UNIVERSITY OF DELHI

Certificate № 17062

STATEMENT OF MARKS

Name of the Candidate Mansim D/o Rajender Kumar Roll No 12502

B.A. (Hons.) Part I/II/III (I/II/III Year (Simultaneous) Examination and Examination in Subsidiary Subjects 200 0
(Annual/ Supplementary)

	Paper / Max. Marks	I 100	II 100	III 100	IV 100	V 100	VI 100	VII 100	VIII 100	IX 100	X 100	XI 100	XII 100	XIII 100	PL	REMARKS
Social Work		28	17	60	63	—										Aggregate of :
	Max. Marks	50	50	50	50	50	50	50	50	50	50	100	100	100		Part – I 168/300
																Part – II Passed
Geography/Economics																Part/ III

M.I.L. or Subject in lieu			English – A		Subsidiary Subjects "Marks in Internal Assessment"												
Subject	Marks 100	Result	Marks 100	Result	Subject	I 100	II 100	III 100	Total 200	Result	Subject	I 100	II 100	Total 200	Result		Grand Total :
HA	56	Passed	47	Passed	—												

Dated 19 JUL 2011

Prepared by :	Checked by :

Controller of Examinations/
Section Officer

UNIVERSITY OF DELHI

Certificate No. 2001

STATEMENT OF MARKS

Name of the Candidate Manju D/o Rajender Kumar Roll No 30472

B.A. (Hons.) Part I/II/III (I/II/III Year (Simultaneous) Examination and Examination in Subsidiary Subjects 2001
(Annual/~~Supplementary~~)

	Paper / Max. Marks	I 100	II 100	III 100	IV 100	V ~~100~~ 50	VI 100	VII 100	VIII 200 F.W	IX 100	X 100	XI 100	XII 100	XIII 100	PL	REMARKS
Social work		—	—	—	62	28	47	50	155	—						Aggregate of
	Max. Marks	50	50	50	50	50	50	50	50	50	50	100	100	100		Part —I /
Geography/Economics																Part —II 342/550
M.I.L. or Subject in lieu		English			Subsidiary Subjects "Marks in Internal Assessment"											Part III Passed
Subject	Marks 100	Result	Marks 100	Result	Subject	I 100	II 100	III 100	Total 200	Result	Subject	I 100	II 100	Total 200	Result	Grand Total
—	—	—	—	—	Soc	54	44	—	98	Passed	—				—	

Dated 12/7/2001

Prepared by :	Checked by :
HNB	V /

Controller of Examinations/
Section Officer

UNIVERSITY OF DELHI

Certificate No. 1178

STATEMENT OF MARKS

Name of the Candidate Manju D/o Rajender Kumar Roll No. 286768

B.A. (Hons.) Part I/II/III (I/II/III Year (Simultaneous) Examination and Examination in Subsidiary Subjects (Annual/Supplementary) 2002

	Paper	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	PL	REMARKS
	Max. Marks	100	100	100	100	100	100	100	100	~~100~~ 50	100	100	~~100~~ 25	~~200~~ 100 Fail		
Social Work.									60	34	57	55	35	150	-	Aggregate of :
	Max. Marks	50	50	50	50	50	50	50	50	50	50	100	100	100		Part –I 168/300
Geography/Economics																Part –II 342/550

M.I.L. or Subject in lieu			English		Subsidiary Subjects "Marks in Internal Assessment"												Part III 391/625
Subject	Marks 100	Result	Marks 100	Result	Subject	I 100	II 100	III 100	Total 200	Result	Subject	I 100	II 100	Total 200	Result		Grand Total : 901/1475
																	Passed

Dated 18 JUN 2002

Prepared by :	Checked by :

Controller of Examinations/
Section Officer

Enrol. No. AV-222/99

Roll No. 286768

University of Delhi

BACHELOR OF ARTS (HONOURS COURSE), 2002.

This is to certify that Manjula D/o Rajender Kumar having been examined in 2002, and found qualified for the degree of Bachelor of Arts (Honours Course) (10+2+3 Scheme) was admitted to the said degree at the Convocation held in 2003.

Subject Social Work

Division First

Registrar,
University of Delhi

Delhi, dated the 22nd February, 2003

Vice-Chancellor,
University of Delhi

देवीअहिल्या विश्वविद्यालय इन्दौर

अंक-सूची

M.A.PRE. SOCIAL WORK MAR-APR 03
ROLLNO.- 9096 KUM. MANJU

DA/02/36677 F/H RAJENDRA KUMAR S.NO. 32
REGULAR INDORE SCHOOL OF SOCIAL WORK, INDORE

विषय	अंक योजना प्रथम	द्वितीय	तृतीय	उत्तीर्णांक	पूर्णांक	प्राप्तांक प्रथम	द्वितीय	तृतीय	योग
INTRODUCTION TO SOCIAL WELFARE	100	...	..	036	100	060	...	...	060
INDIAN SOCIETY AND SOCIAL PROBLEMS	100	...	..	036	100	054	...	...	054
HUMAN GROWTH AND BEHAVIOUR	100	...	..	036	100	087	...	...	087
SOCIAL WORK RESEARCH AND STATISTICS	80	...	..	029	080	037	...	...	037
PRACTICAL NOTE-BOOK O R ELE.COMPUTER	20	...	..	007	020	018	...	...	018
SOCIAL WORK WITH INDI VIDUALS & GRP.	100	...	..	036	100	059	...	...	059
SOCIAL WORK PRACTICUM	100	...	..	036	100	070	...	...	070

	600	योग	385

प्रथम वर्ष		द्वितीय वर्ष		तृतीय वर्ष		कुल योग		परिणाम	श्रेणी	प्रयास
प्राप्तांक	पूर्णांक	प्राप्तांक	पूर्णांक	प्राप्तांक	पूर्णांक	प्राप्तांक	पूर्णांक			
								PASS		1

THREE HUNDRED EIGHTY FIVE OUT OF 600
DATE OF RESULT 09-06-2003 130235036

M.K. Tiwari

विश्वविद्यालय भवन, इन्दौर-४५२००१ परीक्षाओं-प्रति कुल सचिव

देवीअहिल्या विश्वविद्यालय इन्दौर

अंक-सूची

402274

M.A.FINAL SOCIAL WORK FEB-MAR 04
ROLLNO.- 18283 KUM. MANJU

DA/02/36677 F/H RAJENDER KUMAR S.NO. 30
REGULAR INDORE SCHOOL OF SOCIAL WORK, INDORE

विषय	अंक योजना प्रथम	द्वितीय	तृतीय	उत्तीर्णांक	पूर्णांक	प्राप्तांक प्रथम	द्वितीय	तृतीय	योग
SOCIAL POLICY AND ADMINISTRATION	100	...	..	036	100	060	...	...	060
SOCIAL DEVELOPMENT	100	...	..	036	100	065	...	...	065
SOCIAL WORK WITH COMMUNITIES	100	...	..	036	100	064	...	...	064
MEDICAL & PSYCHIATRIC INFORMATION	100	...	..	036	100	061	...	...	061
SOC.WORK IN MEDICAL& PSYCHAIATRIC SETTING	100	...	..	036	100	069	...	...	069
ESSAY IN SOCIAL WORK	100	...	..	036	100	060	...	...	060
SOCIAL WORK (PRATICAL)	100	...	..	036	100	072	...	...	072
					700	योग			451

प्रथम वर्ष		द्वितीय वर्ष		तृतीय वर्ष		कुल योग		परिणाम	श्रेणी	प्रवास
प्राप्तांक	पूर्णांक	प्राप्तांक	पूर्णांक	प्राप्तांक	पूर्णांक	प्राप्तांक	पूर्णांक			
385	600	451	700			836	1300	PASS	FIRST	1

EIGHT HUNDRED THIRTY SIX OUT OF 1300
DATE OF RESULT 22-05-2004 139524040

विश्वविद्यालय भवन, इन्दौर-४५२००१ परिक्षार्थी-प्रति कुल सचिव

Roll No. 18283.

ENGLISH TRANSLATION

FORMERLY KNOWN AS UNIVERSITY OF INDORE, INDORE

DEVI AHILYA VISHWAVIDYALAYA, INDORE

Master of Arts

Certified that Ku. Manju

obtained the Degree of MASTER OF ARTS in this University at the Examination held in Feb-Mar. 2004 **and was placed in the** First **Division.**

Name of the Institution:- Indore School of Social Work, Indore
(In the case of a regular candidate)

The subject in which he/she was examined was :
Social Work.

Dated May 22, 2004

Vice-Chancellor

DEPARTMENT OF SOCIAL WORK
(DELHI SCHOOL OF SOCIAL WORK)
UNIVERSITY OF DELHI

P/2005-06/1945

Dated: 10.1.06

M.Phil in Social Work – Part-I: Annual Examination – 2005-06

Statement of Marks

Name of the student: Ms. Manju

	Paper				
	I	II	III	IV	Total
Max. Marks	100	100	100	100	400
Marks obtained	62	54	60	66	242

Paper I : Research Methods in Social Work & Statistics
Paper II : Review of Studies in Social Work
Paper III : Social Development & Welfare
Paper IV : Health & Social Work

S Tandon
HEAD
Department of Social Work
University of Delhi

3, University Road, Delhi - 110007, India Telefax: 27667233, Telephone: 27667881, 27667147, Telegram: SOCIWORK, E-mail: dssw@vsnl.co

UNIVERSITY OF DELHI

Certificate No. 878

STATEMENT OF MARKS

Name of the Candidate Manju Roll No. 145

M. Phil Examination in Social work Year 2006

Part-I (Written Courses)	MARKS	RESULT
paper I	62/100	
II	54/100	
III	60/100	
IV	66/100	
Total	242/400	
Part II (Dissertation & Viva-Voce)	185/300	

Total Part I 242/400

Total Part II 185/300

Grand Total 427/700

passed

Prepared by	Checked by

Dated 19-4-2007

Controller of Examinations/
Section Officer

Enrol. No. AV-222/99 Roll No. 145

University of Delhi

निष्ठा धृतिः सत्यम्

MASTER OF PHILOSOPHY, 2006

This is to certify that Manju

having been examined in 2006, and found qualified for the degree of Master of Philosophy was admitted to the said degree at the Convocation held in 2008 .

Subject Social Work

Division First

दिल्ली विश्वविद्यालय * UNIVERSITY OF DELHI * निष्ठा धृतिः सत्यम्

Registrar,
University of Delhi

Delhi, dated the 23rd February, 2008

Vice-Chancellor,
University of Delhi

नामांकन संख्या AV-222/99
Enrol. No.

दिल्ली विश्वविद्यालय

UNIVERSITY OF DELHI

प्रमाणित किया जाता है कि जनवरी, 2013 में शोध प्रबंध स्वीकृत हो जाने के उपरांत

मंजु

को 2013 के दीक्षांत समारोह में दिल्ली विश्वविद्यालय की विद्या-वाचस्पति की उपाधि प्रदान की गई।

विभाग समाज कार्य

This is to certify that *on approval of the thesis in January 2013* Manju *qualified for the degree of Doctor of Philosophy (Ph.D.) of this University. The said degree was conferred upon him/her at the Convocation held in 2013*

Department Social Work

Alka Sharma

कुलसचिव
दिल्ली विश्वविद्यालय

D.S.A

कुलपति
दिल्ली विश्वविद्यालय

UNIVERSITY OF DELHI
दिल्ली विश्वविद्यालय

DAA/29/February 2023

Certificate for Compliance of Ph.D. Degree with UGC Regulation 2009/2016

It is verified that **Dr. Manju,** who was a Ph.D. student in the **Department of Social Work, Faculty of Social Sciences,** University of Delhi has been awarded Ph.D. degree and has complied with UGC Regulations 2009/2016 as per the following criteria:

1. Candidate has completed Coursework including Research Methodology paper
2. Ph.D. degree of the candidate awarded in regular mode only
3. Evaluation of the Ph.D. thesis by at least two external examiners
4. Open Ph.D. viva voce of the candidate has been conducted
5. Candidate has published one research paper from his/her Ph.D. work in a refereed journal
6. Candidate has made at least two presentations in conference/seminars, based on his/her Ph.D. work.

Date: 20/02/2023

(K. Ratnabali)
Dean, Academic Affairs

अधिष्ठाता, शैक्षणिक कार्य
Dean, Academic Affairs
दिल्ली विश्वविद्यालय / University of Delhi
दिल्ली–110007 / Delhi-110007

Certificate No. : A 027243

University Grants Commission

NATIONAL EDUCATIONAL TESTING BUREAU

ज्ञान-विज्ञान विमुक्तये

NATIONAL ELIGIBILITY TEST FOR LECTURESHIP

UGC Ref. No. : 1256/(NET-JUNE, 2004) Roll No. R173002

Certified that MS. MANJU

Son/Daughter of SHRI RAJENDER KUMAR

and SMT KAMLA

has qualified the UGC-NET Examination for eligibility for Lectureship held on 20th JUNE, 2004 in the Subject SOCIAL WORK.

His/Her Post-graduation Subject is SOCIAL WORK

Validity of the certificate is forever.

Head
NET Bureau

Date of Issue: 11 MAR 2005

Note: a) UGC has issued the certificate based on the information provided by the candidate and his/her records/certificates have not been verified. The appointing authority should verify the original records/certificates of the candidate while considering him/her for appointment, as the Commission is not responsible for the same. The candidate must complete UGC specified Master's Degree within one year of date of UGC-NET.

b) Wherever SC, ST, PH or VH is shown in the UGC Ref. No., the recruitment body should check the relevant documents of Scheduled Caste/Scheduled Tribe/Physically Handicapped/Visually Handicapped Candidates before appointment.

PREPARED BY :	
CHECKED BY :	
VERIFIED BY :	

Certificate No. : A 027243

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Contents

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UTILIZATION OF REPRODUCTIVE HEALTH SERVICES BY WOMEN LIVING IN SLUMS

Dr. Manju Goel[1] *and Dr. Sunita Bahmani*[2]

Abstract: The study on utilization of reproductive health services by the women in slums of Delhi made an effort to scientifically present the detailed account of the level of knowledge and attitude of the women regarding reproductive health issues, and identify the barriers to reproductive health service use among women in slums. The paper also highlighted the existing reproductive health care service delivery system under the government hospital. The study found that there is a lack of knowledge among women regarding various reproductive health issues. Women's reproductive health is inextricably woven with social and cultural factors that influence all aspects of their life, and it has consequences not only for the women themselves but also for the well being of their family. This study would help the social workers in understanding the issues related to the pattern of service utilization in the area of reproductive health.

Key words: *reproductive health, women, health services*

INTRODUCTION

Women face reproductive morbidity and mortality due to complications of pregnancy, childbirth, unsafe abortions, reproductive tract infections, sexually transmitted infections, effects of harmful contraceptives. The foundations for the reproductive health of women are laid in childhood and adolescence, and are influenced by many factors such as poor nutrition, low level of education or illiteracy, poverty, unhygienic living conditions and several socio-cultural taboos. All the above mentioned factors cause reproductive health problems and a 'culture of silence', due to which women found themselves unable to demand for reproductive health information and services. Underlying poor reproductive health among Indian women is their poor overall status on the one hand and an inadequate delivery system to cater to the needs of secluded, shy and devalued women on the other. Fully achieving the Millennium Development Goal 5 (hence forth refer to as MDG 5) target of reducing by three quarters, between 1990 and 2015, the maternal mortality ratio remains a challenging task; it is the area of least progress among all the MDGs.

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2. Associate Professor, Aditi Mahavidyalaya, University of Delhi, Bawana, New Delhi. E-mail: sbahmani@aditi.du.ac.in (Corresponding Author)

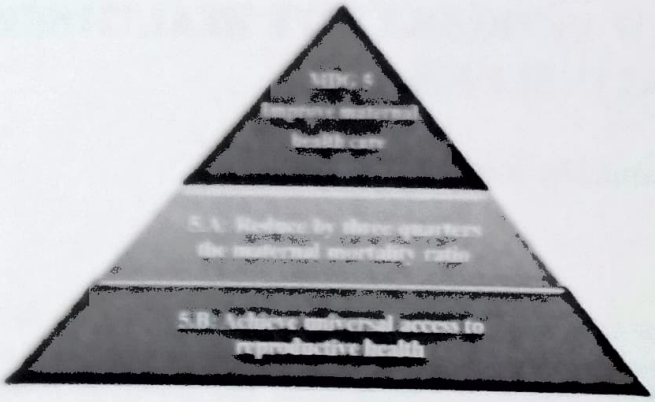

Figure 1: Millennium Development Goal 5

The International Conference on Population and Development (ICPD) Programme of Action (PoA) offered a starting point for MDG 5, as its Chapter VIII gives specific recommendations on how to narrow the gap between 1990 MMRs and the 2015 Targets. These include the promotion of prenatal care, postnatal care, childbirth care, maternal nutrition programmes, adequate delivery assistance, obstetric emergencies, attention to abortion complications, and family-planning services (IISD, 1999).

According to United Nations (2013 a),

- **Maternal mortality has nearly halved since 1990.**
- **Nearly 50 million babies worldwide are delivered without skilled care.**
- The maternal mortality ratio in developing regions is still 15 times higher than in the developed regions.
- **The rural-urban gap in skilled care during childbirth has narrowed.**
- **More women are receiving antenatal care.**
- In developing regions, antenatal care increased from 63 per cent in 1990 to 81 per cent in 2011.
- **The large increase in contraceptive use in the 1990s was not matched in the 2000s. The need for family planning is slowly being met for more women, but demand is increasing at a rapid pace.**

Figure 2: Facts sheet on Millennium Development Goal 5

Measuring progress on Millennium Development Goal 5 on maternal health requires measuring the Maternal Mortality Ratio (MMR), which is indispensable, but difficult to measure accurately, and often unreliable. As the deaths from childbirth not attended by health care staff are often not reported, and women who return home from a hospital or health centre and die or fall ill later from complications are often not represented in national statistics. While the Millennium Development Goals are focused on developing countries, it is important to keep in mind that preventable maternal morbidity and mortality also affects specific, often marginalized, populations in developed nations (United Nations, 2013 b). In many situations women is considered marginalized, for women living in slum, there are added risks, lack of awareness about hygiene, low levels of education, low social status, and the stigma about gynecological problems may result

not only in higher actual morbidity, but also lower treatment rates when sick, thereby resulting in a greater effective burden of ill health among women.

Reproductive health issues includes pregnancy, child birth and post partum care, breast feeding, maternal and infant nutrition, infertility services, sexual behavior, Reproductive Tract Infections/ Sexually Transmitted Infections (hence forth refer to as RTIs / STIs) and Human Immuno-deficiency Virus/ Acquired Immune Deficiency Syndrome (hence forth refer to as HIV/AIDS) services, reproductive rights and freedom and women's status and empowerment. There is an increasing thinking in the scientific community about the need to give stress on maternal health, in essence their reproductive health problems. The Reproductive and Child Health (RCH) program aims at integrating all interventions of fertility regulation and maternal and child health with reproductive health of both men and women. Although the reproductive health concept is not new, as the programs related to women's health did exist before, but they were available as vertical programs namely, Family Planning Program, Mother Health Care program (as a part of Family Welfare Program), TT immunization Program (part of Immunization Program) , Dais Training Program...etc. In 1992 the Child survival and Safe Motherhood Program integrated all the schemes for better compliance. The component of this program are early registration of pregnancy, to provide minimum three antenatal check- ups, universal coverage of all pregnant women with TT immunization, advice on food , nutrition, and rest, detection of high risk pregnancies and prompt referral, clean deliveries by trained personnel, birth spacing, and promotion of institutional deliveries. The current Reproductive and Child Health Program (RCH) has integrated these services and the major interventions which are obstetric care, Medical Termination of Pregnancy and Prevention of RTIs and STIs.

The success of a health system rests on ensuring that health facilities, goods, and services are available, accessible, acceptable, and of good quality on a non-discriminatory basis. MDG 5 does not explicitly capture the importance of expanding and strengthening health systems, and addressing women's rights and empowerment and gender equality as critical components of progress. Overlooking discriminatory practices and the importance of placing special focus on the needs of rural, poor, migrant, and displaced populations has been a blockage to progress on improving maternal health. Maternal and child health (MCH) centers are functioning to cater to the needs of slum dwellers in Delhi. The main strategy of this project are as follows: increase MCH services, improve the quality of MCH services through training of health staff, mothers and other women groups, improve utilization of services by generating community participation, and improve socioeconomic status of women. In urban areas, municipal health departments are mainly responsible for providing preventive and curative health services. The activities of MCH have been run by Municipal Corporation of Delhi.

There are multiple slum clusters in Delhi (approximately 1080 slums cluster spread over eight zones) (Sundar and Sharma, 2002) with localized communities where most of the women are illiterate, and dependent on their husband for their health related decision making. The slum population in Delhi city is growing very fast. While no

reliable recent estimate of slum population in the city is available, it is estimated that about one- fifth of the city's population lives in slums. In the absence of an adequate health care system, the women in slums continue to suffer. There is a need to understand the health problems affecting this group of people and to know their treatment patterns for the same so as to design more appropriate and sensitive health services. It has been noticed that women frequently lack understanding of the dangers of pregnancy to the health of both mother and the child. Reproductive health needs of the women are poorly understood and ill served and little information available in terms of the slum women's reproductive health needs and problems.

In this context, the researcher had taken the initiative to carry out descriptive study to look after the women's reproductive health issues in an urban slum of Delhi, including the knowledge, attitude and the context within which they arise and also identified the barriers to reproductive health use among women in urban slum area. The study also highlighted the existing reproductive health care structure, process and services provided by a government hospital.

METHODOLOGY:

In order to accomplish the objective of the study, approach to triangulation of both qualitative and quantitative research methods was adopted. The design of the study was descriptive. Area of the study was Shalimar Bagh slums, Delhi. There were six slums in the Shalimar Bagh locality. Health care services were provided by Maternal and Child Health Centre. Respondents of the study were women in the reproductive age group (15-45 yrs) and health care providers available at maternal and child health centre. Non- probability method of purposive sampling has been used to select the community. Women were selected by using probability method of stratified random sampling. To select a Sample size of 60 women in the reproductive age group (15-45 years), the researcher stratified the women in the three groups on the basis of age: 15-25 years, 25-35 years, and 35-45 years. The source list of each slum population were obtained from the survey records of Auxiliary Nurse Midwives (ANMs) and authenticity of data have been checked through electoral rolls for each constituency. The researcher then prepared lists of women in the reproductive age group. The list comprised with total population size i.e. 1127 women in the age group of 15-45 years. Then a proportionate random sample of 20 women was selected from within each stratum. Four groups of women were selected for the purpose of focus group discussions using non- probability method of purposive sampling. 17 health care providers were selected using non-probability method of purposive sampling. The data was collected using Interview schedule and focus group discussion schedule with the women and interview guide with the health care providers. Secondary data was also collected through internal as well external sources. Both qualitative and quantitative analysis of data has been done.

FINDINGS

The research talked about the women living in the slum or the disadvantaged group

of the urban population who have little or no access to organized health care services provided by government hospitals and health centers where outreach services of the government institutions are inadequate to meet the needs of the slum women. The respondents (women) of the study mainly belonged to the Hindu (53) and Muslim community. Average monthly income of household was reported to be Rs.2937.40/-. Three-fourth of the women were housewives. Many of the women (38) were illiterate, and some of them (12) attained the primary level of education.

Antenatal Care: Women get antenatal care services either by visiting health care facilities or during community visits made by the health workers. Many of the women (26) did not utilize antenatal care, among those who have utilized (34) these services some of them (15) received it during community visits made by Auxiliary Nurse Midwives (ANM). Women who were not using antenatal care (ANC) services in slums reported that they did not perceive antenatal care to be beneficial to their health, or the health of their unborn child.

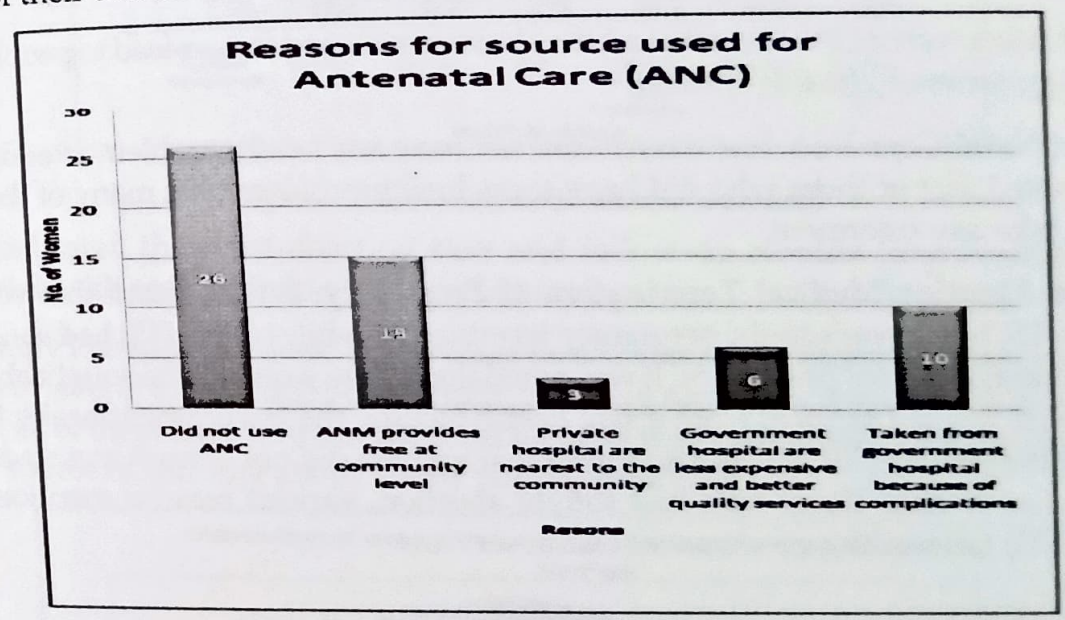

Figure 3: Reasons for source used for accessing Antenatal Care

Respondents indicated that as pregnancy is a natural state there was no need to seek medical care and that such care should only be sought if an obvious problem arises. The common reasons cited for not using ANC services were lack of awareness regarding availability of health care facility, not been allowed to visit hospital by family members, or because they were planning to go to their native place for their delivery. Among those who have utilized ANC services (34), 21 respondents preferred government health care facility and reasons cited were that they were less expensive and better quality of services, was provided free at community level. The main reason reported by women (3) for choosing private hospital was it being the 'nearest facility' whereas government health care services outside the locality, where 'time & travel' costs are higher.

Natal Care: A greater cause of concern was the fact that a large number of women have undergone home deliveries which were attended by untrained Dai.

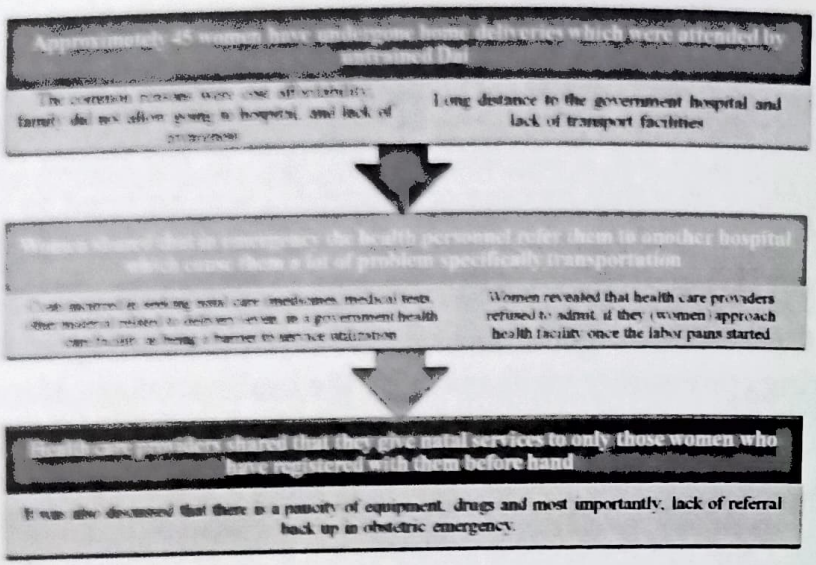

Figure 4: Views on Natal Care Services

The users were of the view that all the above mentioned factors lead to people losing faith in government health system.

Post Natal Care: Very few women did not have any health problem after delivery. It was noted that of those who did have some health problem (50), many of them (34) did not take any treatment.

Safe Abortion/Medical Termination of Pregnancy: It was found that very few women (15) had never sought pregnancy termination while others (45) had sought the medical termination of pregnancy. It was noted that all the women who sought abortion, had always availed services from a safe health facility, the government health facility (23) and the private (22). It was also found that women did not consult any traditional practitioner or dais. Those who had sought abortion, various reasons mentioned by women (23) for availing government health services.

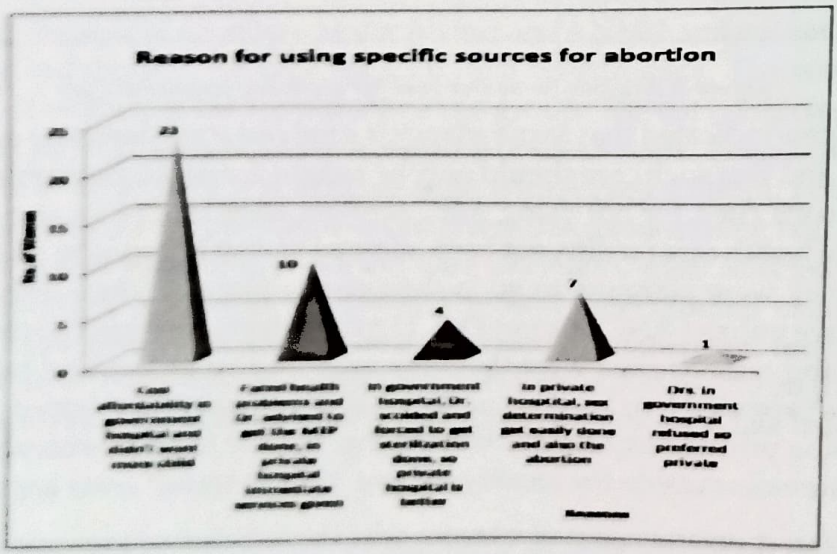

Figure 5: Reasons for using specific sources for seeking abortion

An interesting point has also been revealed by women that they selected the government hospital for abortion because of their poor economic status and also because they thought government services were free. However, after coming to the hospital they realized that services were not free. Because women often had to pay for medicines and required to make repeated visit before an abortion was performed. It was reported that women who had sought an abortion, many of them (20) had not experienced any health problem after the abortion. The remaining women (25) faced one or the other health problem.

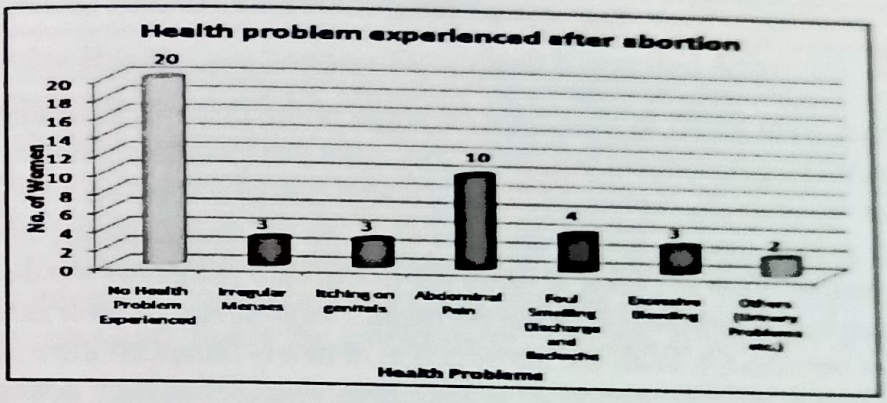

Figure 6: Post abortion reproductive morbidity

It indicated that post-abortion care and follow-up needed improvement. Post-abortion health seeking behavior was also very poor.

Family Planning Services: The average family size was 4-6 members per household. In case of level of knowledge of the family planning services, except for one respondent, almost all of them have heard of the contraceptive methods. Health care providers were major source of learning about family planning services.

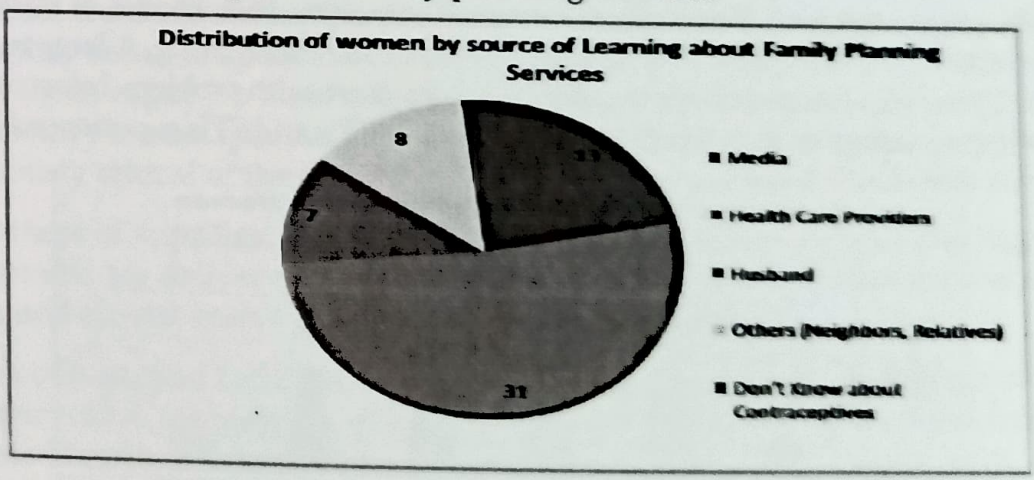

Figure 7: Source of learning about Family Planning Services

The current practice of contraception among the sample women reveals that 40 women were found to be using some method of contraception (including natural methods). Many reasons mentioned for non-usage of contraception.

Table 1: Reasons for non-usage of contraception

S. No.	Reason	No. of Women
1	Husband does not favour	8
2	Need More Chidren	4
3	Need One Son	3
4	Against Religious Belief	2
5	Lack of Awareness About Existing FP Method	2
6	Fear of Side Effects	1
	Total	20

The women were asked to shed light on some of the drawbacks of family planning services provided by government hospitals. They cited that locations of health care facilities were not in convenience (5), careless attitude of health care providers because of which they have to stand in long queues (23), more time wastage (5), staff shortage as there was no doctor and transportation available at night (5), health care providers scolded them badly and forced them to get sterilized (4), either the medicines were not given or rarely given (11), poor quality of services (3). With the introduction of newly launched intra uterine copper devices (IUCD) with the safe use for ten years, a great change has been noticed among the women on the usage of IUCD as compared to sterilization and other contraceptive methods.

Prevention and Treatment of Reproductive Tract Infections /Sexually Transmitted Infections (RTIs/STIs): It was noted that significant number of women (45) did not know about the mode of transmission of RTIs. About cure of RTIs, some of the women (10) responded it was curable and rests (2) said it was not curable. However, a considerable number of women (48) did not know whether it was curable or not. Similar to the findings about RTIs, even findings on STIs gives a picture that women in reproductive age group, tend to be largely ignorant of sexually transmitted infections, their modes or transmission and prevention, and the extent to which they could be life threatening. A large number of women (57) had experienced one or the other reproductive health problem. Information was collected from women on some common symptoms of RTIs and STIs experienced by them.

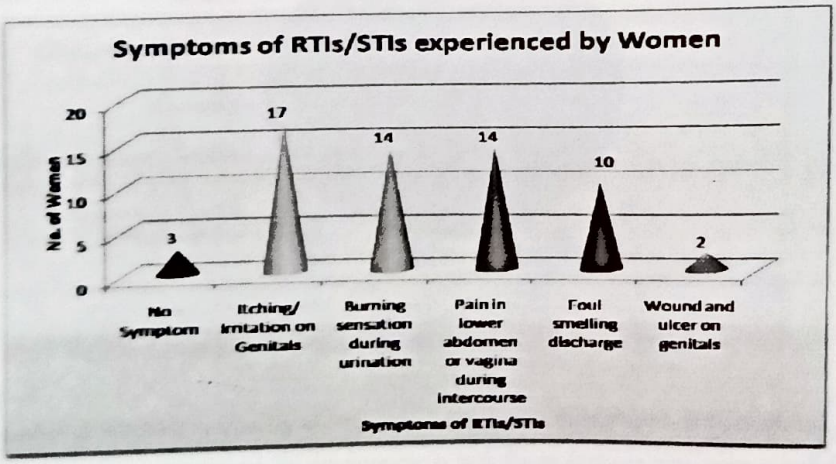

Figure 8: Symptoms of RTIs/STIs experienced by Women

Above mentioned data indicated persistence of the reproductive morbidity among a very large proportion of women in urban slums. The management of such health problems assumes great importance since still a very large proportion of women (41) had not sought any treatment for their health problem. Women were asked to report whether their husband has certain reproductive health problem or not. It was found that they did not know about the same. This clearly indicates the communication gaps existing between husband and wife. Treatment seeking behavior with regards to RTIs/ STIs among men found to be very poor. A small number of them (15) were seeking treatment for RTIs/STIs experienced by them.

Reproductive Health Care Services through an Integrated Approach : Reproductive health services were provided by Maternal and Child Health Centre under overall control of Municipal Corporation of Delhi (MCD). Reproductive health care service delivery system rests on a well-conceived infrastructure to make reproductive health care available to slum dwellers, with female workers (Basti Sevikas), the Auxiliary Nurse Midwife (ANM), the Medical officer in-charge, who has the overall responsibility for providing integrated reproductive health services to the slum dwellers and other qualified personnel and finally the government hospitals at the apex of the edifice.

Reproductive health services provided by the government health facility: The reproductive health services most widely available at health care facility were antenatal care, and family planning. However, reproductive health services need to address far more than these two. Health care providers revealed that most of the antenatal visits women did late in pregnancy. Emergency obstetric care was virtually non-existent. Even health facility had no means for transporting women to the nearest referral hospital, No resident doctor and a driver (on ambulance) were available at night.

Staff shortages: There was a serious shortfall of skilled staff at the field level with appropriate technical skills. The providers mentioned that they are simply frustrated by what they see as the poor condition of government health facilities. They expressed concern about vague job descriptions which they say force them to take on extra work for which they are not qualified, equipped or remunerated. Health care providers were unanimously critical of the lack of services for staff working in this health facility.

Shortage of supplies: Health facilities were lacking in basic maternity equipment, in equipment for delivery, as well as in basic consumable supplies such as syringes, needles and gloves, essential medicines, rings for laparoscopic sterilization.

Lack of transport facilities: Lack of transport has resulted in inadequate monitoring and supervision, termination of basic outreach services and lack of effective referral systems. Health workers reported that the majority of patients with obstetric complications come in by rickshaw, often over long distances. Shortages of adequate transport have had a major impact on both the quality and accessibility of existing services.

In-training provision for better service delivery: Many weaknesses in provider (ANMs and Basti Sevika) competence attributed to poor or non-existent training, cited

by the medical officers. In addition to this, providers expressed concern at the lack of refresher, in-services or, on-the-job training. While higher level authorities suggest that many of these problems have already been identified and that efforts are currently underway to resolve them within the framework of the RCH program.

Beneficiaries access to complete and accurate information about health care services: No guidance and counseling have been given to the patients who seek reproductive health care services. When asked by the researcher why further information was not offered, providers responded, *" If they ask, we tell them; if not, we don't"*.

Skills in interpersonal communication and counseling: During interview almost all the health care providers pointed out the deficient interpersonal communication and counseling skills exists in the health care delivery system. It has been noticed that the superior staff blamed the subordinates having deficient interpersonal communication and counseling skills.

Regular monitoring and supervision of performance: Health care providers also revealed about inadequate monitoring and supervision. Almost all the providers were well aware of the public sector norms recommending that supervisory visit be carried out on a quarterly basis but, even one annual visit is probably more than the reproductive health care facilities can ever expect to receive.

CONCLUSION

The study focused on government health care delivery system but whenever respondents were asked about preference for health care services, they started making comparisons between government and private health care services. The analyses under each component showed that government health care facility have a slight edge over private health facilities. Respondents of the study identified the poor quality of services offered at government institutions to be a motivating factor for delivering at home. Thus the quality of services provided by government health care facilities in the area requires further investigation. Further intervention is also required to establish the types of care provided during an antenatal care consultation to establish the feasibility of using these visits to encourage women, particularly those with high-risk pregnancies, to be linked with a trained attendant for her delivery. Emergency obstetric services should be available at all the health care facility. If there is need of referral to other hospital, transportation should be available all the time (day and night). The women who do not approach health care facility for postnatal care, it can be suggested that home visits should be encouraged as part of postpartum care in order to identify reproductive morbidity after delivery.

Hence, for safe motherhood there is a need of counseling of pregnant women and her family members (husband/ mother-in-law) that antenatal care is essential. The health system needs to support traditional birth attendants with proper training. There is also a need of strengthen maternity care services by ensuring timely detection, management and referral of complicated pregnancy, delivery and post delivery complications,

screening for RTIs/STIs during the antenatal period in order to prevent maternal morbidity and mortality and support for family planning services, and ensure safe delivery services at MCH Centre. The health centres should ensure access to timely emergency obstetric services and provide adequate communication, skilled personnel, facilities and transportation systems, especially to women belonging to slums, keeping in mind their poor economic conditions.

As analysis showed that all the women who sought abortion, had always availed services from a safe health facility i.e. government and private, but the difference is very slight. Non-use of contraception rather than contraceptive failure was reported to be the chief reason by a number of women seeking abortion. The reasons cited for not using contraceptives by women ranged from fear of some methods, lack of awareness about existing family planning method, husband's objection to use, and certain health concerns. This indicates gap between knowledge and use of contraception, knowledge was usually based on information received through the health outreach activities of the programme but not on the basis of actual lived experiences of people, the knowledge did not translate into actual practice. As a result, complications resulting from unsafe abortion constitute major source of reproductive mortality and morbidity. It necessitates to improve quality of services in government health care facility by proper monitoring of MTP services and training of health care providers at various levels. There is a need for provision of counselling for woman and her husband in order to access effective contraception so that abortion can be avoided because of unmet need of family planning.

Analysis of findings reflects that there are various patterns, which influences the utilization of family planning services. These include knowledge of location of health care facilities, and other supply sources, their proximity, the attitude of family planning personnel and the suitability of timings and other hospital procedures. There are many myths and misconceptions prevail in the community regarding contraception like women cited that, IUDs can reach to throat and can cause death. It has been observed that the health care providers rarely referred to the side effects associated with the method being provided like, in the case of injectable methods, where disruption of menstrual bleeding is known to be a major factor contributing to method discontinuation and creates various myths and misconception in the mind of users and community at large. All this strongly gives an impetus on training programmes for providers on client-provider relations and on reproductive health counselling should be developed. There is a need to emphasize more on spacing methods such as pills, condoms and injectable devices effective for long period (5 or 10 years), which would be helpful in improving maternal and child health. Findings above clearly indicates that male involvement is weak and needs to be more actively sought in terms of their participation as adoption of family planning method, depend on inter-spousal consultation.

Analysis of data revealed that a large number of women were still unaware of the infections and diseases related reproductive system. A significant number of women were still unaware whether the RTIs/STIs are curable or not, their modes or transmission and prevention, and the extent to which they are life threatening. This reflects the

ignorance of women towards their reproductive health and also dissatisfying patterns to seek treatment for reproductive morbidity. It has been revealed that males do not come forward for treatment. As a result the same women come over and over again for treatment. It could be the reason for poor follow-up among women who come for RTIs/STIs treatment. In order to ensure better utilization of reproductive health services, male participation or male-shared involvement in reproductive health is of utmost importance. It also highlights the need to educate women regarding the symptoms and consequences of RTIs/STIs. There is a need of routine inclusion of RTIs/STIs screening in antenatal and other gynecological examination because RTIs/ STIs during pregnancy may cause foetal deformity or abortion.

The researcher observed that health facilities were lacking in basic maternity equipment, in equipment for delivery, as well as in basic medicines and other medical supplies such as syringes, needles and gloves. Providers also mentioned shortages of essential medicines such as antibiotics, reagents for STIs testing, and ring for laparoscopic sterilization... etc. One fact the peripheral level provider did not communicate and was revealed by higher level authority, the degree to which shortages derive not necessarily from the lack of supplies, but from the lack of systems to ensure that existing stocks are distributed in response to routine reporting of health facility needs. This reveals the lack of effective communication between health care facilities and higher level authority on logistics-related matters. Above mentioned incidences reveal poor communication, inadequate management and procedures for re-supply were major constraints faced by health care providers. If communities are to receive adequate reproductive health care coverage, then services must either be brought to them or they must be brought to the appropriate health care facilities. Shortages of adequate transport have had a major impact on both the quality and accessibility of existing services. To those in slums areas, providers as well as users, it is a sign that management is either unaware of, or unconcerned with problems at the grass root level. It is a challenge to determine how best to narrow the gap between existing service delivery facilities and the population whose access to them is so limited.

Women in an urban slum remain one of the most underserved segments of the Indian population and there is a need to look broadly at these women's reproductive rights, their needs as well as their limited access to reproductive health care services. There is a need to make programme more sensitive, within easy reach of women and more affordable for the women who belong to the underprivileged section of society, to be able to achieve its intended benefits. In addition, a well- organized referral system, a good supervisory system to monitor the work of health care providers at each level of the health system, a mechanism to ensure that relationship between traditional and organized reproductive health care services is maintained. It is thus important that while aiming at improving the reproductive health standards of the women living in the slums, policy makers should address factors which are responsible for the spread of diseases as well as its socio-cultural dimensions. Use of mass- media in the community to promote institutional deliveries, adopting a family planning method can have great impact on slum women. Talks, discussions, exhibitions and counselling sessions must

be arranged in communities on general and reproductive health, and nutrition by social workers, gynaecologists, and nutrition experts. More innovative and systematic intervention strategies involving slum communities are needed to meet this challenge.

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Self-employed Women and Leadership Qualities

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ABSTRACT

Self-employed women encounter numerous challenges in their everyday life related to their work and home responsibilities. The present study aimed to examine the leadership qualities possess by the self-employed women. The findings of the present study revealed that a significant percentage of the self-employed women lack the basic leadership qualities to function effectively. They expressed the need to learn communication skills. The respondents conveyed the need to understand the coping mechanisms to deal with the stress encountered by them related to their daily routine household work as well as professional responsibilities. The study indicated the emergent need to conduct training sessions on leadership skills, communication skills, time management, and stress management. It also highlighted the need of organizing and forming the women's support groups, and self- help groups.

Key words: *Leadership, self-management, self-employment, communication*

Introduction

In ancient times, generally people were self-employed. They were engaged in agriculture on their own land or used to do something of their own. Very few people used to work as in the defense services or cleaning tasks. With the passage of time, due to industrialization and modernization more people came into job than their own self-employment. It is a known fact that the self-employment provides a flexibility to work and manage things accordingly. Self-employed person can better manage work life with home life. Now a day, many women are in the work life with their home life. Self-employment has become a choice for women. Because self-employment is just like working on your own or we can say that working for self. Although

one needs to work hard because there is a direct connection between earning and efforts.

According to Merriam Webster dictionary (1828), "Self-employment is earning income directly from one's own business, trade, or profession rather than as a specified salary or wages from an employer." Self-employed person could be a business owner, entrepreneurs, and freelancers. Majority of the women preferred self-employment as it contributes to their own and family income. Self-employed women are defined as those who do not receive a salary like that of formally employed workers and therefore have a more precarious income and life (Datta, 2003). Self-employed women are engaged in variety of informal employment like labour work or service providers like, labour, housemaid, helper, rag picker, street vendor, tuition teacher, trainers, tailor, beauticians, and many such kind of employment.

Self-employed women face several challenges due to socio-cultural factors as well as the informal nature of their employment. It is not always easy for them to work and manage home simultaneously. She is expected to take care and manage family requirements like food, sanitation and hygiene, health care, and childcare along with her employment. Self-employed women just like a homemaker women shoulder responsibility for housework, family and childcare. They experience stress associated with these responsibilities as well as employments' related anxiety (Byron, 2005). Gender disparity also creates hurdle for self-employed women and intensify the challenges related to the employment success. Despite many hurdles women are determined and facing all the odds of work and family life courageously. According to Kirkwood and Tootell, (2009) self-employed women practice many ways to deal with their stress and anxieties. They try to manage their roles within family. Without family support, performing at all fronts is very difficult for self-employed women. The family, emotional, and social support are extended by the life partner, family members, friends, and colleagues (Annink, 2017). The present study is done to understand the issues and problems related to self-employed women and examine the leadership qualities of self-employed women.

Research Methodology

The research design of the present study was descriptive. Non-probability method of purposive sampling was used in selecting the sample. The

population of the study was self-employed women from heterogeneous employment. The sample size was 120. An interview schedule comprising closed-ended and open-ended questions was administered.

Objectives

The objective of the study were-

- To understand the issues and problems related to self-employed women
- To examine the leadership qualities of self-employed women.

Findings of the Study

The present study on self-employed women and leadership qualities was an attempt to assess various components related to leadership qualities in self-employed women. The findings of the study are as follows-

Age

The respondents' age was asked in different age category i.e. 18-27 years, 28-37 years, 38-47 years, 48-57 years, and 58-67 years.

Table 1: Age

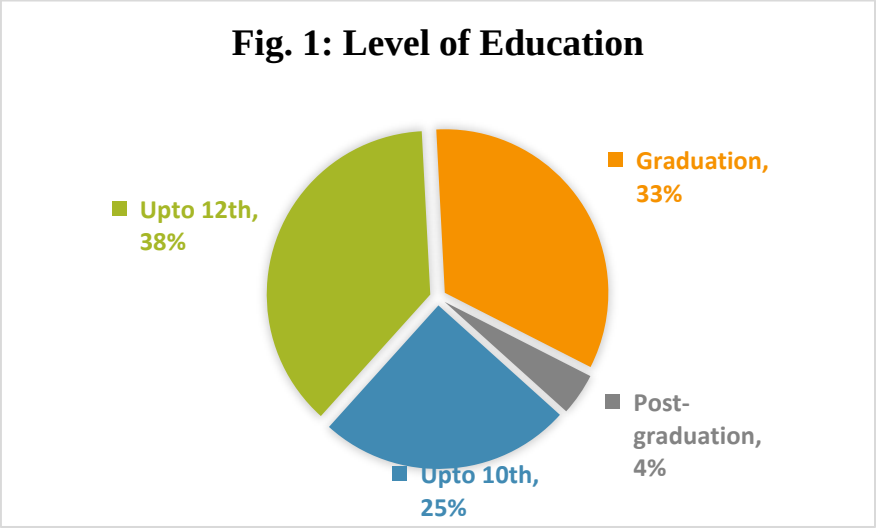
Age Group	Count (f)	Mid-Point (x)	fx
18-27	40	22.5	900
28-37	35	32.5	1137.5
38-47	38	42.5	1615
48-57	5	52.5	262.5
58-67	2	62.5	125
Total	**120**		**4040**

Mean Age ($\bar{x}$) = Σ(fx)/Σf = 4040/120 = 33.67

Table 1 depicts that majority of the respondents i.e., 40, 35, and 38 were from the age categories, i.e., 18-27 years, 28-37 years, and 38-47 years respectively. While five respondents were from the 48-57 years age category and two respondents were from 58-67 years of age category. The mean age of the respondents was 34 years.

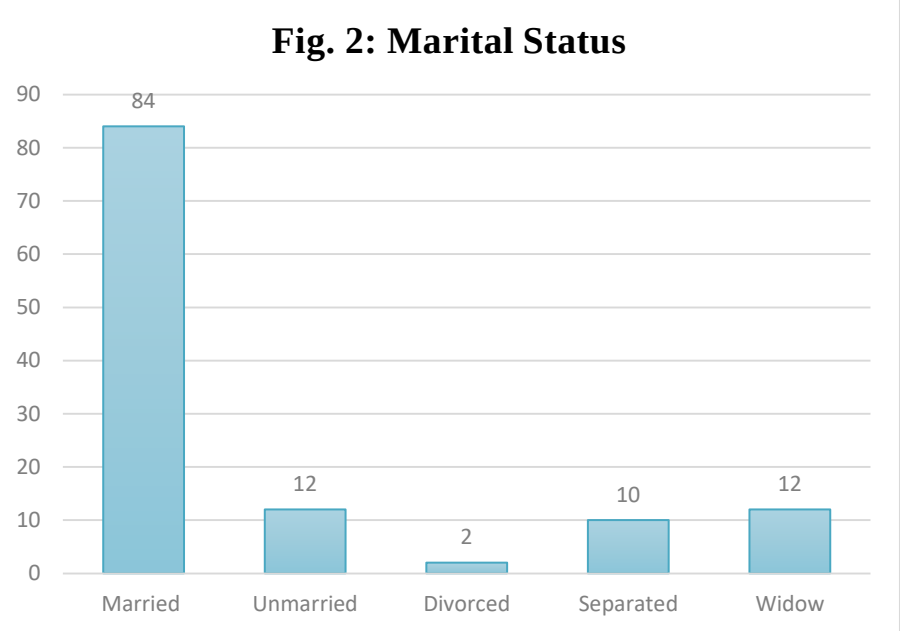
Education

The present study assessed the level of education. Figure 1 represents that 25 percent of the respondents were studied upto 10^{th} standard, 38 percent studied upto 12^{th} standard, 33 percent respondents were graduate and 4 percent respondents were post-graduate.



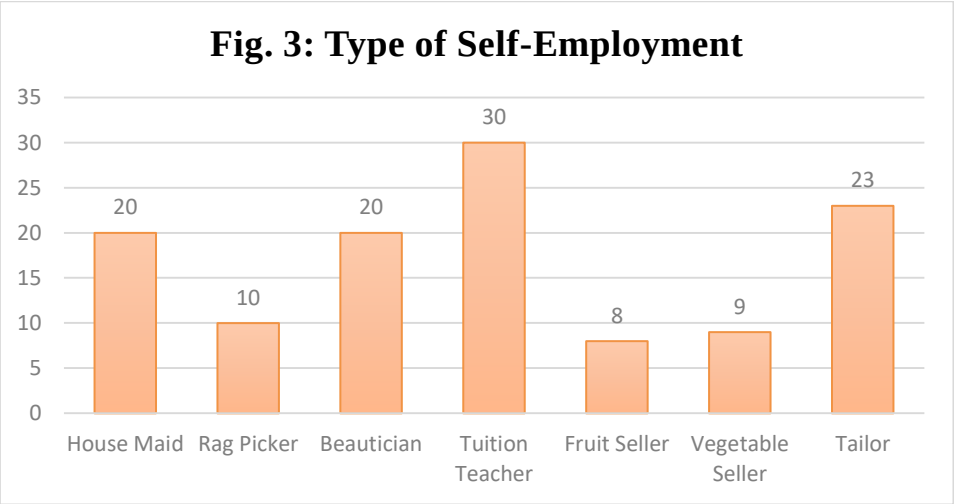
Marital Status

The respondents were asked about their marital status. Figure 2 illustrates that majority of the respondents (84) were married, 12 respondents were unmarried, two respondents were divorced, 10 were separated and 12 were widow.



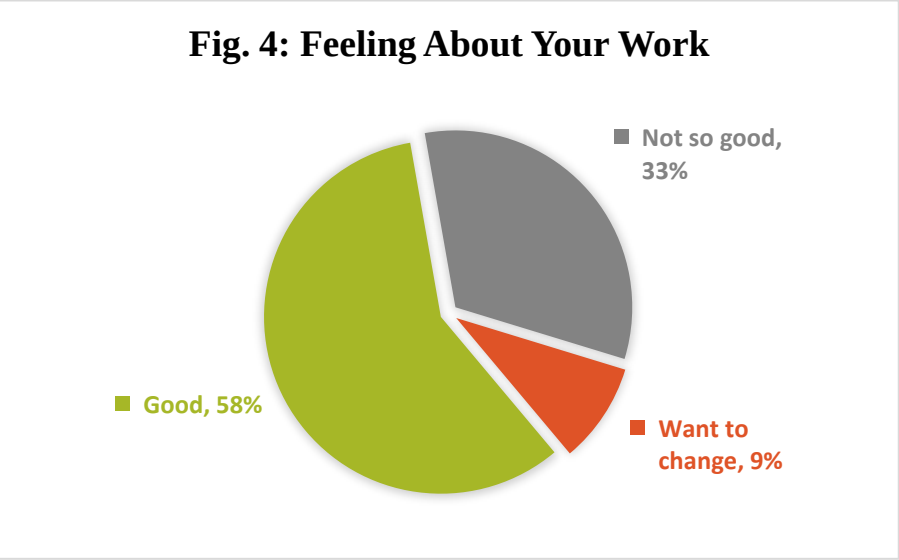
Type of self-employment

Self-employed women were engaged in variety of employments. They were working as housemaid (20), rag picker (10), beautician (20), tuition teacher (30), fruit seller (8), vegetable seller (9), and tailor (23).



Feeling about your work

Motivation and consistently good results are necessary for any self-employed person. Successful and encouraging output provides a feeling of being worthy.



The respondents were asked to describe the feelings they had for their employment. It was found (Figure 3) that 58 percent of the respondents felt good about their employment while 33 percent of the respondents conveyed that it was not so good. The respondents (9%) highlighted that they would like to change their employment. The respondents shared that they were not satisfy with the nature of their tasks so they need a change.

Availability of Support System at home

A woman needs to shoulder many responsibilities at a time. She is known as the best manager of the house. If she is self-employed, she needs a support system so that, she could perform her roles and responsibilities smoothly and effectively.

Fig. 5: Availability of Support System at Home

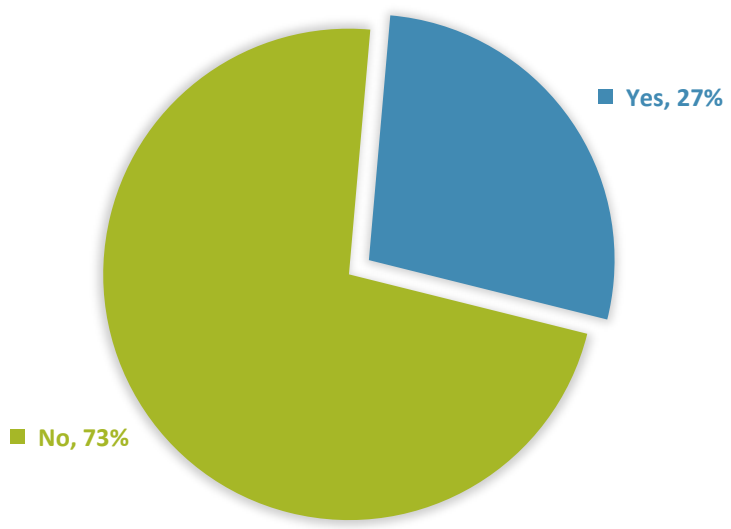
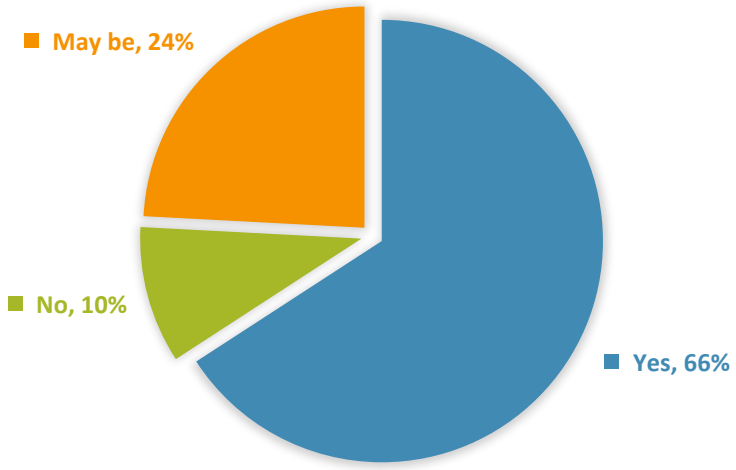


Figure 5 reflects that 27 percent of respondents cited that they had support system available at home while a significant percent (73) of the respondents had no such support system available at home. They also shared that many a times situation at home get worsened and they encountered some sort of self-guilt.

Confident about your work and the skills required

To perform well, we need to be skillful according to the requirements of the employment. Any work requires perfection. To gain profit, one has to be efficient in dealing with their tasks.

Fig. 6: Confidence About Your Work and Skills Required

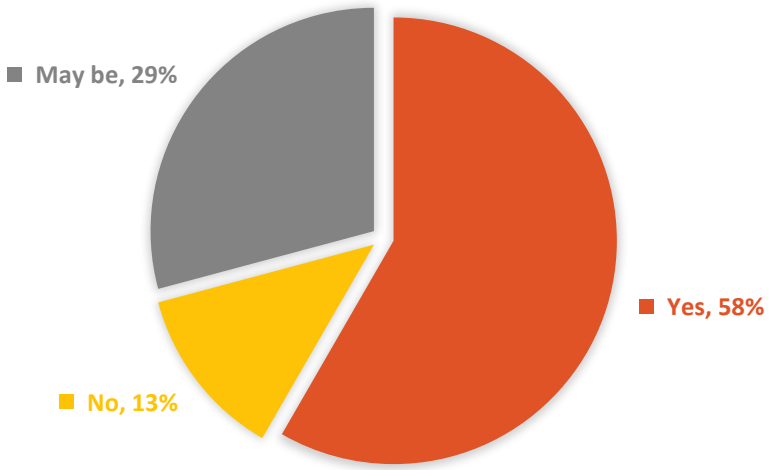


The respondents were asked to mention their level of confidence about their work and skills required for their employment. Figure 6 depicts that 66 percent of the respondents were confident about their work and skills required for the employment, while 10 percent of the respondents were not confident and 24 percent of the respondents were confused and conveyed that they may be confident about their work and skills required for the employment.

Confident about communication skills in specific

Communication skills are the pre-requisite for giving and receiving different kinds of information involved in any employment. One needs to speak appropriately to their clientele. Proper communication is essential for successful employment. It helps in establishing professional relationships.

Fig. 7: Confident About Communication Skill



Above figure 7 represents that 58 percent of the respondents were confident about their communication skills as compared to 13 percent of the respondents, while 29 percent of the respondents were not sure about their communication skills. The respondents felt that many a times they experienced a sense of insult, when someone spoke harshly and they could not answer them back. Some of them were not comfortable in talking in English language.

Skills of Self-management

Self-management is the first task, which a person has to do. In self-employment, one is the boss of self. Hence, accountability of any success and failure goes to the self-employed person. With the difficulties of the work, a person may get anxious, angry, and stressed. Sometimes it becomes challenging to complete the tasks on time. Therefore, self-motivation and self-discipline are required for an efficacious self-employment.

Table 2: Self-Management

Self-management	Always	Sometimes	Not at all	Total
Anger management	45 (37.5%)	48 (40%)	27 (22.5%)	120 (100%)
Time management	41 (34.2%)	49 (40.8%)	30 (25%)	120 (100%)
Stress management	39 (32.5%)	34 (28.3%)	47 (39.2%)	120 (100%)

The respondents self-management was assessed on three components i.e. anger management, time management and stress management. Table 2 reflects that 38 percent of the respondents were capable of managing their anger related to work and 40 percent of the respondents cited that they were able to manage the anger sometimes. While 23 percent of the respondents said that, they were not at all able to manage their anger.

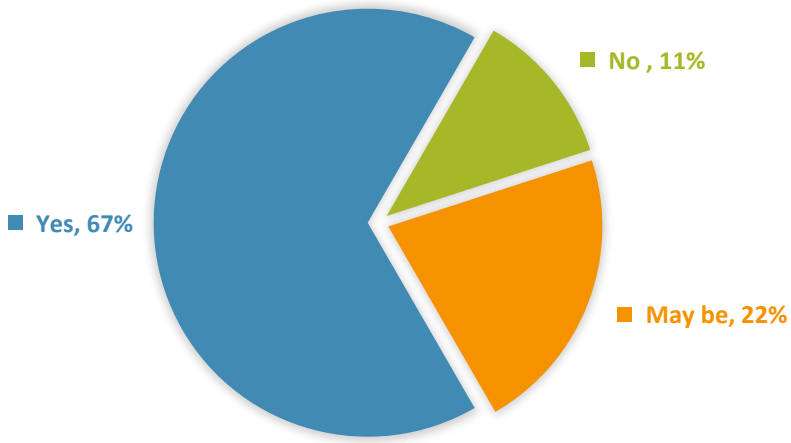
The respondents were also assessed on their skills of time management. The table reflects that 34 percent of the respondents were doing time management properly as compared to 41 percent who conveyed that they were not efficiently doing time management. While 25 percent of the respondents highlighted that they were not at all having skills of time management.

Stress deteriorates the work efficiency. The respondents were asked about their skills in stress management. Table 2 reflects that 33 percent of the respondents felt that they were always do stress management effectively, 28 percent of the respondents revealed that they were able to do stress management sometimes but 39 percent of the respondents shared that they were not at all able to do stress management and it affected their work many a times. Respondents shared many experiences when they were feeling helpless. They found no one to help them in dealing with the stressful situation.

Own Leadership Qualities

The respondents were asked whether they possess leadership qualities. Figure 8 shows that 67 percent of the respondents were opined that they possess leadership qualities, 11 percent of the respondents conveyed that they were not having the leadership qualities. While a significant percentage (22) of the respondents were not sure whether they possess the leadership qualities or not. It is disheartening to note that despite the fact that these women did not possess the leadership skills, they had not put any efforts to gain knowledge on leadership qualities.

Fig. 8: Possess Leadership Qualities



Discussion and Conclusion

Self-employment implicates many uncertainties related to work and earnings and in case of women added worries related to home also. For a self-employed woman, healthy and understanding support system at home is very much required. Findings of the present study reflected that a significant percentage (73) of self-employed women had no support system at home. It stressed on the need to strengthen the social and emotion support system of the family and friends. Organize the training workshop on personality development for self-employed women. It was observed that more than 30 percent of the self-employed women felt that they were not confident or not sure whether they were confident about their work and skills required for the employment. The self-employed women (42%) of the present study were not confident about their communication skills, which are the important and crucial skill for any profession. It was highlighted by the findings that 63 percent respondents were not able to manage their anger effectively. Hence, they need to learn the skills in anger management. The data on time management and stress management also reinforced the need to impart the knowledge and skills among self-employed women on self-management**.** The study highlighted the need to conduct trainings on

leadership skills, communication skills, anger management, time management, stress management, and personality development. It was realized that women should be organized through mahila mandals (women's groups). They should become a part of women's support groups, and self-help groups.

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Street and Working Children - Case Studies

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ABSTRACT

Street and working children face poverty, malnourishment, and homelessness. The present study described the reasons of children's homelessness or working in streets. The respondents were asked to narrate the challenges faced by them as street and working children. The present study found that these children were ill-treated by the people concerned on a routine basis. The chief reasons for working in streets were financial insecurity, parental neglect, parental illness, death of the parents, and violence by the parents or any other adult person connected to the children. Some of them became prone to substance abuse. Street and working children had no choice to choose their career. They were forced to adopt a certain kind of behaviour.

Key words: *Street children, working children, homelessness, poverty, livelihood*

Introduction

Children working in streets face numerous challenges to live a life. A major contemporary social concern is the interventions required to deal with problems faced by the street and working children. Children are the asset for nations. They are the future leaders. Investing on them socially and morally is very essential. However, a significant proportion of child population is homeless or working on the streets for earning their livelihood. They are facing numerous challenges to live their life. They are vulnerable to physical, mental and sexual abuse in the absence of protective parenting. Generally, in the absence of proper rearing and socialization, they get into criminal tendencies and start taking drugs. The street and working children are malnourished, live in poverty and many a times die in hunger.

According to UNICEF, street and working children are boys and girls aged under 18 for whom 'the street' (including unoccupied dwellings and wasteland) has become home and/or their source of livelihood, and who are inadequately protected or supervised (Black, 1993). The street and working children are sufferers because of financial crisis in the family, violent behaviour of the parents, poverty, loss or death of parent(s), severe illness of the primary wage earner.

Review of literature reveals that life in streets is not easy for anyone. Children encounter a lot of problems and difficulties. Poor family status, illiteracy, parental conflict and parental neglect towards children are some of the major causes that increase the cases of street and working children (Dutta, 2018). Working at streets makes the children prone to indulge in substance dependence, violence, and illegal and criminal activities. Many of them are into begging and rag picking. They face distress and anxiety (Savarkar, 2018). The living conditions of street children are pitiable. They live in trash, vacant sewer pipes, and at footpaths. They are prone to get chronic diseases. They remain illiterate because of lack of awareness towards education. There is a need to help these children at family, community, and society level (Kumar, K. V. R., 2014). A study Abraham found that 82 per cent street children stopped their studies. The major livelihoods are collection of old papers, daily wage, begging, helper, shoe polishers, sellers in streets (Abraham, 2015).

Methodology

The study was descriptive in nature. The universe of the study was all the street and working children. Area of the study was Delhi. Age group of the children is 6-12 years. Case study method was used. 10 children were selected by using snowball-sampling method. In-depth interviews were conducted with the use of interview guide. In order to maintain confidentiality, the name of the participants were changed.

Objectives

The present study on street and working children aimed –

- To study the reasons to live or work in the street by children
- To understand the challenges faced by the street and working children in their daily life

Reasons to live or work in the street by children

The present study tried to find out the reasons to live or work in the street by the children. The reason to live or work in the street may be different for each child because of his/her own circumstances. Children living and working in the streets have many narratives to share and some of them are as follows:

Case 1: Naresh 10 years old boy came from a very poor family. Both parents working as daily wage earners. He has three siblings. No one attended the school. The boy worked in a roadside motor garage at Kashmiri Gate, Delhi. He was forced to work and earn for the family.

Case 2: Krishan 9 years old boy live near Old Delhi railway station. His parents live in a village. He stayed in Delhi with some of his relatives. They somehow managed to get him a job as a helper on a tea stall.

Case 3: Ishu (10 years) ran away from his home because of the ill treatment by his father. He came to Delhi thinking to get a good life. He just remembered that he had two brothers. They were poor. His father and mother used to work as a labourer.

Case 4: Ehsaan (12 years) worked in a shoe factory. His father used to work in the same factory. His father died two years back and since then he was working as a helper there. They were four siblings and the mother worked as a maidservant.

Case 5: Chintu (8 years old) belonged to a very poor family and after his parents' separation. His life became horrible. He was staying with his father. His father was careless and did not bother about him. He worked as a rag picker at Old Delhi Railway station.

Case 6: Deepak 11 year old boy lived in streets. His father passed away in an accident. His mother remarried the same year. They were three siblings. They belonged to a very poor family. His mother worked as a maidservant.

Case 7: Bharti was a 12 years old girl. They were four siblings. Her father (who was a rickshaw puller) had cancer and passed away few years back. Mother worked at a factory on meagre salary. She worked as a helper in the same factory.

Case 8: Suman (12 years) hailed from a very poor family. Her father suffered from a chronic disease. Mother took care of him, as he was not able to do his daily life activities. They are three siblings. Suman and her brother (8 years) worked in a shop as helpers.

Case 9: Chetna a 9 year old girl. She and her mother worked with his father. His father is a street hawker. They work whole day tirelessly. She also helped her mother in the household chores and taking care of two younger siblings.

Case 10: Suresh a 10 years old boy. He was working with a street hawker as a helper. His father was a rickshaw puller. He had three siblings. He wanted to study but due to the poor financial condition, he could not attend school.

From the above data, it could be analysed that living or working in the street was not the choice of any children. They were forced to be homeless or work in the street. The poor economic condition of the family forced them to work in such a tender age. Many physical, social, psychological and economic reasons were imposed on them to work in streets. These reasons could be poverty, illness of the primary earner parent, separation of the parents, death of one of the parents, large family size, and violence in the family.

Challenges faced by the street and working children in their daily life

Life of street and working children is full of distress, anxiety and problems. The present study describes the challenges faced by the street and working children in their daily life. Some of the incidences are shared below-

Case 1: Naresh complained of high workload and not able to understand the tasks easily. He had to work hard but found difficult to keep the owner of the motor garage happy. He felt exhausted and distressed.

Case 2: Krishan felt lonely as his parents stay far away from him in village. He was not happy to stay with relatives as he earn very meagre amount and even not able to have three times meals properly. He used to get scolding from his master as well as from the relatives of not doing anything. He felt upset.

Case 3: There were scars on the face of the child Ishu. On asking, he reported that it was from beating by his father. He then ran away from his home and caught by a stranger who asked him to work in a factory. The conditions of working in the factory were bad. They had to work for a long duration.

Case 4: Ehsaan reported of shouting and beating from the factory owner as well as other staff. He told that they did not get any holiday. They have to work in a very crowded room and in unhygienic conditions. Ehsaan wanted to study but his family circumstances would not allow him to pursue studies.

Case 5: Chintu told that he also did beggary. Many a times he did not get food so he ate scraps of food. He was exploited and abused by the elder children near railway stations. The elder children forced him to smoke and even consume some other bad products. He felt insecure and frightened.

Case 6: Deepak's stepfather used to beat him. His mother never stopped his stepfather on abusing Deepak. He was shocked, frightened, and angry and finally ran away from the home. He shared that the life on streets was difficult as the policeman beat the children for wandering around the places. He did not want to go back to home. He has joined non-formal education unit of an NGO.

Case 7: Bharti complained of non-sensitive attitude of the owner and male staff in the factory. Her mother tried to convince her that she would get the same environment everywhere. So she should keep quiet. She was very disturbed and upset.

Case 8: Father of Suman had to undergo a surgery. They needed the money. For the surgery, they took loan from a person. That person asked her and his eight years brother to work in his shop as helpers. He rebuked them every now and then. He complained to her mother that both of them were lazy and did nothing. She felt helpless.

Case 9: Chetna complained of too much work and she felt tired. She told that she could not say no to any work else, her father would beat her and her mother. She was cursing herself being born as a girl.

Case 10: Suresh was distressed of not getting good amount of the work he did. He worked whole day but could not get more than ₹600/- in a month. He was upset, as he wanted to join a school. On the more the behaviour of the master gave him stress and fear. He was not at all interested to work with the street hawker.

The data reflected that the street and working children faced many challenges. Their life was full of trauma, pain and disappointments. They were prone to physical and sexual abuse. They were tortured physically and mentally. The harsh words were used every now and then, which could affect the mental health of any person. In case of children, the early age experiences have serious repercussions in the adult life also. They lived in starvation, poverty, unhygienic conditions, and slavery. They were forced to consume illegal nicotine products. They were exploited not only by their masters but also by their family members and elder children working on streets.

Conclusion

Street and working children deserves a dignify life. It is disheartening to know that these children suffer physically, socially, economically, emotionally and culturally. They are facing hardships and also prone to get stress, anxiety, pain and anguishes. They have low sense of well-being because almost each one of them face one or the other kinds of miseries in life. Their life is full of struggle. It has observed in the present study that the street and working children lack parental care, love and protection. They feel themselves neglected and isolated. There is a strong need of creating sensitization among people regarding the challenges faced by the street and working children. There is a need to ensure the right to education and right to health to the street and working children. Education ensures better prospects in life. Healthy body and mind is the pre-requisite for the better functioning of a person in the society. A special care needs to be given to deal with the emotional and mental health of the children.

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India's Shyness towards providing Reproductive Health Education to Adolescents

Manju Goel*

Despite the fact that as many as one fifth of the India's population comprises of adolescents, their reproductive health needs are poorly understood and ill-served. Dangerously enough, there is no consensus in India over introducing reproductive health education in the school and college syllabus. The present research article aimed at understanding the need of adolescents for reproductive health education. There is a need that students must feel comfortable seeking counseling on reproductive health issues. The tactic is to speak the same language as students do and to keep an open mind. There is no right or wrong answer when talking about reproductive health issues, and every question needs to be addressed, no matter how private. There is a need of involving parents and the community and of fostering an enabling environment by equipping adults, through training and sensitization efforts, to help adolescents. Adult family members of both sexes have to be informed of the need and value of reproductive health education for adolescents, and need to be reassured that young people need their support. The present paper recognized that school are an efficient way to reach young people and

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their families. Teachers can function as healthy role models, advocates for healthy school environments, gatekeepers for students in need of services, resource people for accurate information and effective instructors. Schools could provide a safe place for adolescents to discuss reproductive health issues, get advice and explore non-stereotypical gender roles. However, little is known about how ready schools are to embark in this task.

[**Keywords :** Reproductive health, Adolescents, Need, Challenges]

1. Introduction

"Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes… It also improves sexual health, the purpose of which is the enhancement of life and personal relation, and not merely counseling and care related to reproductive and sexually transmitted diseases" (WHO, 1996). The above definition of reproductive health contained in the programme of the International Conference on Population and Development (ICPD), Cairo is an improved version of the world health organization's technical definition, which was accepted by the United Nations general assembly. It is being followed now for all practical purposes by government and voluntary agencies world over.

The reproductive health thus includes a much wider area than only physical well-being. Reproductive health addresses the physical, social, emotional and psychological dimensions of sex and reproduction and not just the presence or absence of disease of reproductive organs. The proponents of the reproductive health framework believe that reproductive health is inextricably linked to the subject of reproductive rights and freedom. The reproductive health concept extends beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during the various stages of the life cycle. The present paper aimed at understanding the need of adolescents for reproductive health education. The present paper analyze the status of reproductive health education in India by reviewing the research studies conducting on reproductive health education theme.

2. Reproductive Health Status of Adolescents in India

The World Health Organization defines adolescence as the period of life between ages 10 and 19. Adolescence is a stage of

development transition i.e. a bridge between childhood and adulthood. It is a progress from appearance of secondary sex characteristics (Puberty) to sexual and reproductive maturity. It is the stage of development of adult mental process and adult identity and transition from total socio-economic dependence to relative independence (WHO, 1986 and, Gupta et al., 2004).

About one fifth (22-23%) of world's, population is adolescents (Population report, 2001). Situation of adolescents vary by gender, class, and region. About 30 percent of all adolescents are illiterate, 20 percent of all boys and 40 percent of all girls (IIPS, 1995). Among adolescents aged 11-14 years, 76 percent boys and 55 percent girls are enrolled in school. More than half of adolescent boys and less than 20 percent girls were reported to be working for livelihood. Again more than 50 percent of girls marry before 18 years and have at least one child by age 20. Like women, girls' work is largely unrecognized and not valued (Jejeebhoy, 1995 and, Bhende, 1995). Gender disparities in nutritional status, access to health care, educational attainment and growth are also well documented.

Adolescence is a phase when rights of the childhood start shaping while responsibilities and rights of the adults are yet to become accessible. One is 'old enough' for certain things and 'still too small' for certain other things. This phase continues through the second decade of every individual's life. This age group is particularly vulnerable to conditions in their social and physical environments, due to exposure to wide range of positive and negative determinants of health. The interaction of these determinants at each developmental stage helps to define both their level of health and its impact on the later life. The key determinants including social status, income, employment, environment at work, education, social set up, natural and built up environment, personal health practices, individual capacity and coping skills, biological and genetic endowments (Acharya and Dasgupta, 2005). Although adolescents are 1/5th of world's population still it is pertinent to note that many girls are grossly underweight at adolescence (Jejeebhoy, 1995).

Adolescents are an important resource of any country. They have successfully passed the adversaries of childhood and are on their way to adulthood. This is the stage when physical changes are taking place in their development. During this transition period they may face troubles due to lack of right kind of information regarding

their own physical and or sexual development. Many adolescent are sexually active increasingly at early ages. Their vulnerability, ignorance on matters related to their reproductive health, their inadequate knowledge on contraception, and their inability or unwillingness to use family planning and health service leads adolescent to face reproductive morbidity and mortality (Onifade, 1999). Jejeebhoy (1996) in his study showed that adolescent fertility in India occurs mainly within the context of marriage and over half of all women aged 15-19 years have experienced pregnancy or birth of a child. Unfortunately, their education lacks inputs on reproductive health this is despite their strong desires to participate in activities geared towards their own reproductive health and social development needs. It is feared that adolescent girls as well as boys if not duly informed find themselves at risk of pregnancy, child bearing and getting infected by sexually transmitted diseases. From the forgoing discussion it is clear that reproductive health is an emerging issue among adolescents.

3. National Policies for Adolescents in India

It is surprising to note that there has been no dedicated policy for the adolescents in India. The National Health Policy 2002 (GOI, 2002) and the national Youth Policy 1985 (GOI, 1985) has nothing for the adolescents, not even a ritualistic mention. The National Youth Policy 2003 (GOI, 2003) addressed the need and concerns of adolescents to a certain extent.

The National Youth Policy-2003 has defined adolescents within the overall framework of 'youth'. Youth has been defined as the age group of 13-35 years, estimated to be about 37% in 1997 and to reach 40% by 2016. The age group of 13-19 years within this broad definition has been defined as adolescents. Despite recognizing adolescents as a 'separate constituency' and 'adolescents' particularly female adolescents' as a 'priority target groups' the policy document has no dedicated policies for adolescents.

The National Population Policy, 2000 (GOI, 2000) did not recognize adolescents as a group having special needs. The overriding concern in this policy is enforcing the Child Marriage Restraint Act, 1976. Marriage and fertility among young people have been a policy concern because of population growth. Emphasis has been given to protection from unwanted pregnancies and Sexually

Transmitted Infections (STIs) and reproductive health services for adolescent boys and girls in rural India. The operational strategies suggested ranged from providing counseling through Primary Health Centres and Sub-Centres and expansion of the Integrated Child Development Scheme (ICDS) to cover adolescents. These prescriptions do not take account of ground realities and after so many years following the declaration of the Policy, no action has been taken on these counts.

The Tenth Five Year Plan (GOI, undated) estimated the number of adolescents at 200 million in 1996 and has been projected to increase to 215.3 million by 2016. Adolescent girls in the age group of 15-19 years currently account for about 10 percent of the population. In the context of health care for adolescents, the Tenth Plan has proposed certain initiatives: specialized counseling and IEC though NGOs, appropriate nutrition and health education, advocacy for "delay in age" at marriage, health and nutrition interventions during pregnancy in adolescents. It is not clear how these initiatives will be operationalised. The overriding emphasis on education and advocacy does not identify the structure that will implement these initiatives. Clearly, most of these are beyond the functions of health service systems.

Reproductive health services provided by Reproductive and Child Health Programme is deeply rooted in the concern for population growth. The primary focus has been on contraception for adult married women. Other aspects of reproductive health-education, awareness, diagnosis and treatment of STIs, and HIV/ AIDS, services for young unmarried men have been weak or neglected. Where services exist, social constraints pose enormous obstacles for young people to access these services. The National Population Policy of 2000 acknowledged that the services have not reached the young population.

Recently Directorate of Education in collaboration with Delhi State AIDS Control Society (DSACS) has initiated School Adolescence Education Programme titled "YUVA". It seeks to sensitize adolescents about a range of issues confronting them at different stages of their growing up. It includes scholastic and career plan, generic life skills, growing up and health and hygiene, body image and nutrition, interpersonal relationship and effective communication, mental health and substance abuse, adolescents'

sexual and reproductive health. It can be noticed that sexual and reproductive health is one of the area along with other components. In the first phase they have targeted only government schools in Delhi and later on it will reach out unaided and aided private schools and out of school students.

Thus from the above discussion it is clear that adolescent are still growing up without the opportunities, information, skills, health services and support they need to go through sexual development and postpone sex until they are physically and socially mature and able to make well informed, responsible decisions. Moreover many traditional practices and myths surround normal physiological process such as menarche and when adolescent are not given scientific explanation of such phenomenon, they are left puzzled and are unable to differentiate between myth and reality. This has resulted in anxiety and psychological trauma in adults, who as teenagers had held firmly to certain belief about sexuality (Basanayake, 1985). Due to aforesaid reasons, it is felt that there is a need for creating a generation with proper knowledge for good health.

4. Need for Reproductive Health Education among Adolescents

The need to address reproductive health issues of the adolescents has been recognized at various national and international forums. Various Government and Non-government organizations are trying to develop acceptable and effective reproductive health education packages for adolescents. As have been discussed earlier that adolescents' information about their own sexuality and physical well-being is extremely poor.

The experiences of girls and boys are largely shaped by the construction of gender, caste, class and community norms. The experience of adolescence by boys is almost diametrically opposite to the experience of adolescence by girls. Although the institution of marriage underlies and strongly determines the gender differential norms that govern Indian adolescents, the norms of sexuality underlying the general social norms come to the forefront. There is a growing acceptance of the fact that adolescents need proper information.

It is an established fact that adolescence is a period of increased risk-taking and therefore susceptibility to behavioural problems at

the time of puberty and new concerns about reproductive health. Female adolescents, compared to their male counterparts, face disproportionate health concerns following puberty, foremost among these are too-early pregnancy and frequent childbearing. Male adolescents, for their part, often lack a sense of shared responsibility for reproductive matters and respect for reproductive choices there is a growing acceptance of the fact that adolescents need information and education so they can protect themselves and make informed decisions regarding their reproductive health. At the same time it is recognized that parents have important rights and responsibilities in that regards. Despite such awareness, resistance persists. Some people fear that educating adolescents about reproductive health and providing them with related information and services will lead to irresponsibility and promiscuity, although studies have shown that the reverse is true. For their part, many adolescents are reluctant to seek help from adults either within their families or in school they therefore do not get the information, counseling and services they need. There is a need of involving parents and the community and of fostering an "enabling environment by equipping adults, through training and sensitization efforts, to help adolescents. Adult family members of both sexes have to be informed of the need and value of reproductive health education for adolescents, and need to be reassured that young people need their support. Thus parents ought to be the main source of information on reproductive health education but were not giving adolescents what they needed.

It has been seen in the literature that with more children than ever in school, these institutions are an efficient way to reach young people and their families. Teachers can function as healthy role models, advocates for healthy school environments, gatekeepers for students in need of services, resource people for accurate information and effective instructors. Schools could provide a safe place for adolescents to discuss reproductive health issues, get advice and explore non-stereotypical gender roles. However, little is known about how ready schools are to embark in this task.

Literature review has shown that adolescents are becoming sexually active at a younger age. The age of which sexual activity begins varies from 12-18 years (Abraham, 1998; Awasthi and Pande, 1998; Acharya and Das gupta 2005; Sharma and Sharma, 1995). The trends indicate greater permissiveness towards premarital sex (Awasthi and Pande, 1998 and, Sharma and Sharma, 1995)

Adolescent have misconception, myths and little access to correct information and knowledge about sex, sexuality and reproductive health (Ahuja and Tewari, 1995; Awasthi and Pande, 1998; Bhasin et al., 1997; Acharya and Das Gupta, 2005 and, Reddy, 2005). Studies have shown that misconception existed, more among females than males (Amalraj et al., 1997; Abraham, 1998; Shilpa and Ratna Kumari, 1999; Devi, Reddy and Laxmanna, 1998) Most of the studies have recommended the need for comprehensive reproductive health education (Awasthi and Pande, 1998; Abraham, 1998; Ahuja and Tewari, 1995; Somaya julu, 2004; Shilpa and Ratnakumari, 1999). Studies also discussed the crucial role that schools and parents can play in strengthening adolescent reproductive health programme (Bhatia and Swami, 2000; Acharya and Dasgupta, 2005; Devi, Reddy and Laxmanna, 1998). Studies have stressed that adolescent sexuality should be geared in a positive way for boy and girls (Bhasin and Aggarwal, 1999; Sandhya, 2005; Reddy, 2005; Goyal, 1995; and Acharya and Dasgupta, 2005) and the concept of sexual behaviours can also be clarified and inculcated during this phase of life.

The studies carried out so far on reproductive health issues have identified a number of pathways through which different factors may influence reproductive health of adolescents. It's high time to address some of the issues that still need to examine like, identification of the reproductive health needs of adolescents, proper documentation and evaluation of existing adolescents' programmes, designing various approaches to address reproductive health needs of adolescents, ensuring involvement of parents, teachers and at large community also.

5. Implications for Social Work Practice

Social work professionals can help in raising the sensitization among people about the different problems encountered by adolescents in getting information on reproductive health issues. They can highlight the need to make the existing school health service more sensitive to the needs of adolescents. Social work professionals can bridge the gap between the adolescents and adults (parents and teachers) who continue to be the main and easily accessible source of information especially in the area of reproductive health education for adolescents.

Further there is a need that the information regarding reproductive health issues should be made available to adolescents, so that they can make informed and responsible decisions. Social work

professionals can also emphasize on the need to provide education to adolescents and organization working with adolescents to make them aware of their rights and responsibilities for their own personal health care, and to encourage them to demand for reproductive health education that will meet their particular needs and concern.

In order to ensure universal access to reproductive health education for the adolescents the Social workers can emphasize on the need to create and support programs in the schools as well community, also help in realizing the need to create programs and services that address specific health needs of the adolescents.

Thus adolescents need realistic and accurate information related to reproductive health to prepare them for healthy adult relationships and equipping them to protect themselves from risky situations.

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FROM THE DESK OF CHIEF EDITOR

Dr. Nishith Rai, Director

The theme of World Environment Day 2022 is 'Only One Earth'. If one takes a look at its simple meaning or its myriad implications, one can identify the hard-hitting reality behind it. Just one earth, one common home sustains life for its inhabitants. In the past 500 years or so, humankind has made great strides in innovations and technology albeit at great cost to ecological and environmental costs. Over 900 species have become extinct within the past 500 years and the delicate ecosystem on which life has been sustained so far has suffered irreparable damage.

There is awareness among nations and governments across the world that the existing state of affairs is not working in the long run and the development has to be equitable and sustainable for all. However, the difference of opinion lies in who will bear the cost of the sustainable model of development. Many developed nations have been unwilling to adhere to their agreed promises to cut down on CO2 emissions and carbon footprint to achieve the goals stipulated by scientists working on climate change and its overall impact on the world. Developing nations have also shown reluctance to bear the costs of these steps citing the unequal distribution of resources and wealth and protectionist policies in their own countries as necessary to counter the onslaught of globalization. Needless to say that this is a cause for concern. Paris agreement of 2015 is a step in the right direction even though they are practically the bare minimum of what is required.

In India sustainability has always been a way of life in terms of shared cultural principles of giving back to the earth what we take from it and replenishing the ecology. The need of the hour is to take the principles of the same traditional values and work towards building a future that goes beyond the development model of the western world. India has a much bigger role to play in this not just because it's the fastest-growing economy but also because it is going to be among the worst affected with more than a billion population and rising disparity among them.

Sustainability is the keyword to this however; it needs to be in conjunction with the factors that have a broader impact on the communities.

In terms of urban planning, infrastructure development, resource distribution and utilization, there needs to be proper consideration for achieving long-term results that are well thought out and their impacts on the environment studied and accounted for. The costs of such an approach may seem like a lot especially for a developing nation like India however, one only needs to look at the past miscalculations of poor urban planning, unplanned infrastructure development and the unequal distribution of wealth and essential resources that is leading us as a society on the precipice of disaster.

There is no one-step solution to the issue of climate change and environmental degradation. However, every step and action towards mitigating it counts. To repeat there is just One Earth, One home and we need to do everything to keep it livable for us and our future generations.

The contribution to this end is also done by the experts, researchers, academicians, etc. in the field of Urban Development with whose support we at RCUES Lucknow bring out the Biannual Journal Urban Panorama. The journal presents the refereed results of original scientific research, and new developments in policy and practice in the fields of housing, spatial planning, building and urban development.

The aim is to give exposure to recent developments, providing a forum for the exchange and discussion of new ideas. The journal benefits a diverse readership of scientists, specialists, practitioners, and policy-makers in government and in organizations dealing with housing and urban issues.

Lucknow
June, 2022

(Dr. Nishith Rai)
Director

FROM THE DESK OF EDITOR

The Journal Urban Panorama aims to provide an effective means for the exchange of research findings, ideas and information in the fields of urban development and environment among researchers, activists and non-governmental organizations (NGOs) international agency staff, students and teachers.

With every new issue of Urban Panorama, we focus on newer areas of urban and environmental issues and their interconnections. In this issue, we have a bouquet of articles by experts and researchers in the field of urban governance and management.

In this issue of Urban Panorama, Dr. Ananda Nand Tripathi, in his paper titled, 'Administration and Bureaucracy in India', has focused on the fact that how globalization, economic liberalization, and a new policy regime have increased demand for administration transparency and accountability. Improved information, communication, and office management technologies have increased transparency, accountability, and responsiveness in Indian governance. Thus, organizational effectiveness and smooth administration require high levels of motivation to achieve desired goals and objectives. In his paper he examines the evolution of civil services in India and relations between civil servants, citizens and politicians.

Dr. Neelesh Singh, in his paper tilted, 'Social Ecology and Cultural Change: A Study of Relationship between Man and Nature in Varanasi, Uttar Pradesh', delves deeper into the concept of social ecology. A complex and critical framework for the production of holistic theory, profound understanding, and effective, responsible action is provided by social ecology, an emergent meta-discipline. The name shift to social ecology represented a desire to integrate ecological ideas and environmental concern into the nexus of important connections. As development paradigms provide major challenges to India's environment, environmental conservation and climate protection are critical. In the setting of Varanasi, Uttar Pradesh, the current research investigates the theoretical perspective of social ecology and cultural transformation.

Dr. Sunita Bahmani and Dr. Manju Goel, in their joint paper titled, 'Homeless Persons: Socio-Economic Condition and Health Status', highlights that homelessness is a complex problem, a result of social injustice and social inequality. The paper aims at exploring the socio-economic conditions of the homeless persons. It also examines the health status of the homeless persons. The findings of the study reflects that the homeless persons are majorly migratory population having meagre family income. They work as daily wage earners and many of them were in beggary. They had poor health status and limited access to health care services.

Dr. A. K. Singh and Prof. O. P. Singh, in their joint paper titled, 'Empowerment of Urban Street Vendors through PM SVA Nidhi Scheme', discusses how Street vendors provide easy access to a wide range of goods and services in the public spaces of cities around the globe from fresh fruits and vegetables to building materials; garments and crafts to consumer electronics; prepared food to auto parts and repairs. The COVID -19 pandemic and subsequently declaration of lockdown by the government in order to prevent from the virus, street vendors suffered and lost their livelihoods. In view of the restoration of economy and livelihoods, government of India invested about 10 percent of its GDP as fiscal measures

under Self-Reliant India. PM SVA Nidhi scheme is one of such policy initiatives. The scheme aims at empowerment of urban street vendors through providing interest subsidy loan to urban street vendors. It has significantly contributed in poverty alleviation, rehabilitation of street vendors and their empowerment. Against this backdrop, present paper attempts to assess the impact of PM SVA Nidhi scheme on empowerment of urban street vendors in India. The paper is based on secondary data and critical appreciation of pertinent literature.

Dr. Santosh Kumar Singh, in his paper titled, 'Health, Hygiene and Urban Sanitation', examines how diseases linked to poor sanitation and hygiene lead to substantial loss of life and potential. Due to the decreasing immunity suffered by the children in their early years as a result of sanitation linked diseases, the development of cognition is found to be significantly hampered, resulting in a lifelong impact on their development. The state and central governments have a facilitating role that takes the form of framing enabling policies/guidelines, providing financial and capacity-building support and monitoring progress. There has been remarkable progress in improving sanitation in urban centres with the policy initiatives and massive investment in water, health and sanitation sector in India. However, urban centres face challenges in ensuring sustainable and inclusive sanitation as sanitation infrastructure mainly centralised sewerage system , co- treatment facilities at sewerage treatment plants, septage and faecal sludge management at decentralised level are grossly inadequate. Against this backdrop, present paper attempts to examine the perspective of health, hygiene and urban sanitation in Indian context.

Dr. O.P.B. Shukla in his paper tilted, 'Human Resources and Governance and Public Accountability', discusses in detail how globalization, social, economic, and technological changes have increased organization size and complexity. In modern complex organizations, low morale, motivation, communication, etc. of public personnel or employees lead to ineffective management of public affairs and unsatisfactory delivery of public services, resulting in poor public administrative system performance. Better public administration performance depends on effective use of human resources, but the problem is work motivation, morale communication, etc. Due to the changing social and economic landscape, it's important to examine the factors that lead to the best use of man and material. Several social scientists have studied organizational variables and factors affecting the work performance of administration and officials. Among them, classical thinkers and psychologists have studied the motivation to work, which speaks to the mental health of workers and organizational health. This paper examines India's human resources, governance, and public accountability.

Dr. Baby Kizhakkekalam, in her paper titled, 'The Need for Sustainable Water Management- with Special Reference to Kerala', focusses on the essentiality of Water and its role in urban planning being fundamental. There is no life without water but the growing challenges in the form of urbanization economic growth pollution and climate changes are disturbing the stability of the water flow cycle and the maintenance of the environment by exerting pressure on water resource management. The government has shown an interest in Integrated Urban Water Management (IUWM) as a new framework and approach for the nation. Climate change, depleting groundwater level, over exploitation and deteriorating water quality are some of the major challenges to provide drinking water to all. India constitutes 16 per cent of the world's population but the country has only four per cent of the world's freshwater resources. The paper focuses on the need for sustainable Water Management- with Special Reference to Kerala.

Sri Bharti and Prof V.P. Sharma, in their joint paper titled, 'Sustainability in the Changing Global Scenario', discuss that development and sustainability are the impactful

futuristic words and have registered the vocabulary of people ranging from statesmen to policymakers, activists to ordinary citizens over the last few decades. Efforts have been made to streamline the concepts of sustainability in the development phase through mission mode targets such as the Millennium Development Goals (MDG). However, a gradual general consensus among nations has recently emerged on the premise of sustainable development. People are gradually realizing the need to travel beyond the jargon of sustainable development in the face of increasing episodes of cyber-attacks, simulated warfare circumstances, global warming, environmental degradation in the form of frequent and unreliable onslaughts of natural calamities viz. cyclones, heat waves, cold waves, droughts, and so on.

Dr Lal Krishna Mishra and Professor V.K. Tripathi, in their joint paper titled, *''उत्तर प्रदेश लखीमपुर खीरी जनपद में थारू महिलाओं की चुनौतियां एवं सशक्तिकरण''*, प्रस्तुत शोध पत्र में अध्ययन क्षेत्र की थारू महिलाओं के सशक्तिकरण की विविध आयामों का विश्लेषण एवं संश्लेषण करते हुए एक समतामूलक समाज की स्थापना करने हेतु प्रयास किया गया है।

Akshatha Gangadhar and Srikantaswamy Shivanna, in their joint paper titled, 'Photocatalytic dye degradation and biological activities of the Ag_2WO_4/CNT Nanocomposite', discusses about the effort devoted by the scientific community for the enhancement of nanostructure. Silver tungstate (Ag_2WO_4) because of its unique properties and its diverse applications it allows pollution prevention to achieve a sustainable environment. Recently, various nanoscale materials, including silver tungstate (Ag_2WO_4) nanoparticles, have been actively considered for their capacity to effectively prevent bacterial growth. Carbon nanotube (CNT) is addressed in terms of sustainable environment perspective, such as wastewater treatment. In this study the authors built up a straightforward science strategy to combine CNT with Ag_2WO_4. The synthesized nanocomposite is employed for the photocatalytic degradation of Rhodamine-B (RhB) in a single step which resolves organic dye contaminant issues at the same time, removal of heavy metals. The development of CNT with functionalized bunches was investigated by XRD, XPS, EDS, TEM, The normal size of Ag_2WO_4/CNT was around 8.26 nm with uniform size appropriation. Antibacterial impact of Ag_2WO_4/CNT was assessed against two of Gram-negative pathogenic organisms & two Gram-positive microbes. The oxidative potential by antioxidant activity can lookout.

It is expected that the readers at large will be benefitted by the content and new presentation of the journal. Urban Panorama has achieved the present status due to all round support from our authors, referees, members of Editorial & Advisory Board of the journal and also time to time guidance and suggestions from the officials of the Ministry of Housing and Urban Affairs, Govt. of India, New Delhi, and of course the readers.

I am sure joint efforts of all of us will make our task easier to achieve the heights of new successes in the field of Urban Development education and research through such publications.

Lucknow
June, 2022

Rachna Rishi
Publication Officer

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STATEMENT OF FORM IV

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I, Nishith Rai, declare that the particulars given above are true to the best of my knowledge and belief.

Nishith Rai

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GUIDELINES FOR CONTRIBUTORS

The editors and the publishers of this Journal welcome the submission of original research papers and brief research reports, notes for publication on condition that they are submitted solely to the Urban Panorama and that they will not be reprinted or translated without the consent of the editor. Papers will be judged on the content of their original data or interpretation and Referee's comments.

NOTE FOR CONTRIBUTORS

All papers must be accompanied by an abstract and key words with the degree/diploma, etc. of the authors along with the recognized abbreviations and the name of the University awarding the degree/diploma in each case. Authors should also provide the details of their current institutional affiliation.

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Tables and Figures should be indicated by numbers (Table 1) and not location (the Table below).

Manuscripts not accepted for publication would not be returned to the contributions (s) unless the request for their return is accompanied by a stamped and self-addressed envelope.

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Urban Panorama prefers articles (English/Hindi) of practical value.

The Chief Editor is responsible for the selection and acceptance of articles, but responsibility for views expressed in them rest with the author (s).

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Homeless Persons: Socio-Economic Condition and Health Status

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Abstract:
Homelessness is a complex problem. It is a result of social injustice and social inequality. The present study aimed at exploring the socio-economic conditions of the homeless persons. It also examined the health status of the homeless persons. The findings of the study reflected that the homeless persons were majorly migratory population having meagre family income. They were working as daily wage earners and many of them were in beggary. They had poor health status and limited access to health care services.

Key words : *Homelessness, socio-economic, health, displacement*

Introduction :

Human beings have certain basic need to live life. These basic needs are food, shelter, and clothing. As discussed by Maslow need hierarchy that after basic needs met, the humans aspire for safety and security needs, belongingness need, self-esteem and finally self- actualisation. There are people in society who find it difficult to meet even their basic needs and they are homeless people. Homelessness is the condition of lacking stable, safe, and adequate housing. The definition of homelessness differs from country to country and whiles some countries yet to build concrete definition. According to the Universal Declaration of Human Rights, Homeless can be defined as those who do not live in a regular residence due to lack of adequate housing, safety, and availability. As per the 2011 census count there were 17,73,040 homeless people in India. The number of homeless in urban area registered in census were 52.9 % while 47.1% registered in rural areas. Census of India follows the definition that a person or family recognised as homeless if they do not live in a census house and a census house refers to a structure with roof (GOI, 2011).

People can be categorized as homeless if they are living on the streets, moving between temporary shelters, including houses of friends, family, and emergency accommodation and living in private boarding houses without a private bathroom or security of tenure. They have no permanent house or place to live safely. Homelessness can be because of displacement, persons compelled to leave their places of domicile, who remain as refugees. Reasons of homelessness are multifaceted. There could be physiological, geographical, economical, and behavioural reasons and they are interlinked.

According to Fanning, K. (2021) many families experienced homelessness every year. The young children also became homeless because of their families. They are at greater risks of catching infections and illnesses. The early childhood experiences might have serious physical, social, psychological consequences in the later years of their life. Review conducted by Leona, L.B. (2006) reflected that homeless people also suffered from mental illnesses. They do not have access to health care services because of lack of awareness. Their socio-economic condition do not allow them to avail the private health care services. Hence, they face stigma, trauma and social exclusion.

Singh, et, al. (2018) found in a study that homelessness was universal. All the countries around the world had one or the other form of homelessness. There was a huge gap between homeless persons and other sections of the society. It had become the symbol of social injustice and social inequality. Homelessness was prevalent in rural as well as urban areas but majority of the homeless were living in the urban areas.

The daily life challenges are not easy to tackle by anyone; it becomes all the more difficult for the homeless person. The present study tried to explore and examine the socio-economic conditions of the homeless persons. It had also identified the health related problems and challenges faced by the homeless population. Homelessness is a complex social problem; it needs to be dealt cautiously. The present study focused on the homeless persons living in Delhi.

Objectives of the study :

- To explore the socio-economic profile of the homeless persons.
- To examine the health status of homeless persons.
- To find out the access of homeless persons to health care services.

Research Methodology :

The present study was undertaken with the homeless persons in the different areas of Delhi, viz., Avantika, Nangloi, Badli, Shahbad Dairy, Dilshad

Garden, and Rohini. The study was exploratory in nature. The sample comprised of 70 homeless people of different age group and gender. Purposive sampling was used to collect the data. An interview schedule was used to study the sample population. The interview schedule was comprised of both closed ended and open ended questions. The analysis of the data was done using pie charts, table, and descriptive scripts of the statements given by the respondents.

Findings of the study

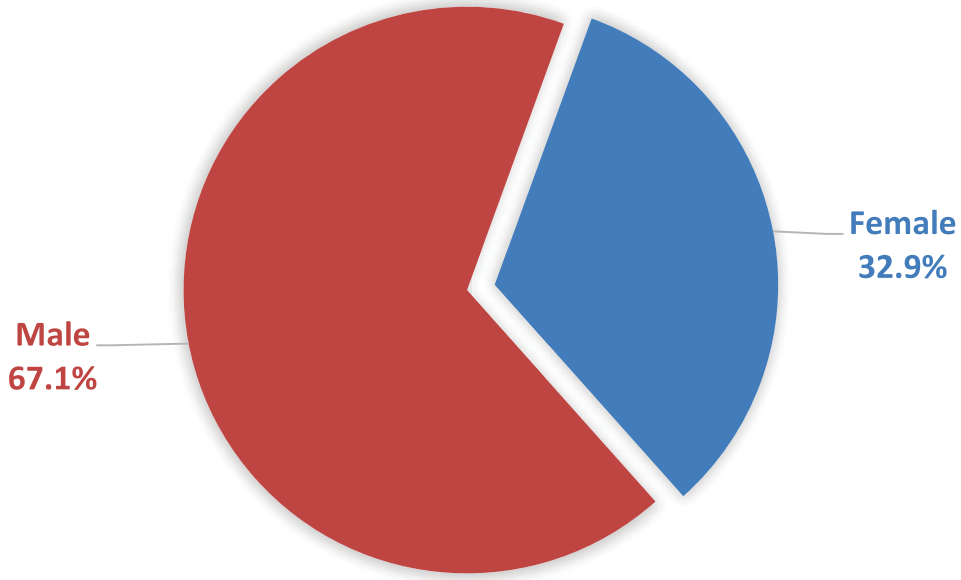
Homeless persons live in poor sanitary conditions. They work as daily wage earners and earn very meagre amount. The findings of the study reflected many aspects of their pitiable conditions.

Gender

The data was collected related to the gender of the respondents as male, female and others.

The respondent of the study were from the gender- male and female. Figure-1 reflected that 67.1 percent respondents were male while 32.9 percent respondents were female.

Fig : 1 Gender



Age:

Age of the respondents was asked

in various categories i.e., 10-20 years, 20-40 years, 40-60 years and 60-80 years.

The majority of the respondents were 20-40 years of age group and 40-60 year of age group. Table 1 depicted that six of the respondents were from 10-20 years of the age group, while the remaining were from the age group 60-80 years. The mean age of the respondents was 39 years.

Table 1 : Age

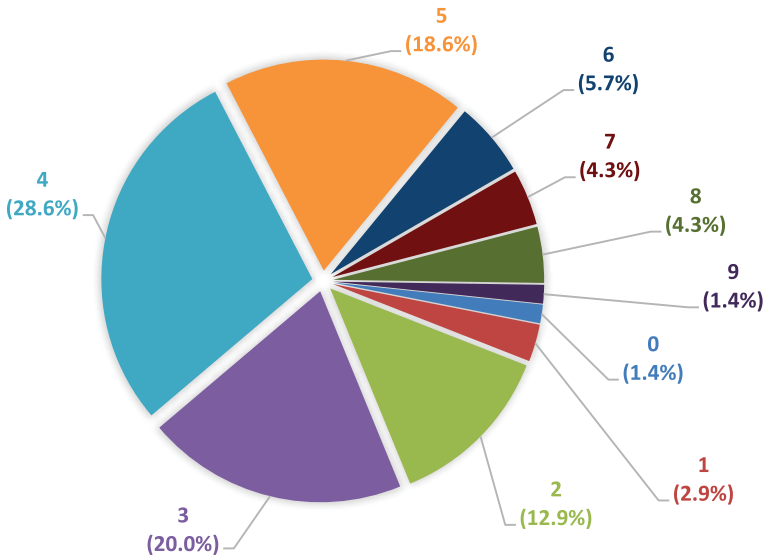
Age Group	Count (f)	Mid-point (x)	fx
10-20	6	15	90
20-40	31	30	930
40-60	29	50	1450
60-80	4	70	280
Total	**70**		**2750**

Mean Age (□) = Σ(fx)/Σ(f) = 2750/70 = 39.29 years

No. of Family members:

Homeless can be only an individual or they may be homeless as a family. The respondents were asked to

Fig. 2 : No. of Family Members



mention the number of family members.

The data in figure-2 showed that 18.6 percent of the respondents had at least 5 members in the family, 28.6 percent responded to have 4 members in the family while 20 percent and 12.9 percent had 3 and 2 members in the family respectively. Nearly 20 percent respondents cited to have 6,7,8, 9, and 10 members in the family.

Native Place:

The respondents were asked to inform about their native place in order to explore their ethnic belongingness.

The data (Figure-3) reflected that majority (70%) of them were migrated from other states and countries and in that, also 47.1 percent were from Bihar while 30 percent of the respondents were from Delhi. The other states and countries mentioned by the respondents were Nepal, Punjab, Rajasthan, Uttar Pradesh, and Bengal.

Source of Income:

Homeless persons generally work as daily wage earner or they are into beggary. The respondents cited various source of income.

Figure-4 depicted that 32.9 percent of the respondents were beggars. While 25.7 percent were vendors and 20 percent were rickshaw pullers. The data reflected that the majority of the other respondents were rag pickers. They were living and sleeping on sewer line running through the slum. It was observed that many of

Fig. 3 : Native Place

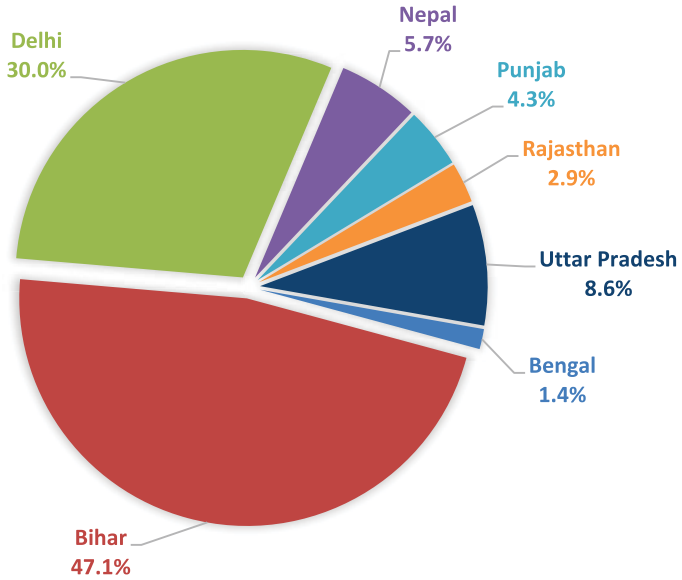
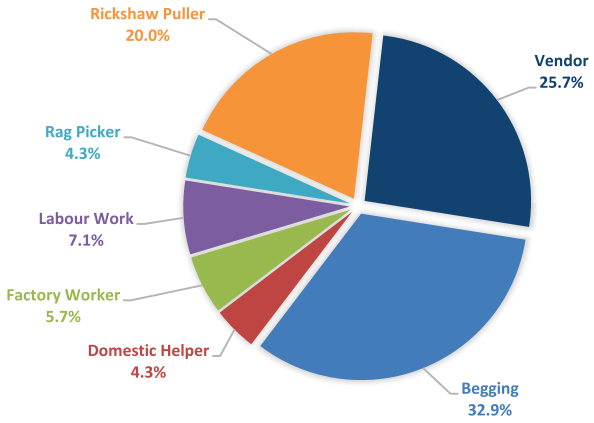


Fig. 4 : Source of Income



the areas had no water supply and people were struggling day and night for the basic amenities of life. Shortage of public toilets resulting to open defecation causing sanitation and hygiene issues in the locality. It was found the homeless persons were working as daily wage earners like labour work, factory worker and domestic helper.

Family Income:

The family income comprised of the earning of all the members collectively. The respondents were asked to inform about their monthly family income.

The data on family income in table-2 revealed that a significant number of the respondents (51) could earn less than Rs. 5,000/- per month. While 18 of the respondents said that there family income was between Rs. 5,000-10,000 per month. The average monthly income of the family was Rs. 3964.29/-

Table-2 Family Income (monthly)

Family Income	Count (f)	Mid-point (x)	fx
less than 5000	51	2500	127500
5000-10000	18	7500	135000
10000-20000	1	15000	15000
Total	**70**		**277500**

Mean Family Income (□) = Σ(fx) / Σ(f) = 277500/70 = 3964.29

Health and Illness Issues

The respondents were asked to highlight the health problems and illnesses encountered by them. The responses received were skin diseases, cough and cold, allergies, sleeplessness, accidents, injuries, asthma, and other respiratory problems. They also responded that they do suffer with illnesses like cancer, Tuberculosis, and HIV/AIDS. It was observed that the respondents suffered from both short term and long term illnesses. Many women had reported the reproductive health illnesses. They had shared that they experienced itching at the genitals, white discharge, and lower abdominal pain. When asked to get the treatment. They replied that that they had never visited the health care facilities.

Access to Health Care Facilities :

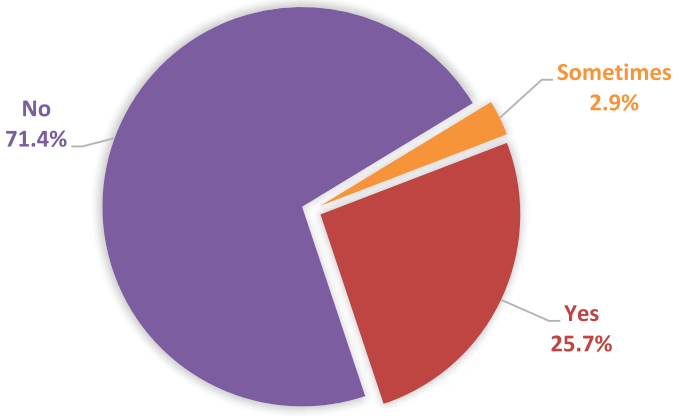
Health care facilities should be accessible to all but the homeless persons do not have access to health care services. The respondents were asked whether they had the access to health care services or not. They were also asked to cite the reasons for the same.

The present study tried to find out the access of homeless persons to health care facilities. It was found that majority of the respondents (71.4%) were not accessing any health care services. While only 25.7 percent of the respondents were availing the health care facilities. The respondents cited various reasons for not having access to health care services. The respondents revealed that they did not know much about the existing health care services. Many of them shared that they did not have money for the treatment. Some of them cited the rude and harsh attitude of the hospital staff made them reluctant to avail the health care facilities.

Discussion and Conclusion :

The homelessness is a curse on society. The people living as homeless faced many problems in their life. The findings of the study reflected that the

Fig. 5 : Access to Health Care Facilities



homeless persons were engaged in the daily wage earning. Their monthly family was so less that they cannot even afford the basic amenities to survive in a better environment. The family size comprised of many members in the family. The need assessment of the homeless people must be carried out by the future research. There is need to specifically highlight the role of civil society and government and non-government organisation for the welfare of the homeless persons.

The health status of the homeless person was very poor. Many of them had faced the chronic diseases like cancer, tuberculosis, mental illnesses, and HIV/AIDS. They had also encountered the accidents and other kind of injuries in their daily life. Living on footpath made them vulnerable to illnesses like Asthma and other respiratory problems. The problems related to reproductive health had also raised by women but they did not talk on it much because of the stigma attached with talking on reproductive health matters. The findings of the study revealed that the lack of awareness was a major reason of not accessing the health care services. The other reasons of not availing the health services were related to poor economic condition. The respondents also highlighted the fact that the rude and harsh attitude made them passive to utilize the health care services. It is the need of the hour to look at the health issues and problems of the homeless persons and develop effective strategies to combat the homelessness. Health care facilities should respond to them sensitively so that the homeless persons can easily avail them. The civil society organisations, government and non- governments organisation should create awareness among people on existing health care services.

❑❑❑

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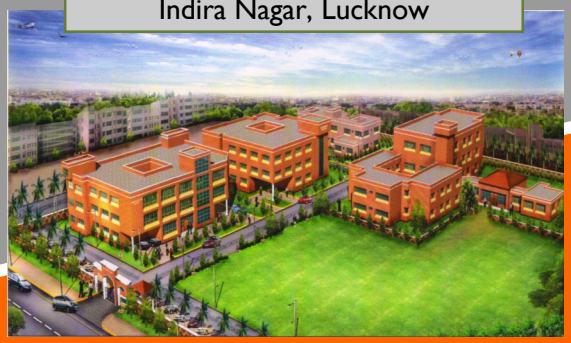

Reproductive Health Education

Adolescents' Knowledge, Perception and Programmes

Manju Goel

SHIPRA

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Prefac

"Reproductive health education
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Adolescence is a period of growth and dev
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Contemporary Practices and Perspectives

Edited by

Bishnu Mohan Dash
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14

Developing Adolescents: A Social Work Perspective

Manju

ABSTRACT

Social work intervention with adolescents is challenging and stimulating. Most of the adolescents have strong social support to deal with the life challenges, but many of them do not have consistent social support and thus struggle throughout the adolescent and emerging-adulthood years. Developing adolescent lifestyle requires interdisciplinary, collaborative, and comprehensive efforts. Adolescents' behavior, attitude, and beliefs are shaping the societies of the future. Thus, it is imperative to promote healthy practices during adolescence and to prepare them for the transition to adulthood. Social work intervention with adolescents requires the teacher and parents representations so that they could help adolescents build more relevant ones. Moreover, the adolescents' environment must be taken into account while developing any program as adolescents' representations are not only based on what they learn at school, but also on all the other aspects of an adolescent's life. There is a need to inculcate life skills abilities for adaptive and positive behavior that enable adolescents to deal effectively with the demands, challenges, and stress of everyday life. Life skills abilities acquisition facilitates adolescents to act responsibly, take initiative, and take control.

Introduction

Adolescence period is marked with certain major developmental changes and challenges, i.e. to acquire and consolidate the social competencies, attitudes, autonomy, problem-solving skills and social and ethical values necessary to make a successful transition into adulthood. Adolescents experience puberty, expanded cognitive abilities, a new sense of self and identity, and often new and increased expectations at school and work. Relationships with parents and peers change too. Growing adolescents need to develop social skills to form and maintain healthy relationships with family, peers, and rest of the social communities. If these social relationships are of better quality, it will prove to be beneficial for the psychological health, improved academic performance and success in social relationships as adult. Contrary to this, absence of such quality relationships yield negative outcomes and can have serious repercussions on adolescents' academic as well as personal and social life. Absence of quality social relationships promote high risk behavior such as alcoholism, drug abuse and casual relationships, rebellion, disorientation, peer pressure and curiosity. The psychological push factors such as the inability to tackle emotional pain, conflicts, frustrations and anxieties about the future are often the driving force for high risk behavior. It is imperative to impart life skills education for empowering the adolescents to act responsibly, take initiative and take control. Life skills education is based on the assumption that when adolescents are able to rise above emotional impasses arising from daily conflicts, entangled relationships and peer pressure, they are less likely to resort to anti-social or high risk behaviors. The life skills education aims to impart skills such as communication, decision-making, positive thinking, coping, assertiveness, anger management, self-esteem building, resisting peer pressure, and personal goal-setting.

Intervening in the lives of adolescents is challenging. Social work practice with adolescents involves working not just with the adolescents but also with their families, peers, schools, and neighborhoods. Helping adolescents to confront adversity and develop mechanisms that promote resiliency is critical, especially

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37. GERONTOLOGICAL SOCIAL WORK: UNDERSTANDING THE IMPORTANCE OF ELDER CARE

Manju Goel

"One who always serves and respects elderly is blessed with four things: Long Life, Wisdom,Fame and Power".

—***Manusmriti Chapter 2:121***

Elderly are defined as persons 60 years of age and older. Unfortunately, there are numerous negative stereotypes about older persons. The reality is that older persons live independently and maintain close relationships with family and friends. Personality remains relatively stable throughout the lifespan. Older persons do experience age-related changes, both physical and cognitive. Common age-related physical changes include hearing impairment, weakening vision, and the increasing probability of multiple chronic conditions such as arthritis, hypertension, heart disease, diabetes, and osteoporosis. While there is some degree of cognitive impairment, cognitive changes in older persons are highly variable from one person to another, but can include decline in information processing speed and memory problems. These changes do not typically interfere with daily living. Because a large number of older persons take several medications, drug interactions and drug side effects are more common than in younger age groups.

The size of India's elderly population is greater than the total population of many developed and developing countries. According to World Health Statistics, (2011), eighty three million persons in India are 60 years of age and older, representing over seven percent of the nation's total population (WHO, 2011). Over the next four decades, India's demographic structure is expected to shift dramatically from a young to an aging population resulting in 316 million elderly persons by 2050 (James, K, 2011). The aging population is a sign of successful development in
and educati

About the Editors

Prof. Sushma Batra, MSW, M.Phil, Ph.D., has more than 35 years of teaching experience in Department of Social Work, University of Delhi. Apart from this, she has been pursuing her special areas of interest to work with older persons and persons with disability over the years. She had guided number of research scholars in pursuing their research work as part of M.Phil, Ph.D. Programme on various issues related to social work discipline. She was the Honorary Director of Women Studies and Development Centre of University of Delhi, Head of the Department of Social Work, University of Delhi, Honorary Director of Utthan, and Extension Project of Centre for Child and Adolescent Well-Being of the Department. She has authored many books on various issues relating to social work and has published many articles in reputed journals.

Dr. Bishnu Mohan Dash, MSW, M.Phil, Ph.D. ICSSR Post-Doctoral Fellow, presently working as Assistant Professor, Department of Social Work, Bhim Rao Ambedkar College, University of Delhi. He is recipient of Academic Excellence Award, 2018, and Best Teacher Award, 2019 (Government of Delhi) authored/co-authored/edited eight books and published articles in reputed journals including Sage, Routledge, Blackwell & Wiley etc. His areas of interest are Rural Development, Child Welfare, Social Work Education and Field Work Practice.

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Preface

The book "Fundamentals of Social Work" provides an overview of various basic aspects of social work profession. The book has been divided in two parts. Part one is comprised of nine chapters and part two also includes eight chapters.

Part One, introduces the reader with the basic concepts in social work, social work education and its relation with other disciplines; theories in social work; methods recognized in social work; roles and functions of a professional social worker, and genesis of social work education as a discipline in India and other parts of the world. It also covers attributes and skills required to be a professional social worker.

Nita Kumari has authored first chapter of this book titled "Introduction to Social Work". The chapter introduces the reader with defining social work profession and its mission. It gives brief introduction on code of ethics—values and principles. The chapter also provides a brief description on the scope of social work profession, roles of a professional worker and methods of working with people and communities.

Puneet Kumar Ojha has contributed a chapter titled "Social Work and Its Relationship to Other Disciplines". The chapter introduces the young readers the basics of social work and its relation with other disciplines such as medicine, psychology, history, sociology, public administration, law and economics. Social work discipline draws its knowledge base from various disciplines of social and biological sciences to understand various aspects of human life and redress complex human problems.

Sayantani Guin traces the evolution of social work practice in India from charity approach to human rights approach in her chapter titled "Social Work in India: From Charity to Human

17
International Social Work

Manju Goel

Introduction

Social Work is an applied profession that uses knowledge to effect change at all levels, i.e. individual, institutional, and societal. Social work practice and policy are increasingly shaped by global phenomena, and there are many opportunities for social work to make an impact on the world level. Therefore, a dynamic, action-oriented conceptualization of international social work is required. Social workers can benefit from knowing how the issues in their state are played out in other states. There is so much to learn of innovative practices and of possible solutions to social problems that never would have been imagined without an international exchange of information. International Social Work is generally understood to encompass global and policy issues, comparative social policy, international professional organisations, social work practice focused on development of human rights, or migration, especially that in international agencies. International social work practice is also specific to the human rights of vulnerable populations such as racial, ethnic, and sexual minorities, poverty, homelessness, hunger, migration, child welfare policies, geriatric care, youth welfare, family welfare, women empowerment, HIV/AIDS prevention, substance abuse treatment, income maintenance and support programmes, services to people with disabilities, probation and correctional social work, community organizing and development, family disintegration, juvenile delinquency, and health care provisions.

The concept of international social work was first used by George Warren in 1943 to describe social work practice in agencies that were engaged in organised international efforts. Sanders (1984) and Sanders and Pedersen (1984) defined international social work as a distinct field of practice and stressed the importance of specific skills and knowledge to enable social workers to work in international agencies such as the International Committee of the Red Cross. Over time, the term international social work also came to encompass domestic social work practice with immigrants and refugees. Healy (2001) does not view international social work practice as a field, but uses the term international action and makes the case that due to increased global interdependence, both local social workers and domestic human service agencies have greater opportunities and even a responsibility to engage in international activities. The use of the term international action as the basis of the definition of international social work has led to four practice categories:

- *Internationally related domestic practice and advocacy:* It includes working with the refugees and immigrants, international populations, international adoptions, and so forth.
- *Professional exchange:* It involves communication of knowledge and sharing of experiences.
- *International practice:* It involves direct work in international agencies, such as relief and disaster work.
- *International policy development and advocacy:* It involves the formulation of policy positions and actions to resolve global social problems.

International Social Work includes the exchanges of ideas by social workers at international meetings as well as inter-country work, intergovernmental work, and relief work. International Social Work contains four main types of activities: (a) international social case work; (b) international assistance, public and private, to disaster or war sufferers and distressed minority groups; (c) international conferences on social work; and (d) international cooperation by governments and private bodies through the medium of the league, in combatting disease and securing social and political peace and harmony throughout the world (Warren, 1939).

FIGHTING HIV/AIDS:
THE GRACIOUS WAY

Edited by

Bishnu Mohan Dash

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10

HIV/AIDS in Doctoral Programme

Manju Goel

Introduction

"HIV/AIDS: Stigma, discrimination and prevention" is one of the courses being offered by IGNOU in its pre-doctoral and doctoral programmes focusing on various aspects of HIV/AIDS, its nature, epidemiology, intervention strategies and issues pertaining to stigma and discrimination. The Programme Coordinator, Dr. Gracious Thomas, was concerned about the HIV infected and the affected who faced discrimination from across the board. Even after two decades of living with HIV, there was widespread discrimination in most societies. The course written by a group of committed academics has explained various aspects of stigma and discrimination in the context of HIV apart from describing other issues associated with HIV/AIDS. Stigma, a socially constructed process that categorizes people into "them" and "us" on the basis of race, gender, sexual orientation, and disease, among others, leads to discrimination against the stigmatized individuals or groups who are devalued in comparison to those in the mainstream.

HIV/AIDS-related stigma and discrimination are issues of great concern because of their ramifications on access to HIV/AIDS prevention, treatment, care, and support for people living with HIV/AIDS. The contributors to the course accentuated to examine the impact of HIV/AIDS on various aspects of social, political, and economic life; prevention,

treatment, care, and support for people living with HIV/AIDS; HIV/AIDS and different section of society like women, children, working population of organised and unorganised sectors; legal aspects concerning HIV/AIDS at the national and international level; theories and models of stigma and discrimination; stigma and discrimination by health care and social service providers; response strategies for social workers and; best practices in HIV/AIDS prevention and education.

HIV/AIDS: Nature and Demography

The introduction chapter describes the nature and demography of HIV/AIDS and provides a basic understanding about HIV/AIDS. HIV/AIDS was one of the serious problems facing the world at that time and nobody was beyond its reach. The text emphasised that the understanding of the profile of the disease is important for social workers and required their intervention in preventing and controlling the spread of the epidemic.The author intricately has woven the facts on history and origin of HIV/AIDS and controversial theories on the origin of HIV/AIDS. Global scenario on the pattern of the spread of HIV infection is discussed and summarized by giving the main characteristics of HIV and AIDS.

Social and Economic Implications

The impact of HIV/AIDS on various aspects of social, political, and economic life especially with reference to less developed countries has been examined in a separate chapter by reviewing several documents on economic growth, corporate firms, agriculture, and health sector. The author has categorised the impact of HIV into socio-economic impacts as well as macro-micro-level implications. At the household level, the most frequently felt impact of HIV is increased spending on treatment and care. It was reflected that affordability of Anti-Retroviral drugs was not easy for most of the households affected with the HIV/AIDS. The chapter has also discussed about gender inequality resulted by HIV/AIDS.

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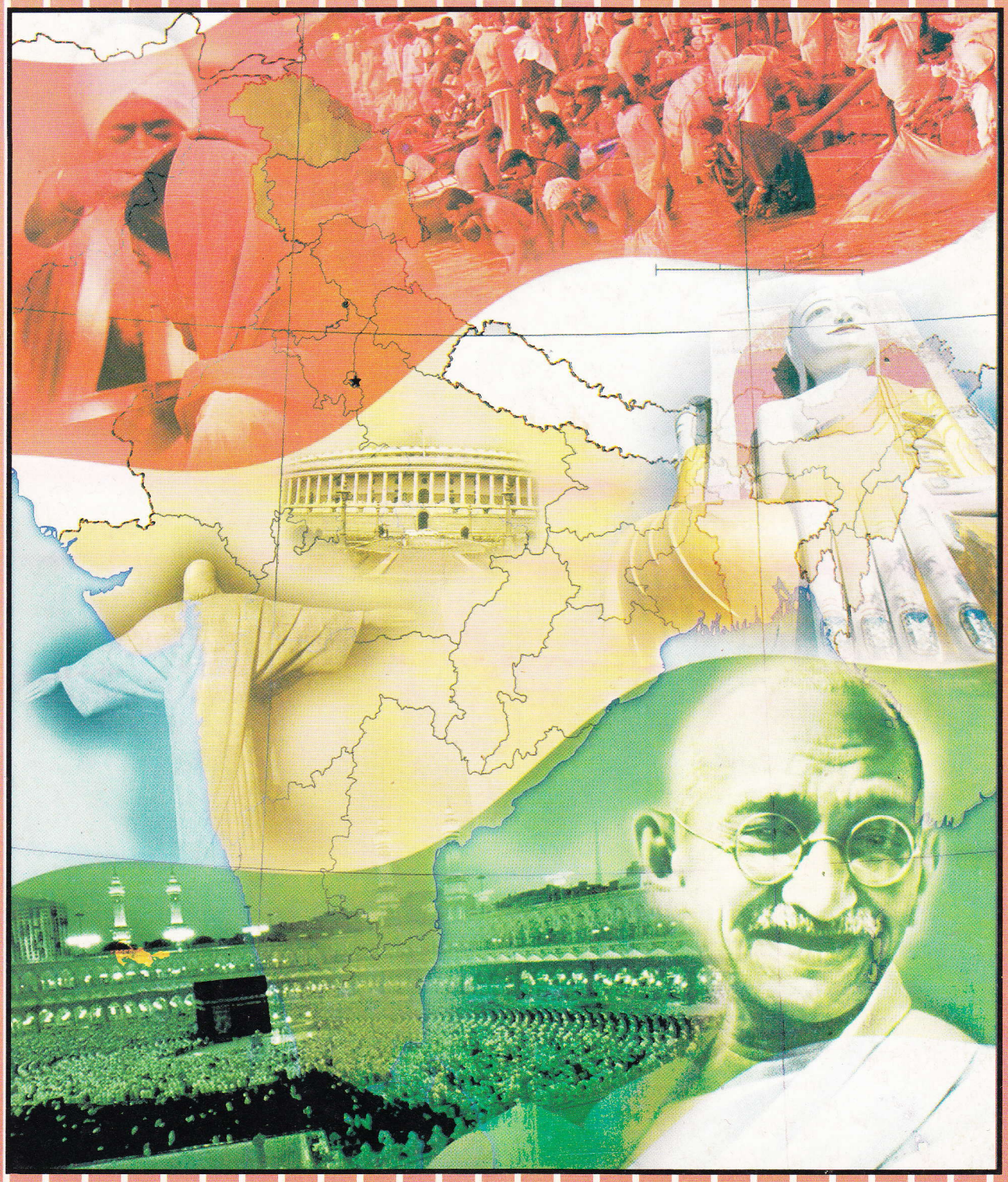

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श्री कुलवंत सिंह, अनुभाग अधिकारी (प्रकाशन)
समाज कार्य विद्यापीठ, इग्नू, नई दिल्ली

मई, 2009

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इन्दिरा गांधी राष्ट्रीय मुक्त विश्वविद्यालय के विश्वविद्यालय कार्यालय मैदान गढ़ी नई दिल्ली से अधिक जानकारी प्राप्त की जा सकती है।

इन्दिरा गांधी राष्ट्रीय मुक्त विश्वविद्यालय की ओर से निदेशक समाज कार्य विद्यापीठ द्वारा मुद्रित एवं प्रकाशित।

लेजर टाइप सेटिंग : टेसा मीडिया एण्ड कम्प्यूटर, C-206, A.F.Enclave-II, नई दिल्ली

मुद्रक : प्रभात ऑफसैट प्रेस, नई दिल्ली–2

इकाई 1 समाज कार्य का इतिहासः राज्य की पहलें

इकाई की रूपरेखा

1.0 उद्देश्य

इस इकाई का उद्देश्य आपको भारत में, प्राचीन, औपनिवेशिक और आधुनिक काल के विशेष संदर्भ में भारत में समाज कार्य के विकास और उद्‌भव की जानकारी प्रदान करना है। समाज कल्याण और समाज कार्य पहलों की झलक प्राप्त कर भारत के इतिहास का पुनरावलोकन करना भी है। इस इकाई का अध्ययन करने के बाद आपः

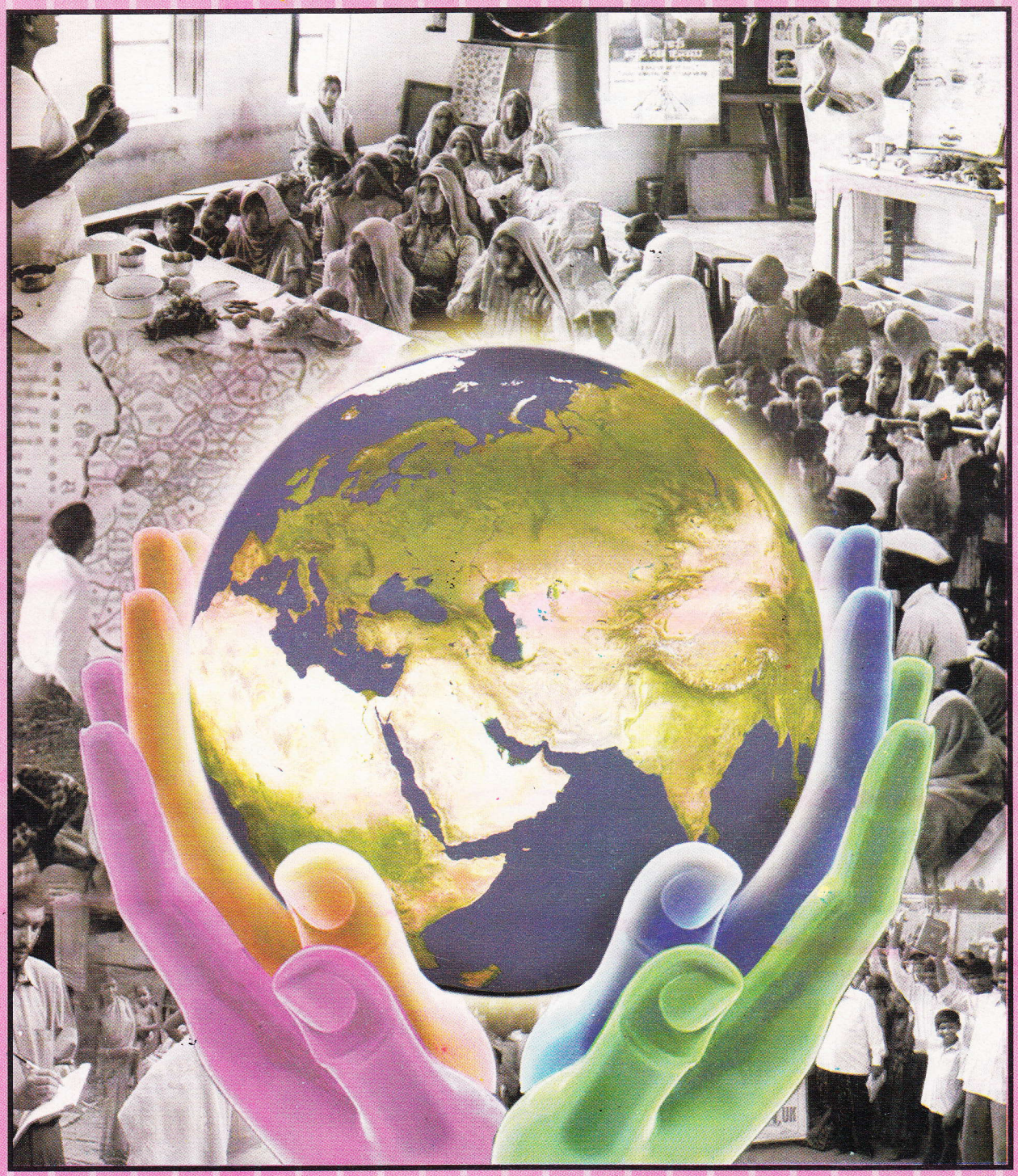
- भारत में समाज कार्य का उद्‌भव ज्ञात कर सकेंगे;
- उन विभिन्न आवश्यकताओं को समझ सकेंगे जिन्होंने कल्याणकारी कार्यक्रम (welfare programme) प्रारंभ करने के लिए राज्य को बाध्य किया;
- विकास कल्याणकारी सेवाओं में धार्मिक विचारधाराओं (religious ideologies), कृतियों (writings) और संस्थाओं (institutions) का प्रभाव जान सकेंगे;
- प्रत्येक प्रावस्था में दी गई सेवाओं का स्वरूप; अर्थात् प्राचीन, औपनिवेशिक और आधुनिक, ज्ञात कर सकेंगे तथा उनमें अंतर कर सकेंगे; और
- समकालीन समाज (contemporary society) में समाज कार्य पद्धतियों के भिन्न-भिन्न क्षेत्रों में केन्द्रीय और राज्य सरकारों के विभिन्न कार्यक्रमों के बारे में जानकारी प्राप्त कर सकेंगे।

1.1 प्रस्तावना

भारत में समाज कार्य का इतिहास युगों पुरानी घटना है। यद्यपि, व्यवसाय के रूप में समाज कार्य पश्चिमी देशों द्वारा स्वीकार तथा विकसित किया गया है। फिर भी जिन आधारों पर व्यवसाय खड़ा है, भारत के इतिहास की नींव पर सुदृढ़ता से विद्यमान है। समाज सेवा के उद्‌भव के बीज, विश्व की विचारधाराओं, जैसे धर्म-निरपेक्ष (Secular), मानवता (humanism), प्रोटेस्टैण्टवाद (protestantism), बुद्धिवाद (तर्कणावाद) (rationalism), कल्याणवाद (welfarism), उदारतावादी लोकतंत्र (liberalism democracy) और उपयोगितावाद (utilitarianism) में ढूंढ़े जा सकते हैं। कल्याण की धारणा (notion of welfare) भी भारत में ***धर्म*** ***(Dharma)*** की जड़ों से उत्पन्न हुई मानवीय पीड़ाओं और स्वार्थी इच्छा भी मानव

इंदिरा गांधी राष्ट्रीय मुक्त विश्वविद्यालय
समाज कार्य विद्यापीठ

MSW-005
समाज कार्य प्रैक्टिकम



विभिन्न परिवेशों में समाज कार्य प्रैक्टिकम 4

विशेषज्ञ समिति

खंड निर्माण दल

इकाई लेखक

इकाई 1 डॉ. के. हेमलता, क्राइस्ट कॉलेज, बैंगलोर
सुश्री सुषमा मूर्ती, क्राइस्ट कॉलेज, बैंगलोर

इकाई 2 सुश्री मंजु गुप्ता, दिल्ली विश्वविद्यालय, दिल्ली

इकाई 3 श्री जोसलीन टी. लोबो, रोशनी निलया, मैंगलोर

इकाई 4 सुश्री संगीता धर, डॉ. बी.आर. अंबेडकर कॉलेज, दिल्ली विश्वविद्यालय, दिल्ली

इकाई 5 श्री जोसफ वर्गीज़, क्राइस्ट कॉलेज, बैंगलोर

पाठ्यक्रम संपादक एवं कार्यक्रम संयोजक

प्रो. ग्रेशियस थॉमस
इंदिरा गांधी राष्ट्रीय मुक्त विश्वविद्यालय
नई दिल्ली

कार्यक्रम सह-संयोजक

डॉ. अशोक सरकार एवं
श्री गुरुपद सरेन
इंदिरा गांधी राष्ट्रीय मुक्त विश्वविद्यालय
नई दिल्ली

खंड सम्पादक

प्रो. पी. के. गांधी
जामिया मिल्लिया इस्लामिया
विश्वविद्यालय, नई दिल्ली

मुद्रण प्रस्तुति

श्री कुलवंत सिंह
अनुभाग अधिकारी (मुद्रण)
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इंदिरा गांधी राष्ट्रीय मुक्त विश्वविद्यालय के पाठ्यक्रमों के विषय में और अधिक जानकारी विश्वविद्यालय के कार्यालय, मैदान गढ़ी, नई दिल्ली-110 068 से प्राप्त की जा सकती है।

इंदिरा गांधी राष्ट्रीय मुक्त विश्वविद्यालय की ओर से निदेशक, समाज कार्य विद्यापीठ द्वारा मुद्रित एवं प्रकाशित।

लेजर टाईपिंग : राजश्री कम्प्यूटर्स, वी–166ए, भगवती विहार, उत्तम नगर, नजदीक सेक्टर 2 द्वारका, नई दिल्ली–59

मुद्रक :– कल्याण इन्टरप्राईजेज, 215/5, अम्बेडकर गली, मौजपुर, दिल्ली–53

इकाई 2 चिकित्सा, मनोचिकित्सा और बाल देखभाल

इकाई की रूपरेखा

2.0 उद्देश्य

इस इकाई का उद्देश्य स्वास्थ्य देखभाल, मानसिक स्वास्थ्य और बाल देखभाल स्थापनाओं में समाज कार्य अभ्यास की जानकारी प्रदान करना है। इस इकाई को पढ़ने के पश्चात् आपः

- अपने संबद्ध क्षेत्रों में अभ्यास करते हुए बच्चों, परिवारों, स्वास्थ्य देखभाल प्रदाता और समुदाय के साथ प्रभावी रूप से काम करने के लिए अनिवार्य कौशलों, मूल्यों और विधियों की बेहतर जानकारी हासिल कर सकेंगे;
- इन परिवेशों (settings) में सामाजिक कार्यकर्त्ताओं की भूमिकाओं और दायित्वों को जान सकेंगे; और
- इन स्थापनाओं में समाज कार्य व्यावसायिकों के लिए अवसरों (कार्यक्षेत्र) का निर्धारण कर सकेंगे।

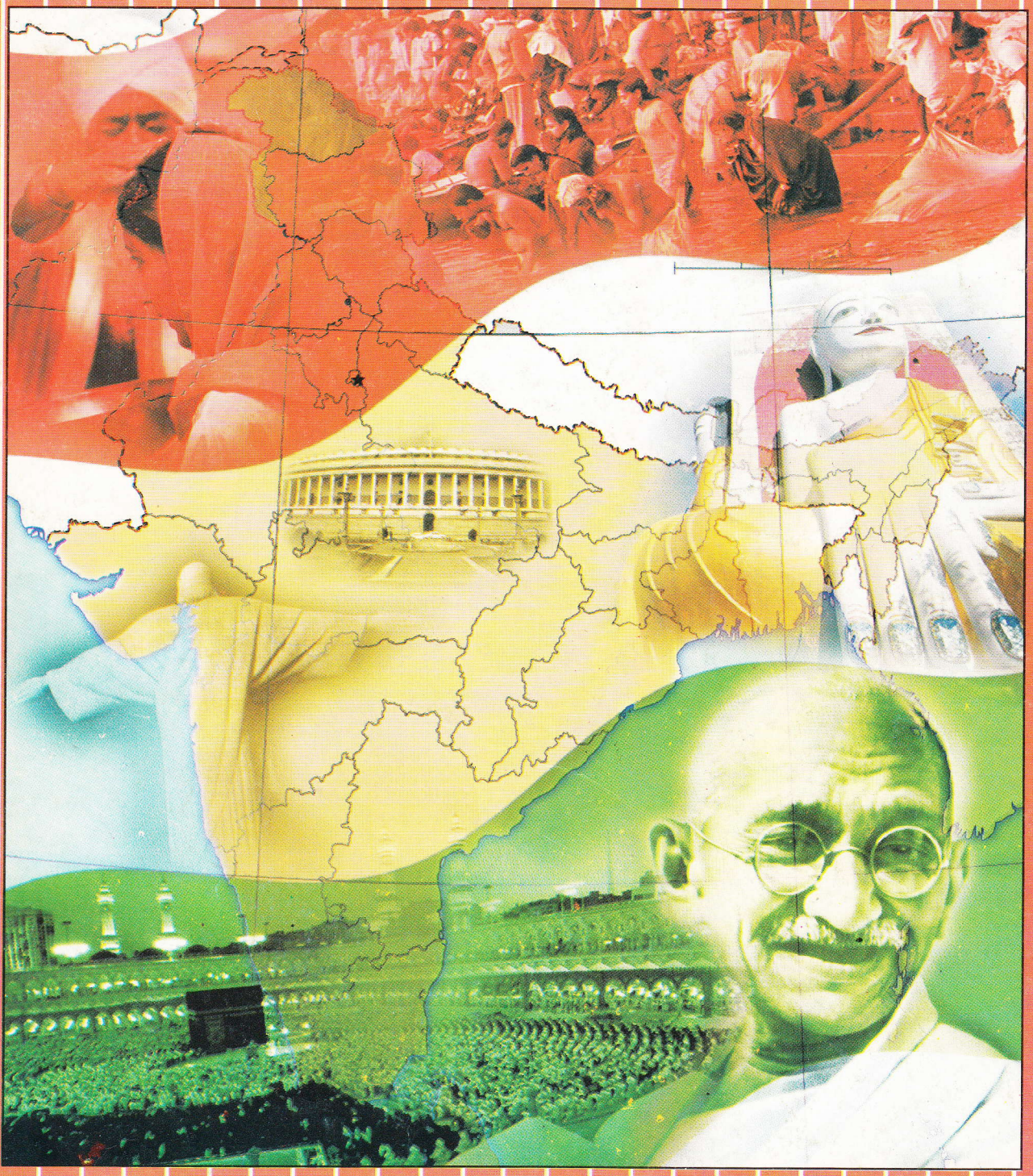
2.1 प्रस्तावना

समाज कार्य उन व्यक्तियों के लिए व्यवसाय (क्षेत्र) है जो लोगों के जीवन को सुधारने व बेहतर बनाने में मदद करने की तीव्र इच्छा रखते हैं। सामाजिक कार्यकर्त्ता व्यक्तियों को उनके माहौल में बेहतर रूप से काम करने, अपने संबंधों से निपटने (व्यवहार करने) और व्यक्तिगत व पारिवारिक समस्याएँ सुलझाने में सहायता करते हैं। स्वास्थ्य देखभाल में निरंतर होने वाली वृद्धि, मांगों और परिवर्तनों ने स्वास्थ्य देखभाल और बाल कल्याण व विकास के स्थापनाओं सहित सभी क्षेत्रों में सामाजिक कार्यकर्त्ताओं की ज़रूरत और जीवन क्षमता पर गंभीर प्रभाव डाला है। व्यक्तियों के लिए स्वास्थ्य देखभाल उचित समय पर, व्यापक और न्यायसंगत पहुँच (सुविधा) में पर्याप्त अंतर है, इनमें आबादी के अधिकांश वर्गों तक स्वास्थ्य देखभाल की सुविधा सीमित ही है। बच्चों के उत्तरजीविता, विकास, सुरक्षा और सहभागिता अधिकारों को सुनिश्चित करना समाज कार्य व्यवसाय के कार्यक्षेत्र के अंतर्गत आता है।

आजकल, स्वास्थ्य देखभाल समाज कार्यकर्त्ता विविध परिवेशों में विभिन्न सांतत्यक देखभाल सेवाएँ प्रदान करते हैं। समाज कार्यकर्त्ता जन स्वास्थ्य, गंभीर और दीर्घकालीन

Indira Gandhi National Open University
School of Social Work

MSW - 002
ORIGIN AND DEVELOPMENT
OF SOCIAL WORK IN INDIA



Evolution of Social Work Practice in India

1

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UNIT 1 HISTORY OF SOCIAL WORK: STATE INITIATIVES

Structure

1.0 OBJECTIVES

The aim of this Unit is to provide you with an understanding of evolution and emergence of social work in India with special reference to state initiatives during ancient, colonial and modern period. It is also revisiting Indian history to have glimpses of social welfare and social work initiatives. After reading this Unit you would be able to:

- trace the origin of social work in India;
- understand various needs which compelled the state to initiate welfare programme;
- impact of religious ideologies, writings, institutions in developing welfare services;
- nature of services delivered in each phase i.e. ancient, colonial and modern and differences in it; and
- learn various programmes of Central and State governments in different areas of social work practice in contemporary society.

1.1 INRODUCATION

History of Social Work in India is an age old phenomenon. Though Social Work as a profession was recognized and developed by western countries yet the bases on which the profession rests upon very well exist in the foundation of Indian history. The seeds of evolution of Social Work could be explored in world ideologies i.e. secular, humanism, protestantism, rationalism, welfarism, liberalism democracy and utilitarianism. The notion of welfare stemmed up in India in the roots of ***Dharma***. The history of human sufferings and selfish desire too persisted in human society and so existed the mutual assistance to provide protections to humanity. History speaks volume of initiatives taken by kings, queens, landlords, foreign conquerors and invaders, and also under the system of diarchy and later under the constitutional reform of 1935 which ushered in a new era of popularly elected government in the provinces. Social Work emerged as a profession from the perspectives of social services, charity, reform and welfare. Social Work traveled a long way from welfare to empowerment and development and the present emphasis of the profession is

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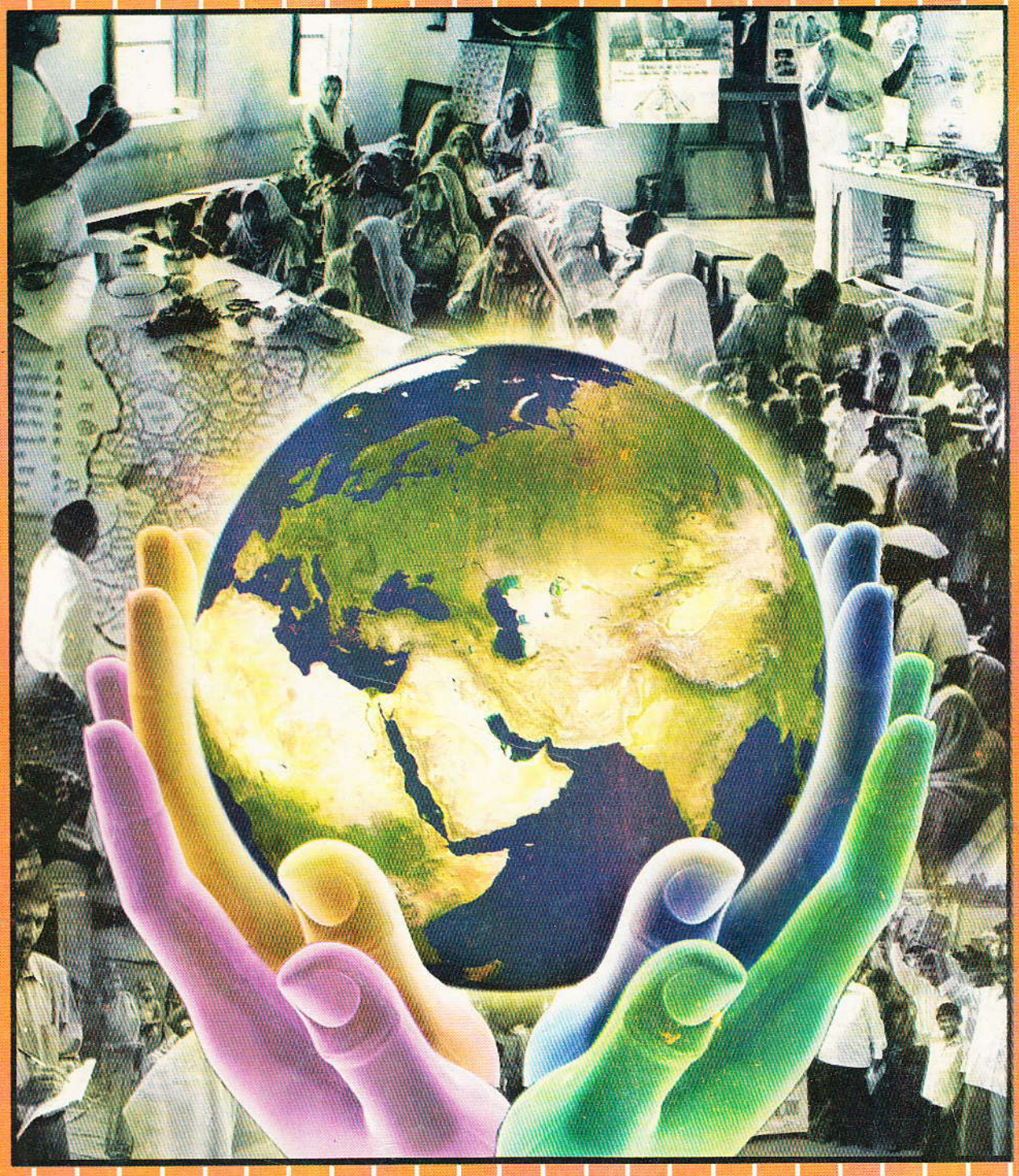
MSW - 005
SOCIAL WORK PRACTICUM

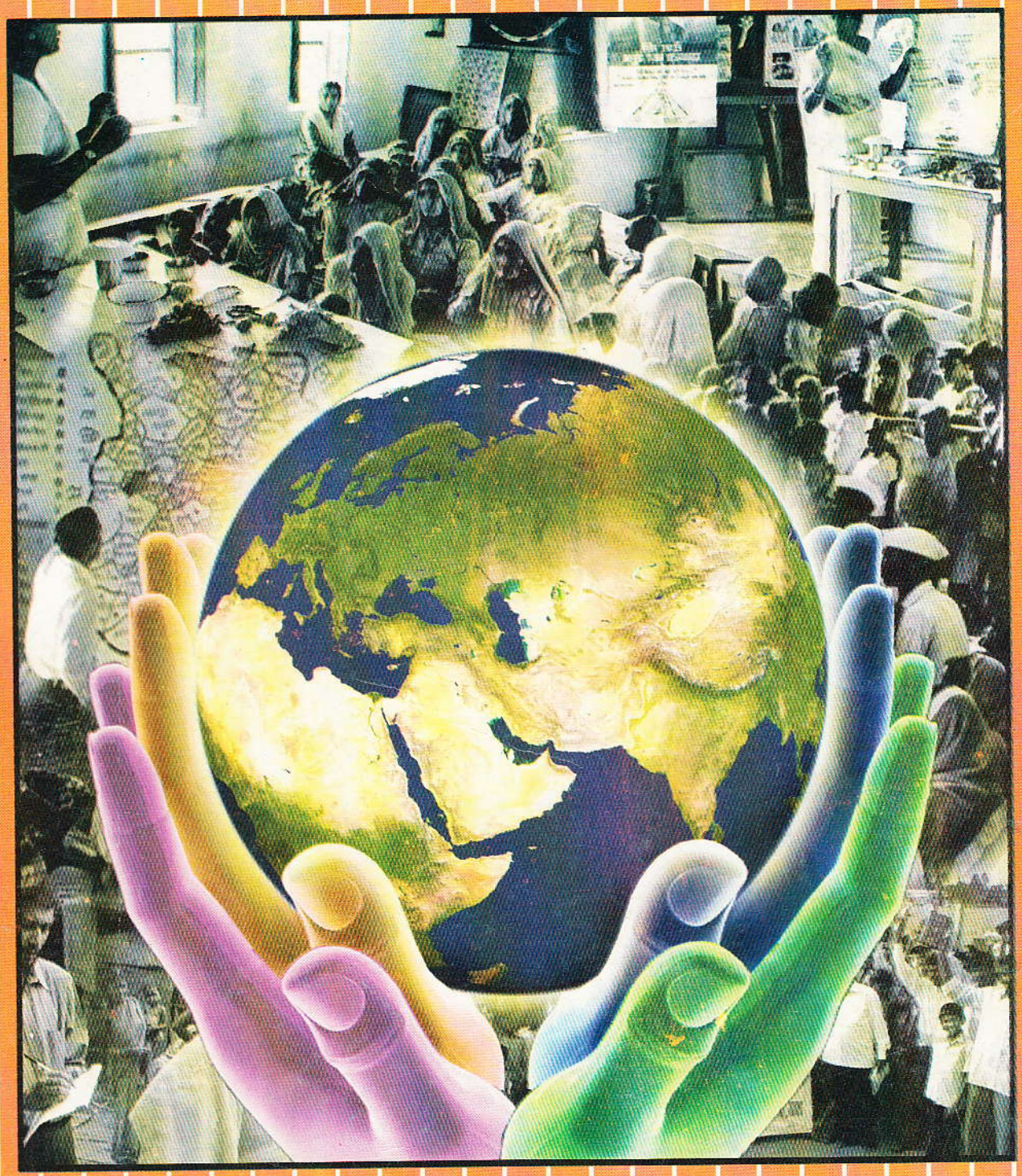


Social Work Practicum in Various Settings

4

Indira Gandhi National Open University
School of Social Work

MSW - 005
SOCIAL WORK PRACTICUM



Social Work Practicum in Various Settings

4

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UNIT 2 MEDICAL, PSYCHIATRY AND CHILD CARE

Structure

Ms. Manju Gupta*

2.0 OBJECTIVES

The Purpose of this Unit is to provide you with an understanding of social work practice in healthcare, mental health and child care settings. After reading this Unit you would be able to:

- gain a better understanding of skills, values, and methods necessary to work effectively with children, families, health care providers, and the community when practicing in the respective fields;
- understand the roles and responsibilities of social workers in these settings; and
- appraise the scope of social work professionals in these settings.

2.1 INTRODUCTION

Social work is a profession for those with a strong desire to help in improving people's lives. Social workers help people function better in their environment, deal with their relationships, and solve personal and family problems. The constant growth, demands, and changes in health care have had a serious impact on the viability and need for social workers in all areas including settings of health care and child welfare and development. Access to timely, comprehensive, and equitable health care for individuals varies considerably, with significant percentages of many segments of population having only limited access to health care. Ensuring rights to survival, development, protection and participation to children form the scope of social work profession.

Currently, health care social workers provide services across the continuum of care in various settings. Social workers are present in public health, acute and chronic care settings providing a range of services including health education, crisis intervention, supportive counseling, and case management. Professional social workers are well equipped to practice in the health care field, because of their broad perspective on the range of physical, emotional, and environmental factors that have an effect on the well-being of individuals and communities.

*Ms. Manju Gupta, Delhi

ADITI MAHAVIDYALAYA

University of Delhi

antardhvani 2015

Certificate of Appreciation

This certificate recognizes the commendable efforts, commitment and active participation of Dr. Manju Goel for his/her contributions in showcasing good practices and achievements of the college during Antardhvani held on 20th to 22nd February 2015.

The college is proud to won a commendation prize from University of Delhi.

Dr. Nalini Singh
Convenor

Kalpana

Dr. Kalpana Bhrara
Principal

UNIVERSITY OF DELHI

Research Display at the Convocation Ceremony

19 November 2016

Certificate of Appreciation

Awarded for being selected for the Research Display

Project Code: AM 302

Project CodeTitle: Development of an Educational Program to Enhance Food Label Understanding among Early Adolescents: Peri Urban Delhi

College: Aditi Mahavidyalaya College

Principal Investigators: Upasna Seth*, Sandhya Vatsyayana, Manju Goel, Sneh Gangwar

Students: Annapurna Sharma, Elika Anand, Kajal Saini, Kanishka, Kirti Kumari, Nabanita Das*, Priyanka Bhardwaj, Radhika Khanna, S. Eeshwarna, Shayma

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Chairperson, Research Council

Dr. Deepika Bhaskar
Coordinator, Innovation Desk

* Presented the poster


विश्व युवक केंद्र
आपके उत्कृष्ट सामाजिक योगदान के लिये
अंतर्राष्ट्रीय महिला दिवस-2017
के अवसर पर
आपको सादर सम्मानित करता है।

डा. मंजू गोयल

ADITI MAHAVIDYALAYA

(UNIVERSITY OF DELHI)

DR. MANJU GOEL

Alumni Achievers Award 2018-19

3rd Alumni Meet

24th Feb, 2019


Vishwa Yuvak Kendra
Felicitates
Dr. Manju Goel
On The Occasion of
INTERNATIONAL WOMEN'S DAY- 2023
"DigitALL: Innovation and Technology for Gender Equality"