intellectual disability are very variable but tend to follow a similar pattern. It is usual for the family to grieve the loss of the 'normal child' while at the same time having to come to terms with disability, both emotionally and practically. 66% of the parents feel they are somehow responsible for the cause of their child's disability. Barbara Cordoni (1987) states that one of the questions often asked by parents are whether the child has acquired this because of their sins. Is it a punishment for their sins. More than 60 % of the respondents receive support from their spouse to take care of their child, helps in training the child and provides emotional support.

The study shows that 60% of the parents do not hesitate to take their child to social functions and they provide support to their child, but the rest 40% has some difficulties in doing so. The sociological challenges were analyzed by including 10 statements of 3 point scale. The highest score was 22 and minimum score was 9. After categorization it was found that 53% of the respondents has low sociological challenges while for 30%, they faced high sociological challenges with regard to their child's condition. The reasons vary from the child's adjustment and achievements in school, child's interaction with other children in neighbourhood that proves to be a challenge to the parents. The economic challenges were also analyzed by including 10 statements of 3 point scale. The highest score was 24 and minimum score was 9. Only 6.7 % of the respondents experienced high economic challenge owing to their child. 26.7 % felt medium economic challenge. Economic challenges are experienced for the fact that children need special care and training to cater to their brain processing demands. Institutions like ICCONS, Vani Hearing Aid Centre, National Institute of Speech and Hearing provides special training for such children for which they charge an amount for each session. Hence the expense for the session, travel and accommodation can pose to be a challenge to the parents.

4.4 Attitude of the family members towards the Learning Disabled child.

60% of the parents reports of sibling rivalry. Morgan 1988, Kazak & Marvin 1984 says that siblings of a child with disability could feel that they receive less attention and that they have more responsibilities which may result in sibling rivalry. 40% of the respondents feel their child is isolated from others. Parents seem to express concern about the social isolation of their child. (Waggoner and Wilgosh, 1990). Teenagers with Learning Disability have shown to interact less with their peers and to spend more free time alone. (Martin and Carvallo, 2008). 53% of the respondents feel sympathy to the child.

5. Suggestions

The author tries to put forward the following suggestions as part of the study.

- Awareness about Learning Disability should be given at the school level in PTA meetings or special classes can be arranged for teachers and parents so that many students can be identified and the responsible persons can deal with such children in the required manner. Many a times the school does not seem to support such students and consider them to be not normal. Awareness should be created that such children are quite normal or extraordinarily talented; it is only in the processing difference that they appear to be different.
- Better awareness should be created among public about this disability as it is becoming common. The film "Tare Zameen Par" was a good initiative in this regard where stigma towards scholastically backward students was a bit reduced during that period.
- The Integrated Education Department (IED) established in some schools should be extended to all schools and special attention can be given exclusively for children with learning needs.

6. Conclusion

" If I can't learn the way you teach, teach me the way I can learn"- A child with Learning Disability.

The study on the Challenges faced by Parents of Children with Learning Disability is a study which tries to address a serious socio behavioural dimension of dealing with parenting of Learning Disabled child. The challenges faced by parents of children with Learning Disability are very high. There is wide scope for more studies in the area, a policy level intervention for Learning Disabled could lessen the burden for parents.

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Marital Adjustment and Marital Relationship among Indian Merchant Seamen

Nisha Paul[1]

ABSTRACT: Marriage is a society approved way of establishing a family of procreation. Its purposes, functions and forms may differ from society to society, but it is present everywhere as an institution (Jeejan, J, 2003). The quality of marital adjustment is a crucial factor in marital relationships. Work nature of merchant seamen is full of dangerous living conditions and unbearable working conditions Other than that they have to stay away from their family for long period. It results in less quality time with their families. In this study researcher descriptive research design has been adopted for the study and probability sampling method has been used to select the respondents of the study to understand the marital relationship and marital adjustment among the Indian merchant seamen.

Keywords: Indian Merchant Seamen, Marital relationships, Marital adjustments, Marriage

1. INTRODUCTION

In marital relationship alone two human beings enter in to a complete physical, mental and spiritual union with each other. Marriage is a universal institution where the qualities of love, devotion, co-operation and sacrifice are found. It is established by the human society to control and regulate the sex life of man. It is closely connected with the institution of family. In fact, family and marriage are complementary to each other.

We can say that the marriages are celebrated with happiness and begin with high hopes and expectations. It is glorious in the beginning. But this romantic view soon begins to clash with realities. However all marriages pass through the phase of sweet and sour experiences. Partners have to make adjustment. More they are prepared for adjustment better will be the quality of marital life. Good relationship would not come as a result of love alone. It has to be accomplished couples and families should be more realistic about the challenges of living together and cooperating in all areas of life.

Marital Adjustment is the adjustment in the marital life that has many dimensions- adjustment with husband, in-laws, and peers. In all society, marriage is not only the union of two individuals, but it is the union of two family two traditions, two culture etc. So adjustment or coping and getting adapted to married life are more important. Marital adjustment is necessary in child rearing and as the parent is first person to socialize child. The child gets the first lesson of co-operation, tolerance, self-confidence from the family (Mittal and Muktha, 1995).

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Marital quality is defined as how good the marriage is according to the spouse at given point of time. Marriages in which partners say they are happy and satisfied are judged to be higher quality than those marriages in which partners express unhappiness or dissatisfaction. After marriage, couples that emphasize or develop shared personal traits, a common value system, shared leisure activities and joint friends generally have high quality marriages (Tulsi, 2005).
The merchant marine is that part of the maritime trade industry concerned with transporting cargo (and sometimes passengers) from place to place via water routes; it is also known as the commercial shipping industry. Workers on these ships are divided into three crews: the deck crew, which handles navigation and cargo operations, the engine crew, which oversees the generating system that propels the ship, and the steward department, which sees to meals and living quarters. Each crew is commanded by a designated officer. Contrary to what many people think, working in the merchant marine doesn't mean that you sign up for duty in the navy or other military force. The merchant marine is a private industry, although vessels may be obligated to help the military in times of war (Peter, N, 1991).

Merchant mariners usually share their living areas with other crew members. While at sea, they are exposed to all kinds of weather, often cold and damp conditions. Most mid- and lower-ranking workers must stand watch for four hours at a time. Also, fire, collision, and sinking are all possible, so workers must be physically and psychologically prepared for such hazards (Res, H, 1991).

Merchant mariners are away from home for extended periods, but earn long leaves. Most are hired for one voyage, with no job security after that. At sea, they usually stand watch for 4 hours and are off for 8 hours, 7 days a week. Those employed on Great Lakes ships work 60 days and have 30 days off, but do not work in the winter when the lakes are frozen over. Workers on rivers and canals and in harbors are more likely to have year-round work. Some work 8- or 12-hour shifts and go home every day. Others work steadily for a week or month and then have an extended period off. When working, they are usually on duty for 6 or 12 hours and are off for 6 or 12 hours (Mathew, K.T, 2010).

So we can say the job of merchant seamen is a profession which faces dangerous living conditions and unbearable working conditions. Apart from this it makes their family life in problem. A merchant seaman is away from home for long period in this period it is difficult for them even to communicate with family because it depend on weather and job condition. In rough sea only way to communicate is through satellite system it is costly and depends on fluctuations in weather. So in this sea life a person is has to face difficulty in their role as a parent, a partner, an in law etc. This profession faces dangerous attrition rate, studies says that fear of family destruction is the reason for high attrition rate.

Marriage and family is a universal institution and it contains its sweet and sour period. Depends on every stages of life it undergoes fluctuations so that it could withstand the storm and calm weather. In merchant mariners profession role of marital adjustment is very important for better quality of life. Because here an absent parent, partner, in-law, child is supplementing his role, in

this dilemma the support of wife children, parents, in-laws, friends etc is very much necessary. In this study researcher is trying to learn about the marital quality and marital adjustment of Indian merchant seamen.

2. Method

2.1 Statement of Problem

In choosing a marriage partner, both men and women are guided to some extend by a concept of an ideal mate built up during adolescence. The more the individual must readjust with reality, the more difficult the adjustment to the mate will be marital adjustment is one of the most difficult adjustment young adults must make. During the early years of marriage, the couple normally must make major adjustment to each other, to members of their families, their friends. While these adjustments are being made, there are often emotional tensions and thus it is a stormy period. After adjusting to each other, their families, and friends, they must adjust to parenthood. This increases the adjustment problems if it comes while the earlier adjustments are being made. There are many areas where adjustability is required. The chief areas are economics, in-law relationship, social activities, recreation, associating with friends, religious life and training and discipline children. All the couples face problems in these areas. The couples that are happy have met the problems, with in these areas. Their marriages are successful because they have accepted the task of adjusting to each other's view point. They have arrived at the working arrangements.

Marital adjustment as long is in a popular topic in studies of family, probably because the concept is believed to be closely related to the stability of a given marriage. The marital adjustment is not only the merging of two different personalities. For the peaceful marital life both couples should be bound on these areas of adjustability. But due to many reasons like job nature, economic problem, stressful life situation, etc many couples fails to fulfill these requirements in marital life. The merchant seamen come under this category due to their job nature. In seamen carrier, they are both continuous and fractured and often step out of step with lives at home. The impact of routine absence on couple and family relations identify how work patterns and extended absence lead to temporal desynchronize and fragmentation of the life course. This lack of temporal harmony posed a challenge to family relations. A seamen carrier and a stable family life are seemingly in compatible consequently, many seamen either for sake of family life abandon life at sea, for normal pattern of family life. Disruption of normal home life and marital harmony are cited as the major causes of high attrition rate among merchant seamen. A merchant seaman has many limitations in the marital life due to the nature of job. The earlier period where they are mostly required by presence they are absent. It creates in problems in mate adjustment, in law adjustment, financial adjustment etc. It develops as the time moves. Majority seamen leave the job after ten years of experience for the sake of family. Therefore these factors set forwarded for the present study

2.2 Scope of Study

The Merchant seamen are a working group, differing from other vocations due to their peculiarities in job nature itself. This job nature has its consequence in their relations and

obligations as a member of family. But this group is away from the attention of all researches. Even though the Seamen in all aspects have many identified and unidentified needs and problems they are not yet considered by shipping companies and outer world. The major scope of my study is that there were no much previous studies conducted in this field.

The shipping field which is one of the oldest carriers from decades is now facing many problems; less experienced staff because as compared with other professions there is large amount of job withdrawal after initial years of carrier. It results consumption of time, money of shipping company in training, new recruitments and occurrence of accidents due to less experienced staff. This also results in the decline of the professional quality and development. The increasing number of divorce cases is also reported among seamen also a challenge to this profession. The shipping companies are still unnoticed about these facts. This study will be a notice to the knowledge of governmental bodies and shipping companies about these realities and to maintain the efficiency and commitment of their staff by considering their health, marital life and their duties to home and society.

2.3 The Area of the Study

The universe of study is Indian merchant seamen working in foreign ships operating from Mumbai with special reference to Pensiluar & Oriental shipping company, which has its home port in Southampton, United Kingdom. This shipping Company is mainly focused on cruise lining. There is almost 1100 crew members belong to different nationalities working in a vessel. In this 400 Indian crew is there and among them 250 are married. The researcher is focusing on the marital adjustment of the Indian Merchant Seamen

2.4 Objectives of study

The general objective of the study is to understand the marital adjustment of Indian merchant seamen working in foreign ships. The specific objectives are as the following:

- To study about the financial management among couples.
- To study about in-law relation in family.
- To study about the role of physical proximity in marital adjustment.
- To study about the emotional attachment and mutual understanding for the familial wellbeing
- To study about child rearing and mutual understanding.

2.5 Research Design

A descriptive research design is used because the researcher is trying to describe the marital adjustment of seamen community and how it differs from individual to. Study wants to portray the characteristics of a group. As the descriptive research design, describes the different factors in marital adjustment in relation with merchant seamen.

2.6 Sampling

Probability sampling is used. In this simple random sampling is used. The respondents' are picked up from Indian merchant seamen working in foreign ships. The sampling size is 100 respondents.

2.8 Method and Tools of Data Collection

The data collection is based on primary method and secondary method. In primary method data is collected through questionnaire the researcher collects data from the Indian merchant seamen working in foreign ships. And in secondary method data is collected through books, journals, articles, newspaper, and internet.

3. **Results and Discussion**

In general the merchant seaman has good marital adjustment and has joint financial management and they have well in law adjustment, they respect each other's family members. The merchant seaman considers home management and responsibility to children as a joint responsibility. The emotional attachment even though in the absence of seamen in family is good

- More than half (56) of the merchant seamen has good Marital adjustment and just above one fourth (26) has very good marital adjustment.
- In age of the respondents, it is clearly stated that in merchant seamen 78 % belong to early adulthood. There is a tremendous decrease in merchant seamen in late adulthood it shows the quitting of job by large numbers.
- It is found that most of the population belongs to newly married group .About 47 % belong to this group. And there only two percentage of population who has marital years more than 16 years. It is founded that it is for the sake of family life the seamen is quitting the job, because as the number of years in marital life increases there the number of job quitting merchant seamen increases
- More than half of merchant seamen (58%) have shipping working contract with in three to six months.
- 60 % of merchant seamen have less than ten years of experience in shipping field. Most of them resign the job before retirement. A seaman wants to be in job for ten to fifteen years.
- One of the major finding is that most of the merchant seamen (61%) belong to low income group that is about majority of population has below one lakh salary.
- It is founded that physical proximity is highly mentioned in the study. Even though the seamen away from home utilize maximum to be joined together. Majority(90%) of the respondents said they are fully enjoying and satisfied in sex
- 84% of seamen's In-law relation is good. And it is founded that in-law relation is good in joint family than those seamen belong to nuclear family. The seamen and family is more joined with in-laws in joint family.
- It is founded that financial management is a joint responsibility of couples in seamen family. More than half (54%) of respondents opted that they are worried about family expenditure.
- Emotional attachment and mutual understanding is high among the seamen couples. Because of their absence in home their understanding to partner is high.82 % opted that they feel miserable in the absence of each other.
- 88 % Merchant seamen consider looking after children and number of children should have is a joint responsibility and joint decision.
- Majority (82%) of merchant seamen believes in family planning.

- In merchant seamen respondents in early adulthood had founded more sexual satisfaction than other age group.
- It is founded from study that there is significant relation between income and mutual understanding of couples. With high income mutual understanding is also high.
- It is founded that the seamen who have three to six months duration of shipping contract are less involved in family responsibility than the seamen with more than six months working contract.
- In the study it is founded that with the increase in age there is increase in mutual understanding in sex.
- In the study it says that mutual confidence and trust is more on newly married seamen than on others.

The above mentioned findings carry the inter relational variables involvements in marital adjustment of Indian merchant seamen in foreign ships. The financial management among couples, In-law relation in the family, role of children, physical proximity, emotional attachment and mutual understanding play an important role in study.

Most young people enter in to marriage convinced that they are already well adjusted and they will not have the difficulties in getting along with each other. Adjusting is a conscious deliberate learning process to understand accept and change. In marriage, there is always some tension because marriages involve the relationship of two persons of opposite sex. When there is continuous and never ending process In marital relationship alone, two human beings enter in to a complete physical, mental spiritual union with each other. Marriage is a universal institution where the qualities of love, devotion, cooperation, sacrifice are found

4. Conclusion

The marital adjustment and marital quality is similar to each other in various aspects. In marital relationship alone two human beings enter in to a complete physical, mental and spiritual union with each other. Marriage is a universal institution where the qualities of love, devotion, co-operation and sacrifice are found. It is established by the human society to control and regulate the sex life of man. It is closely connected with the institution of family. In fact, family and marriage are complementary to each other. For a seafaring carrier had to face routine absence from home, lack of communication etc .The marital adjustment meant the integration of the couple in a union in which the two personalities are not merely merged, or submerged, but interact to complement each other for mutual satisfaction and achievement of common. The Marital Adjustment has its base on emotional attachment and the absence of couples does not have an effect on marital quality. There are many areas where adjustability is required. The chief areas are economics, in-law relationship, social activities, recreation, associating with friends, religious life and training and discipline children. All the couples face problems in these areas. The couples that are happy have met the problems, with in these areas. Their marriages are successful because they have accepted the task of adjusting to each other's view point even if they are able to be with each for short period. They have arrived at the working arrangements.

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