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Sixty Years of Professional Sociology in Kerala: An Institutional Genealogy

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Abstract

The discipline of sociology has been part of the academic landscape of Kerala for over sixty years now. Yet there has been little work chronicling its life and times. This article attempts to fill the gap in the literature, and traces the institutional genealogy of sociology in Kerala through three generations. The first-generation sociology departments were those established in the 1960s. Another set of departments were established in the late 1970s and early 1980s, followed by the sporadic formation of departments through the late eighties and early nineties. The third generation of sociology departments can be traced to the post-2010 decade. The names of some significant individuals associated with each institution in its earliest phases have been mentioned. Disparate instances of sociology being taught as a minor subject from the 1930s are also recorded, as precursors to

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sociology departments. The article touches upon the introduction and popularity of sociology as a subject of distance education and as taught at the school level, and the complementarity of these two factors. The varying historical contexts through which sociology in Kerala developed are seen to affect the nature of institutions. The role of the state, identity-based organisations and enterprising individuals in the development of sociology in Kerala are analysed. The data for this article was drawn from investigations made as part of a doctoral research project.

Keywords: Professional Sociology, Institutional Histories, Higher Education in Kerala, Distance Education, Sociology at School

Introduction

The discipline of sociology has been part of the academic landscape of Kerala for over sixty years now. Yet there have not been comprehensive studies or analyses of its origin and developments. This is not an isolated issue. While there has been a steady stream of writing on the 'sociology of sociology in India' or 'sociology of Indian sociology' and on trends in the development of sociology and social anthropology (for instance, Chaudhuri, 2003; Chaudhuri, 2010a; Madan, 2011; Patel, 2011; Srinivas and Panini, 1973), historical accounts of the development of sociology in different parts of India are not easy to find, though one comes across the odd article (see for instance, Nanda, 2010; Saikia, 2017; Shah, 2000). It is noted that "the sociological traditions of India have yet to find their historians" (Madan, 2011: xiii) and that "…a comprehensive history of the development of sociology in India is yet to be written" (Sunil, 2013: 113). Sica claims that such is true of the history of sociology in any country (cited in Collyer and Manning, 2021). Book-length treatments of the history of sociology are uncommon in India, as they are elsewhere in the world (Collyer and Manning, 2021). Textbooks

and journal articles are the major products of this sub-field within sociology, yet even these are rare in the case of sociology in Kerala.

The past decade has seen the publication of reflective works on sociology in Kerala. Luiz (2014) set the tone using Michael Burawoy's fourfold classification of the roles of sociology to examine the contributions of the discipline in the fields of public discourse, policymaking and academics. Joseph (2015) carried the debate forward, noting the various dilemmas of an academic practitioner of sociology in Kerala at different points of time during the academic year: "angst" about the inflow of students at the beginning; concern for the self-evaluation of students of sociology in comparison with those from other disciplines during the course of the year; and anxiety regarding their career and employment opportunities towards the end (2015: 91-92). Continuing the discourse on sociology in Kerala, Vincent (2016) provided a wide-ranging analysis of the issues that surround the practice of sociology in the state. However, none of these works have provided an adequate sociological analysis of the origins of the discipline in Kerala. This article addresses the gap by sketching out the genealogy of sociology in Kerala.

Genealogies were developed in the discipline of anthropology as a way of tracing lineage through generations in order to understand the interlinkages between individuals and groups in a community. Genealogies provide a view of the past that can help us to understand the ways of the present. This article attempts a genealogy of sociology in Kerala by delineating the links between the various institutions involved. A view of the beginnings of sociology in Kerala could help us understand the trajectories that it took later and in turn provide a beacon to move forward. This article will trace the genealogy of sociology in Kerala through three generations beginning from the 1960s. It will also provide a view of the 'precursor institutions' where sociology existed as a minor course well before Indian

independence. An analysis of this historical development is presented in the final section.

Precursors to sociology departments in Kerala

The discipline of sociology was a late entrant in the academic scene of Kerala as compared to some of the major centres of the discipline in India. Sociology took hold in India in the pre-independence period. Madan (2011) notes that a combined master's course in economics and sociology was introduced at Calcutta University around 1908. The University of Bombay began offering lectures in sociology in the year 1914, though a department of sociology and civics was set up under the Scottish town planner Patrick Geddes only in 1919. The University of Lucknow, where a combined department of sociology and economics was established in 1921, became another major centre for sociological studies.

By this time sociology had become familiar in the southern region as well. Brajendranath Seal who became the vice-chancellor of Mysore University introduced sociology as a subject at the BA level in 1917 (Srinivas and Panini, 1973: 191). In 1928-29, sociology was introduced as one of the optional subjects at the BA level at Osmania University. The discipline also took roots at the Deccan College and Post-Graduate Research Institute at Poona under the leadership of Irawati Karve in the late 1930s (Srinivas and Panini, 1973). Srinivas and Panini (1973) do not make reference to Madras University or institutions in Kerala in their sketch of the history of sociology and social anthropology, but we find evidence that colleges in the region were offering subsidiary courses[1] in sociology for undergraduate students from the 1930s.

The website of St Berchmans College, Changanassery states that sociology was taught as a minor course for the degree in economics from the inception of the programme in 1934: "Right

from the beginning, the (economics) Department consisted of Departments of History, Political Science and Sociology" (St Berchmans College, 2018). This is a claim that I have heard elsewhere (Sunil Babu C.T., personal communication). The presence of sociology at St. Teresa's College Ernakulam in the same period supports this claim. Sociology was introduced as a subsidiary subject in 1937 for those pursuing a degree in economics (St. Teresa's College, 1975: 4). Sources from St. Mary's College Thrissur, established in 1946, affirm that sociology was taught as a subsidiary course on and off since the inception of the college (Shipsy Augustine, personal communication). Sociology has also been taught as a minor course at NSS College Changanassery from the time the college was established, in 1948 (V. Seethalekshmi, personal communication; Suresh Babu, personal communication). All these colleges were at the time affiliated to the University of Madras. In 1957, following the formation of Kerala state, the affiliation of these colleges was shifted to the University of Kerala.

Independence and the urge for nation-building gave a spurt to higher education in the country. The discipline of sociology also spread its wings, with departments established in different parts of the country to teach sociology at the undergraduate and postgraduate levels (Srinivas and Panini, 1973). Present-day Gujarat state saw the inauguration of courses in sociology from the late 1940s and early 1950s (Shah, 2000). Annamalai University in Tamil Nadu had programmes from the 1950s (Sujatha, 2010). In the north-east, sociology teaching became full-fledged only in the 1960s (Nanda, 2010). Departments of sociology were established at the University of Delhi in 1959, and at Jawaharlal Nehru University, Delhi and the University of Hyderabad in the 1970s.

In Kerala, BA and MA programmes in sociology were introduced from the 1960s. Keeping aside the precursor

institutions mentioned earlier, we can discern three generations in the growth of sociology in Kerala. The first-generation sociology departments were those established in the 1960s. Another set of departments were established in the late 1970s and early 1980s, followed by the sporadic formation of departments through the late eighties and early nineties. The third generation of sociology departments can be traced to the post-2010 decade.[2]

The first-generation sociology departments in Kerala

The first generation of scholars who taught sociology in Kerala had inevitably been trained outside the state. There were those educated at Bombay, Rajasthan, Trichy, Dharwad and Nagpur. A few, including priests and nuns, had received their training in sociology at institutions in the United States. This section will deal with some factors surrounding the establishment of the first-generation departments. Some significant individuals associated with each institution in its earliest phases are mentioned.

Sociology was first introduced at the postgraduate level in Kerala at the Loyola College of Social Sciences (henceforth Loyola), established by the Society of Jesus[3] near the capital city of Thiruvananthapuram in 1963. The college came into existence with a postgraduate programme in sociology, soon followed by another in social work (Jose, 2014). In its early years, the department and the college were headed by Joseph Puthenkalam SJ who had a master's degree in economics from another Jesuit institution, St. Joseph's College, Trichy (P.T. Mathew SJ, personal communication). He obtained his doctorate in sociology from Bombay University under the guidance of K.M. Kapadia in 1963. Puthenkalam's monograph *Marriage and Family in Kerala* (1977) published by the University of Calgary remains an important source of information on kinship in Kerala. Another Jesuit, Jose

Murickan SJ, who had a doctorate in sociology from St. Louis University in the USA (P.T. Mathew SJ, personal communication) was instrumental in building the research orientation of the department. The college was recognised as a research centre in sociology in the year 1973 (Loyola College of Social Sciences, 2021).

Bishop Chulaparambil Memorial (BCM) College, a women's college managed by the Knanaya Catholic diocese of Kottayam was the first to begin an undergraduate programme in sociology in Kerala, and one which was exclusively for women. Prior to this, the college was offering a diploma course in social service. Grace Makkil (T.M. Grace), who had a postgraduate degree in labour and social welfare from Xavier Labour Relations Institute Jamshedpur (now XLRI – Xavier School of Management), was the first faculty member and head of the department of sociology. She was soon joined by a priest, Joseph Karottukunnel, and a nun, Mary Michael SVM, who had completed their postgraduate degrees from the United States (Infoweavers, 2020).

Sacred Heart College, Thevara, run by the Carmelites of Mary Immaculate (CMI) congregation of Catholic male religious in Ernakulam district began its bachelor's programme in sociology in the year 1964. This was preceded by a diploma in social service that was offered from 1955 (Sacred Heart College, 1995) and the Masters in Social Work, which was functional since 1961 (Prasant Palackappillil, personal communication). Joseph Ligouri CMI was the founder-head of the department. With him were C.K. Nalinababu and Varghese Erattupuzha (Sacred Heart College, 1995). In 1967 the postgraduate department of social work was shifted from Sacred Heart to its sister institution, Rajagiri College of Social Sciences (Wilson, 2012).[4]

Church Mission Society (CMS) College, Kottayam established by missionaries of the Church Missionary Society from Britain in 1817, inaugurated a postgraduate programme in sociology in 1965. K.E. Verghese, with a doctorate in history from Balliol College, Oxford University and teaching experience in the United Kingdom, Uganda and Nigeria, was asked to take up the task of starting a sociology department. Verghese had written books such as *Slow Flows the Pampa: Socio-economic changes in a Kuttanad village in Kerala* (1982). With him were Sarah Mathew, who had done her PG in sociology from Histop College Nagpur, Mary Thomas, who had studied at Rajasthan University and T.V. John (Mathew, 2021).The department became a research centre in 2008 (CMS College Kottayam, 2021).

As mentioned earlier, St. Teresa's College, managed by the Carmelite Sisters of St. Teresa (CSST) congregation, records the teaching of sociology from 1937. A diploma in social service was offered from 1957, but was later discontinued. In 1966, the nun Marie Cecile CSST launched a postgraduate programme in sociology at the college. Marie Cecile had done her BA from Madras University and her MA in sociology from Bombay University. She also had a certificate in social research from Tata Institute of Social Sciences, Bombay (Lebia Gladis N.P. CSST, personal communication). A single-main bachelor's programme in sociology was started at this women's college in 1971. Flora M. Dey, Mercy Francis (who later became the first female Mayor of Kochi), Ramola B. Joseph, the diocesan priest George Koilparambil, Annie Thomas, Anne Felice CSST and Mariamma Joseph joined the department in the 1970s.The department became a research centre in 1985(St. Teresa's College, 1986: vii).

Vimala College, Thrissur was established by the nuns of the Congregation of the Mother of Carmel (CMC) in 1967 with the bifurcation of St. Mary's College, Thrissur. Undergraduate and postgraduate departments from St. Mary's College were

shifted to the new college due to space constraints (St. Mary's College Thrissur, 2021b). With this, the bachelor's programme in sociology that had been started at St. Mary's College the previous year was shifted to Vimala College (Vimala College, 2020). Samuel CMC is considered the founder of the department. She was joined by Sheelamma Antony, an alumna of Loyola.

At St. Joseph's College, Irinjalakuda in Thrissur district, managed by the Catholic nuns of the Congregation of the Holy Family (CHF), the faculty in sociology have always been attached to the economics department. A degree in economics was started in 1967 (St. Joseph's College Autonomous, 2018) and sociology was launched as its subsidiary course. Bianca CHF who had dual postgraduate degrees from the United States was the first faculty to teach sociology there (St. Joseph's College Autonomous, 2018).

Saint Berchmans, or SB College, as the institution is popularly known, is managed by the Catholic archdiocese of Changanacherry.[5] It began a bachelor's programme in economics in the year 1934. While the college website hints at the presence of sociology as a subsidiary course since the 1930s, other documentary evidence regarding this has been hard to come by. A document on the history of the college does not mention sociology even as it notes other subjects taught at the college in the year 1939 (St. Berchmans' College, 2007). Whatever the case, sociology has literally been a single-man department at the college since it was introduced. Antony Kurialacherry, a priest of the Changanacherry archdiocese who had studied political science and sociology from the United States is said to have taught both these subjects here in the early 1960s (Jacob Mathew, personal communication). A document regarding the history of the college however mentions that it was only in 1967-68 that "sociology was introduced as a subsidiary subject for BA Economics and English" (St. Berchmans' College, 2007). Mathew Pulickaparampil, another priest of the archdiocese of

Changanacherry who completed his postgraduation from Loyola University in the United States is said to have taught sociology at SB College from this time.

Five years and eight Christian management-run colleges later, Zamorin's Guruvayurappan College (henceforth Guruvayurappan College), managed by an educational agency that works on behalf of the Zamorin of Calicut, introduced sociology in northern Kerala in 1968 with a combined Malayalam-sociology UG programme. G. Ramachandra Raj, who had a doctorate from Rajasthan University, was the first appointee at the department. He left after a few months to join the sociology department at the University of Kerala. Shy Ali Koya who had done his postgraduation from Karnatak University, Dharwad became the next head of the department. He was joined by D.D. Namboodiri who had completed his postgraduation from Rajasthan University in 1970 (D.D. Namboodiri, personal communication). In 1978, a postgraduate programme in sociology was started and Joni C. Joseph, T.K. Bhagyalatha and P. Nirmala Bhai, doctorate-holders from the university of Kerala, were appointed. In 2020, the department became a research centre for sociology.

It was in 1969 that a department of sociology was established at the University of Kerala, at its Kariavattom campus (henceforth Kariavattom[6]). This was also the first instance where sociology entered the government-managed sphere of higher education in Kerala. P.K.B. Nayar, who had master's degrees in sociology, economics, economic development, political science and history, and had completed his doctorate in sociology from Pittsburgh University in the United States was appointed as reader and head of the department. Another reader, C.M. Abraham, who had formerly taught at universities in north India, left the department to join Madras University soon afterwards (P.K.B. Nayar, personal communication). Following his departure, G. Ramachandra Raj, who had been with the department of sociology at

Guruvayurappan College and G. Narayana Pillai, an alumnus of the first batch of sociology students from Loyola, joined Nayar at the department. A PhD programme in sociology was inaugurated in 1970 (Resmi, 2013).

Second-generation departments

After a gap of almost a decade, more departments of sociology were established at colleges run by private managements. Most of the faculty who established or joined the second-generation departments of sociology in Kerala were products of Loyola and Kariavattom as these were the major research centres for sociology in the state. The narrative in the following section is not in strict chronological order. We begin with a view of sociology at three colleges run by the Nair Service Society (NSS).

Although sociology was introduced at NSS College Changanassery in the 1940s itself, it was much later that the subject came to be handled by faculty who had studied sociology (V. Seethalekshmi, personal communication). At the college, sociology is offered as a complementary subject for students with philosophy, political science and English as their main subjects. At NSS College, Pandalam, established in 1950, where a BA in political science was started the same year and another BA in English began in 1959, sociology was offered as a subsidiary course for students of these disciplines at least from the 1970s. U. Lalitha Devi and T.K. Thulaseedharan Pillai were the faculty involved (P. Devan, personal communication). At Mahatma Gandhi College, also managed by the NSS, a BA in sociology was born of the efforts of T.K. Thulaseedharan Pillai in the 1980s. The other faculty at the department were Jaya Kumari S. and V.S. Syamala Devi (V. Seethalekshmi, personal communication; P. Devan, personal communication).

Other community-based organisations were also showing an interest in the discipline. A department of sociology was started at Mar Athanasius College, Kothamangalam in 1980 under the initiative of T.M. Paily who went on to become the principal of the college. Sara Chacko, Ashley Mathew, Mary Thomas and Valsamma Mathai were others who served the department through the next couple of decades. At SN College Chempazhanthy, managed by the Sree Narayana Trusts, Kollam, an undergraduate department in sociology took root in 1981 (Sree Narayana College Chempazhanthy, 2021). The first-generation faculty at the department were R Kasthuri, K.B. Thankamony, K. Usha and B. Jayasree. Farook College, established in 1948 by the Rouzathul Uloom Association, started a combined sociology and Malayalam bachelor's programme in the year 1981 (Farook College, 2021). In 1990 the double-main programme was bifurcated and sociology was offered as a single main undergraduate programme (BadhariyaBeegum, personal communication). N.P. Hafiz Mohamad, a distinguished literary figure who has won the Kendra Sahitya Akademi award and the Kerala Sahitya Akademi award, K. Mohamed Basheer and K.K. Syed Abid Husain Thangal, who went on to become a member of the Kerala Legislative Assembly, were associated with the department from its inception. At NAM College Kallikkandy, managed by the Muslim Educational Foundation Panoor, sociology has been taught as a subsidiary course for history students since the establishment of the college in 1995. E.K. Munira Beebi has been the sole sociology teacher at the college, which is affiliated to the University of Kannur (NAM College Kallikkandy, 2020).

We can see the affinity of sociology with women's colleges run by Catholic nuns persisting in the second generation. Having given up its undergraduate programme in sociology to Vimala College in 1967, St. Mary's College Thrissur, managed by the nuns of the CMC congregation, reintroduced sociology as a

subsidiary course in the 1980s (St. Mary's College Thrissur, 2021a). At Mercy College Palakkad, a sister concern of St. Mary's College Thrissur, a subsidiary course in sociology came about with the inauguration of a bachelor's programme in economics in 1981 (Mercy College, 2020). The nun Leoni CMC was the founding faculty member. At Carmel College Mala, also managed by nuns of the CMC congregation, sociology was chosen when the college was granted its first undergraduate programmes in 1984 (Carmel College Mala, n.d.). The Carmelite nun Samuel CMC, the pioneering force behind the department of sociology at Vimala College and St. Mary's College, was also responsible for starting the department of sociology at Carmel College. At Morning Star Home Science College, yet another institution run by Catholic nuns, sociology has been taught from 1981 – initially as part of the pre-degree programme, but later as a subsidiary course, with Santha Sebastian as the sociology faculty (Morning Star Home Science College, 2019).

There were takers for sociology from the cooperative sector and the government sector as well. Co-operative Arts and Science College, or 'Madayi College', as it is popularly known, was established by the Payyanur Cooperative Educational Society Ltd. in Kannur district. A bachelor's programme in history inaugurated in 1991, as well as the BA in English started in 1993 had sociology as a subsidiary course. Saji P. Jacob, Dilip K.G. and Peter M. Raj occupied the sociology post at Madayi for brief tenures before they left to join departments elsewhere.[7] For long, KNM College was the only government college in the state to offer a programme in sociology. A BA in sociology was sanctioned in 1995, followed by a postgraduate programme in 2012. From 2017 the college has also been a research centre in sociology (K.N.M. Arts & Science College, 2016a; K.N.M. Arts & Science College, 2016 b).

The department of sociology at Sree Sankaracharya University of Sanskrit, Kalady was established along with the university in 1995. Sociology was initially conceived as part of a triple main programme. Sara Neena T.T. who had obtained her research degrees at Bharathiar University in Tamil Nadu and Dilip K.G. who had completed his doctorate from Kariavattom were appointed at the department. When the former received appointment at Vimala College, the department became a single-man faculty and stayed so for many years. In 2009 the department was upgraded to a research centre with an integrated MPhil-PhD programme (Sree Sankaracharya University of Sanskrit, 2021). The department started offering a PG programme in 2014.

Interlude: Sociology through distance education and sociology at school

Independence had increased the demand for higher education in erstwhile colonies. Yet resource crunches meant that conventional, or 'regular' educational institutions were unable to meet this demand. This led to the worldwide proliferation of distance education through the late twentieth century. Universities in Kerala began to provide the option for private registration from the early 1970s.

At present, sociology is among the favourite subjects of students who take up distance programmes in Kerala for their undergraduate or postgraduate degrees (see Luiz, 2023 for details). Chaudhuri points out that sociology played a "crucial social function" in providing "a soft option for the first/second generation learners by virtue of being 'general' (less technical) and by virtue of dealing with the familiar thing called society. This degree becomes the social and cultural capital for the marginalized" (2010b: 20). Such a function for the discipline can be observed in other states as well (see Singh, 2010; Kumar, 2010; Chaudhuri, 2010b). In Kerala, in addition to the image of sociology as a 'soft'

subject, liberal valuation and the shortage of seats in sociology in the regular format could have contributed to its popularity. However, the devaluation of distance education often meant that being a 'popular' subject was a "dubious honour" (Singh, 2010: 107).

Sociology has also carved out a space at schools, as an optional subject at the higher secondary school (HSS) level. There are also chapters on sociology in high school textbooks. Concepts such as gender, discrimination and social structure are tangentially introduced in social science textbooks from class five. While the discipline remains overshadowed by economics, political science and history, its outlook is strong. According to one estimate, roughly 24000 students in Kerala clear their higher secondary programme annually having studied sociology as one of their optional subjects (Charles Varghese, personal communication).[8]

It would be necessary to understand the complementarity of sociology as a subject of distance education and as a subject taught at school. Sociology provided one of the easiest means of gaining the educational capital of a graduate or postgraduate degree in Kerala. The creation of a number of sociology posts at the higher secondary school level led to a surge in the demand for sociology in the distance stream, especially from high school teachers who aimed for promotions to the HSS level. The supply of teachers qualified in sociology, aided by the strong network of the HSS fraternity, created further demand for sociology posts at the school level. At the same time, the spread of the subject at the HSS level, combined with the shortage of regular seats at the undergraduate level could be further fuelling the demand for sociology through the distance stream.

Third-generation departments

Sociology at the collegiate level has not been able to keep up with its popularity at the HSS level. While many thousand

students finish their schooling having studied sociology every year, there are only around 550 regular seats for sociology at the undergraduate level in Kerala, and under 350 seats for postgraduation. Therefore, the second decade of the 21st century saw the proliferation of sociology programmes in the self-financing (the colloquial term for student-financed) sector, especially in the Malabar region.

The government sector has also taken an interest in sociology. At Rajiv Gandhi Memorial Government Arts and Science College, Attappadi, Palakkad located in a tribal-majority region, sociology has been offered as a minor subject for BA students majoring in public administration and history from the inception of the college in 2012. In 2014, a postgraduate department of sociology was started in the self-financing mode at the campus of the University of Calicut while Government Arts and Science College, Thavanur became the second government college to start a BA in sociology in the state. In 2015, Thunchath Ezhuthachan Malayalam University started a department of sociology that transacts courses, exams and research in Malayalam. In the same year, the University of Calicut started the Institute of Tribal Studies and Research (ITSR) at Chethalayam, Wayanad, that runs residential BA and MA courses in sociology aiming "to meet the higher education needs of the tribal community" (University of Calicut, 2021). Government Arts and Science College, Tazhava, Karunagappally started a BA in sociology in 2018.

Conclusion: Structure, agency, and sociology in Kerala

We can discern some broad patterns in the way sociology has become institutionalised in the state. Sociology came to Kerala on a major scale post-independence, free from the colonial linkages of social anthropology. Early social anthropological works on Kerala date decades before independence, with

contributions from L.K. Ananthakrishna Iyer and A. Aiyappan, among others. Their works are esteemed in anthropological circles, but as they were not involved in the institutional structure of sociological teaching-learning in Kerala, their contributions are not a part of the sociological imagination here.

Neither does sociology in Kerala claim the heritage of the founding fathers of sociology in India. Private college managements, mostly Christian, have led the way in the establishment of sociology departments, especially in the first and second generations. Keeping aside NSS College Changanassery, the first eight colleges to offer sociology programmes were managed by various Christian churches and congregations. This was followed by Guruvayurappan College, under the patronage of the Zamorins, the erstwhile ruling family of Calicut. Only after this did the government sector turn to sociology, with the establishment of the department at Kariavattom. Church support to sociology continued through the second generation of departments. The CMC alone established two independent departments to teach sociology at the undergraduate level and offer sociology as a complementary course at two other colleges. In addition to Christian managements, caste- and community-based managements also took up the cause of sociology in the second generation. This included the NSS and the Sree Narayana Dharma Paripalana (SNDP) Yogam, which have been significant actors in the education field of Kerala alongside Christian managements (Kizhakekariyil, 1986).

The establishment of sociology in Kerala may owe much to identity-based organisations, but once it entered the university system, it gained a momentum of its own. From the time students began graduating in sociology, there has been a pool of scholars who could teach sociology. Teaching opportunities in sociology being scarce in Kerala, enterprising individuals who had the social

capital to influence college managements found ways to create new departments and bring about posts in sociology by the second generation. The surge in demand for higher education post-independence and the relatively free hand that managements had in appointments in the early years after state formation aided this trend. Stories of departments being started to cater to the career aspirations of candidates who shared community affiliations with college managements have been shared from different quarters. According to a faculty member, "*palayidathum eligible people pinnaalenadannaanallo departments establish cheythathu.*" ["Departments were established at many institutions because eligible candidates went after it."] The case of government colleges does not seem to have been very different. Specific individuals are pinpointed as being behind the creation of whatever departments and posts exist in sociology in the government sector today. This seems to be a feature of not just the sociological field but higher education as a whole. Narratives from other parts of the country tell us that caste, kinship and money play an important role in faculty recruitment elsewhere as well (see for instance Kumar, 2010).

By the time the third-generation sociology departments were being set up, the context of higher education had undergone major paradigm shifts. The period from the 1980s witnessed the massification, differentiation, marketisation, privatisation and internationalisation of education (Jaiswal, 2019: 230-31). In India, the balance of payment crisis of the early nineties brought the state under pressure to make various structural adjustments. Its ripples were seen in the higher educational sector of Kerala. Student-financing of education (as opposed to state-subsidised education) became more common. The economist M.A. Oommen records that "arts and science colleges affiliated to universities increased from 172 in 1991 to 958 in 2020, a 5.5 times growth." Of these, "476, or nearly 50%, are self-financing colleges." He

attributes this to "the accelerated flow of foreign remittance since the economic reforms of 1991… education proved to be a lucrative investment candidate for many including powerful social groups" (2021: 6). These trends did not leave sociology untouched, as is seen from the growth in the number of self-financing institutions offering sociology programmes.

Concurrently, there is a continuing reluctance on the part of the government to promote the discipline. Of the 66 government arts and science colleges in Kerala, only four teach sociology. Government colleges at Thavanur and Karunagappally offer undergraduate programmes in sociology while the college at Attappadi has only a complementary programme in sociology. KNM College is the only institution under the collegiate education department that offers a master's programme and research in sociology (in addition to a BA). The distance of sociology from the state has been costly on various fronts. Among the nearly one thousand colleges in the state, hardly fifty offer programmes in sociology. Due to this, sociologists have remained a small minority among higher education faculty and have not developed as an interest group that could influence government policy to its advantage.

There are many more institutional factors that have influenced the state of sociology in Kerala. Two major institutions related to sociology in India – the Kerala Sociological Society and its journal the *Kerala Sociologist* have not been taken up in this article. Their role in the fortunes of sociology in Kerala need to be explored in more detail. The state of sociological research is another matter that needs exposition. The genealogical analysis itself would need greater elaboration of the role of specific organisations and historical contexts in bringing up sociology in Kerala. For the time being, due to constraints of space, this article has presented a brief historical sketch of the origin and expansion of sociology at higher education institutions in Kerala. It will

hopefully clear the way for wide-ranging reflections on the past, present and futures of the discipline in the region.

Notes

1 A term used to denote minor subjects.

2 The three-generation classification of sociology in Kerala is inspired by a similar classification in the history of Loyola College Trivandrum (Jose, 2014).

3 The Society of Jesus, or 'Jesuits', a global congregation of Catholic male religious, have established educational institutions across the world. Some of the prominent Jesuit institutions in India are St. Xavier's College, Mumbai, Loyola College, Chennai and St. Xavier's University, Kolkata. Jesuits affix SJ to their name to denote their congregation.

4 Antony Kariyil CMI who went on to occupy one of the topmost positions in the Syro-Malabar Church of Kerala began his teaching career at the department in 1974.

5 An older spelling of Changanassery, which is still retained in the title of the Catholic archdiocese.

6 This is how the sociology department of the University of Kerala is known in local sociological circles.

7 They spent more years of service at respectively, Loyola College, Sanskrit University and Kerala Institute of Local Administration (KILA).

8 The Kerala Sociological Society in 2015 deputed a sub-committee to prepare a status report of sociology in Kerala. Much thanks to Charles Varghese for sharing the details collected for the report.

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Transitional Struggles: Sociological Insights from the Suicides of Ananya Kumari Alex and Praveen Nath in Kerala

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Abstract

Situated within Kerala's complex socio-cultural matrix, this article gives an in-depth exploration into the interstitial spaces that transsexual individuals direct, particularly against the backdrop of entrenched gender norms and societal expectations. Grounded in Emile Durkheim's theory of suicide, this research uses case study methodology to explain the socio-cultural determinants contributing to the tragic demises of Ananya Kumari Alex on July 20, 2021, and Praveen Nath on May 4, 2023. Both Ananya Kumari Alex and Praveen Nath, after undergoing gender affirmation surgeries, dealt with many challenges that resonate deeply with Durkheimian constructs of integration and regulation. These challenges are exactlydefined, comparing individual

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experiences with the broader societal framework and governmental response post incidents. Directing the complex terrains of gender binaries, this study explores the processes of acceptance, alienation, and self-affirmation prevalent among the transsexual community in Kerala. It also critically appraises the state's intervention and its potential in addressing these challenges. By interrogating these cases through a Durkheimian lens, the article enriches the epistemological foundation concerning transgender experiences in Kerala, emphasising the pressing need for inclusive socio-political strategies promoting inclusivity and understanding.

Keywords*: Transgender Narratives, Societal Paradigms, State Initiations,SRS,Gender Affirmation*

Introduction

Transgender individuals, navigating the complicated terrains of socio-cultural norms and self-identity, often find themselves at the crossroads of personal affirmation and societal acceptance. Kerala, a state celebrated for its progressive socio-political history, is not immune to the complexities of this plot. The state's rich tapestry, highlighted by its high literacy rates and unique cultural ethos, casts a contrasting shadow over the lived experiences of its transgender population.Gender binary construction has historically been a cornerstone of societies worldwide. Based on dichotomous male-female disparities, this binary perspective frequently marginalises those who do not fit neatly into these categories. Transgender people challenge this binary in their quest to establish their actual identities. However, individuals repeatedly face various problems, from parental rejection to cultural estrangement.The path becomes considerably more complicated for transsexuals who underwent surgery. After surgery, they navigate a world that seeks unity with the binary but find themselves in a liminal space. They are expected to 'fit' into one of the two recognised gender categories, even if society does not accept them entirely. This is especially noticeable in Kerala, where

contemporary expectations and traditional standards frequently hit, resulting in a potent mix of expectations.Furthermore, transitioning, including top and bottom surgery, is a deeply personal and psychological journey. The exterior shift is met with several interior conflicts and societal reactions ranging from acceptance to outright hostility.

Historically, India's relationship with its transgender community has been a paradoxical amalgamation of reverence and marginalisation. The hijras, as meticulously documented by Nanda (1999), have held unique positions in Indian society, simultaneously sanctified and ostracised. Such complexities transcend time, manifesting in contemporary challenges concerning health and well-being. As Bockting, Robinson, &and Rosser (1998) emphasise, the transgender community deals with unique vulnerabilities, necessitating personalised interventions.

In charting the evolution of transgender identities, especially in the Indian context, Hall and Pickett (2018) underscore the complex journey from self-recognition to societal affirmation. Meanwhile, Narrain & Bhan (2005) provide a panoramic view of India's queer politics, capturing the numerous challenges faced by the community in a socio-political arena that often oscillates between acknowledgement and denial. Dutta (2012) further enriches this discourse, tracing the historical fluidity of gender identities across India.

Émile Durkheim's exploration of suicide, articulated in his pioneering work 1897, unpacks the complicated relationship between individual behaviours and broader social structures. At the heart of Durkheim's theoretical framework is social integration: the extent to which individuals perceive themselves as vital components of the social entities they inhabit. A deficit in this sense of belonging can result in egoistic suicide, marked by profound feelings of alienation from pivotal social pillars such as kinship or communal affiliations. On the opposite end of the spectrum, excessive social immersion can lead to altruistic suicide,

where individuals, driven by an intense compulsion for collective welfare, choose to end their lives. Another salient dimension in Durkheim's analysis is the principle of moral regulation and societal acts that define individual aspirations. A disruption or absence of these regulatory norms might engender anomic suicide, a consequence of individuals grappling with a societal landscape devoid of clear moral directives. Such a state of normative vacuum or anomy leaves them susceptible to existential despair. While rooted in the socio-cultural setting of Durkheim's era, his conceptual framework established foundational pathways for future sociological inquiries, dissecting the interstices between personal agency and societal influences in suicide.

In using Emile Durkheim's influential work on suicide as a theoretical lens, this research intends to investigate deeper into the complex sociological distinctions surrounding the tragic demises of Ananya Kumari Alex andPraveen Nath. Durkheim's emphasis on social integration is paramount, especially considering the transgender community's navigation through multifaceted socio-cultural landscapes. The levels of alienation or inclusion experienced by Ananya Kumari Alex and Praveen Nath in relation to vital societal institutions, such as family, workplace, and broader communities, indicate their degree of social integration. Concurrently, Durkheim's notions of moral regulation bring forth the challenges faced by transgender individuals in reconciling with fluctuating societal norms and expectations. By understanding Ananya Kumari Alex's and Praveen Nath's attempts (or lack thereof) to align with these shifting norms, especially after their gender transitions, discern underlying anomic tendencies, if any. Their post-operative experiences, professional hurdles, and the societal response to their transitions play into this theoretical matrix. This Durkheimian framework, therefore, offers a strong methodological approach todiscriminating the complex web of sociological factors potentially contributing to their untimely deaths.

However, within this broader Indian canvas, Kerala emerges as a distinctive picture. The state's proactive stance, as articulated in its 2015 Transgender Policy, indicates its commitment to addressing transgender issues head-on. However, the accounts of Ananya Kumari Alex andPraveen Nath highlight that policies on paper might only sometimes translate to live realities. This research endeavours to bridge this gap, presenting an in-depth exploration of the transitional struggles of the two individuals contextualised within Kerala's socio-culturalsettings. Through their narratives, the study seeks to illuminate the broader challenges, aspirations, and hopes of Kerala's transgender community.In 2015, Kerala took a commendable step by introducing a Transgender Policy, positioning itself at the forefront of states addressing the concerns of the transgender community. This policy acknowledges the systemic discrimination and violence the community has endured and charts a roadmap to ensure their social, economic, and health rights. One of its significant aspects is its emphasis on the post-surgical needs of transgender individuals, ensuring that medical and psychological support is available to those who undergo gender-affirming procedures. This recognition is vital, given the physical and emotional challenges such surgeries entail. The policy also emphasises education, skill development, and sensitising various sectors to create an inclusive environment.

Moreover, it's crucial to recognise that the policy, although comprehensive, has challenges. Both bureaucratic obstacles and societal prejudices have often hindered implementation. There's an evident curiosity from society about transgender individuals' personal lives, including their sexual and post-surgical experiences. While the Kerala Transgender Policy of 2015 is a laudable start, its effectiveness will only be felt when administrative and societal attitudes align with its inclusive vision.

Methodology

Adopting a qualitative research design, this study relies on the case study methodology, ensuring a comprehensive exploration of the chosen instances. The data acquisition process encompassed semi-structured interviews with close acquaintances, family, and friends of Ananya and Praveen, providing first-hand accounts of their lived experiences. Public records, news articles, and social media narratives were examined to capture the broader public perception and responses following the incidents. A thorough review of academic literature and pertinent government policies after these events was also undertaken to enhance this primary data. The collective data underwent thematic analysis, where emerging patterns and narratives were identified and cross-referenced with existing literature. Upholding rigorous ethical standards was paramount, with participant consent, anonymity, and the sensitive portrayal of findings being key considerations.

Objectives

1. To critically analyse the societal factors contributing to the tragic demises of transsexual individuals in Kerala, focusing on the cases of Ananya Kumari Alex and Praveen Nath.
2. To understand the layered challenges these individuals faced, especially after undergoing top and bottom surgeries.
3. To evaluate these cases broader implications for the transgender community within Kerala's socio-cultural landscape

Case Study: The Life and Struggles of Ananya Kumari Alex

Ananya Kumari Alex, a 28-year-old transgender woman from Kerala, India, was symbolic in the region's trans community. A pioneer in her profession, she became Kerala's first transgender radio jockey and was actively involved in television as a makeup artist and anchor. Beyond her professional achievements, she was a prominent activist advocating for transgender rights.

Early Life, Gender Affirmation and Post-Surgery Complications

Growing up, Ananya led a reasonably healthy life with only typical health issues. As she transitioned into her adolescent and adult years, her struggle with gender incongruence became pronounced. This culminated in her undergoing Gender Affirmation Surgery in June 2020.

Post the surgery, Ananaya's life took anunrestrained turn. She began experiencing severe physical and psychological complications, which included chronic pain and other post-operative complications. These adversities required her multiple in-patient admissions to emergency wards. Her medical experiences were further spoiled when she faced supposed mistreatment in a hospital in January 2021.

Financial and Professional Struggles

Following her Gender Affirmation Surgery, Ananya grappled with profound physical challenges that directly imposedon her professional life. The chronic pain and difficulties in mobility became not just a health concern but a significant hurdle in her work. For instance, long hours of anchoring or makeup sessions became active due to her need for frequent breaks. The onset of the COVID-19 pandemic only intensified her professional dilemma. With lockdown measures in place, opportunities in her domain, particularly entertainment and media, decreased, curtailing her regular income.

Her financial grief didn't end there. Escalating medical bills, a by product of repeated hospitalisations and treatments, drained her finances. Moreover, the alleged inadequacies in post-operative care from the hospital increased her medical expenses and led her to voice her grievances publicly. While shedding light on the hospital's alleged negligence, this move also inadvertently led to some backlash. Notably, there were murmurs within the transgender community about the hospital possibly retaliating, as it was among the few that provided specific treatments. This

apprehension perhaps affected Ananya's rapport within certain community circles and, in turn, her professional outreach.

Societal Interactions and Distress

Ananya's plight was not solely medical. She became vocally critical of the alleged negligence she experienced post-surgery, voicing her grievances on various media platforms. This led to a polarised response. On one side, she faced antagonism from certain medical professionals and segments of the transgender community. On the other, she gathered sympathy and support from various quarters.

Declining Health and Final Days

Key informants, including her close friends and family, described Ananya's deteriorating physical health. She frequently spoke of severe pain, difficulty walking, and respiratory challenges. Her mental health also showed signs of strain due to the compounded stressors of health, finance, and societal reactions. Weeks preceding her demise, Ananya's distress peaked when she registered a formal complaint against the hospital responsible for her surgery. The financial implications of her medical treatments and healthcare practitioners' perceived lack of empathy weighed heavily on her. In July 2021, Ananya Kumari Alex tragically took her own life.

Case Study: Praveen Nath and the Impact of Cyberbullying on theLGBTQ+

Praveen Nath, commonly called"Mr Kerala Transman," symbolised hope and progress for Kerala's transgender community. Despite his significant contributions and breaking barriers as the first transgender bodybuilder in the state, he faced scary challenges, including cyberbullying, which tragically led to his untimely death at 24.

Early Life and Gender Affirmation and Post-Surgery Complications

From the town of Palakkad, Praveen Nath's journey has been one of identity, challenges, and eventual victory. Early on,

school experiences and societal expectations made him question his gender identity. This introspection and a pivotal visit to Nimhans Hospital in Bangalore introduced him to the concept of 'transman'. While higher education posed its challenges due to discrimination, Praveen persisted. His transformation journey included multiple surgeries, aligning his body with his self-perceived identity. Among these trials, a passion emerged: bodybuilding. His dedication in this field saw him rise to become Kerala's first transman bodybuilder.Praveen came to terms with his gender identity during high school. Amidst the whirlwind of emotions and self-discovery, he grappled with romantic feelings towards girls, unaware of LGBTQ+ terminologies that would provide clarity. Counselling and his subsequent association with Nimhans Hospital in Bangalore would pave the way for understanding and embracing his identity as a transman. Praveen underwent top surgery in 2019 at Kochi. The procedure, intended to bring his physical self in alignment with his gender identity, accompaniedby feelings of liberation from past insecurities. However, in January 2022, he underwent a Metoidioplasty at Ernakulam. Unfortunately, post-surgical complications get up, necessitating multiple corrective surgeries. A series of challenges, from urinary leakage to prolonged bed rest, rushed Praveen into deep emotional chaos. Doubts regarding his bodybuilding future added to his distress, highlighting the intricate journey of gender affirmation surgeries.

Financial and Professional Struggles

Outside of the medical realm, Praveen faced significant challenges. After his initial surgery, he was clouded with uncertainty about his future. Despite a keen interest in acting, he felt restricted by societal perceptions of his identity. This emotional weight compounded, leading to a suicide attempt. However, a glimmer of hope emerged during the COVID lockdown when Praveen learned of a position at 'Sahayatrika', an NGO on the

'advocacy Board.' Securing the job, he relocated to Thrissur, marking a new professional chapter.

Societal Interactions and Distress

Among professional paces, Praveen's personal life underwent instability. His marriage to a transwoman was initially celebrated but soon became fodder for public speculation and online harassment. An ensuing relationship with an underage girl further ignited societal scrutiny, adding to his distress. The impact of external judgments was profound, leading Praveen to attempt suicide again.

Final Days

Against personal and health challenges, Praveen's recognition as Mr Kerala Transman in 2021 was a beacon of hope. Yet, worsened by rumours about his marital life, cyberbullying cast a long shadow. His subsequent admission to Thrissur Government Medical College Hospital, reportedly after consuming poison, underscores the severe consequences of societal pressures and online harassment.

Discussions and Analysis

Ananya's life story offers a poignant insight into the complex challenges faced by transgender individuals, even post-transitioning. It underscores the significance of inclusive support, both medically and societally, for those undergoing such profound personal journeys.For many transgender individuals, Gender Affirmation Surgery (GAS) is critical to their identity journey. Kerala's initiatives in financially supporting these surgeries are commendable, yet concerns about its quick and sometimes commercialised application have surfaced.

The World Professional Association for Transgender Health (WPATH) released guidelines in 2012, stressing that healthcare for transgender individuals should be highly individualised. It's not a one-size-fits-all situation. The emphasis should be on understanding and addressing each individual's unique needs and challenges rather than rushing them into surgery.Additionally,

GAS shouldn't be commercialised or exploited. Everyone considering the procedure should be fully informed about its potential outcomes, risks, and the necessary post-surgery care. Ideally, a multidisciplinary team, including surgery, psychiatry, and endocrinology specialists, should collaborate to offer a holistic care approach.The journey to GAS isn't just about the surgery itself. It encompasses mental evaluations, hormone treatments, and more, ensuring the individual is mentally and physically prepared. Sadly, some institutions focus narrowly on the surgical procedure, sidelining the comprehensive care approach.While some transgender individuals opt for GAS, their choice, based on their identity, experiences, and financial status, should be respected. Health professionals could tap into a wealth of knowledge within the community for a more enriched understanding and better care standards(World Professional Association for Transgender Health, 2022).

Recent incidents, notably Ananya's ordeal, have spotlighted the glaring issues concerning post-surgical care for transgender individuals. After undergoing gender affirmation procedures, Ananya faced the trauma of four corrective surgeries atthe hospital, pointing to severe shortcomings in post-operative care.While these surgeries are immense in the lives of transgender individuals, many report an alarming trend: being discharged from hospitals shortly after these intensive procedures, regardless of the healing status of their surgical wounds. This quick income heightens the risk of complications, yet the community hesitates to voice concerns or criticisms against medical institutions. The unwillingness stems from a fear of further marginalisation or backlash, as with Ananya, who faced opposition within her community for merely pointing out post-surgical issues.

Furthermore, deep-seated cultural norms place undue pressure on these individuals, shaping societal expectations around femininity and masculinity. Consequently, decisions about surgeries and interventions are often overshadowed by the desire

to fit neatly into the established binary of male and female bodies. A broader misunderstanding compounds this pressure: the perception of Gender Affirmation Procedures (GAP) as mere cosmetic adjustments. Yet, research such as the 2018 study from Cornell University underscores their critical role in the psychological well-being of transgender individuals, stressing the importance of recognising them as medical necessities.

Both society and medical professionals must shift their perspective, seeing GAP not as a choice but as an essential medical procedure. This shift would respect the rights of transgender individuals, ensuring they make informed decisions about their bodies. Professionals are responsible for providing accurate information at every stage, underpinned by studies and experience. To truly serve the transgender community, medical training should be broadened, incorporating psychologists, psychiatrists, and social workers knowledgeable in the unique challenges faced by this group. Moreover, community resource centres should be established within the transgender community, equipped to provide valuable information, support, and awareness to its members and the wider public.

Praveen Nath's life story, marked by significant achievements and challenges, provides crucial insights into the complexities faced by transgender individuals. While his successes in bodybuilding and advocacy inspired him, his struggles underscore the need for societal acceptance, mental health support, and cyberbullying interventions. It serves as a poignant reminder of the need for compassion and understanding in addressing the unique challenges faced by the LGBTQ+ community.

Praveen Nath's tragic journey is a serious testament to the lethal impacts of cyberbullying and societal prejudices on the well-being of the LGBTQ+ community. Cyberbullying, a contemporary threat enabled by digital platforms' expansive reach and anonymity, inflicts deep psychological wounds. Those subjected

to it often experience heightened irritability from constant negative feedback. This online harassment fosters profound insecurity, driving individuals to question their self-worth and, in extreme cases, pushing them toward the tragic path of suicide.

In its often-misplaced audacity, society presumes the authority to investigate, comment on, and criticise deeply personal choices, further increasing the distress of those like Praveen. This intrusiveness is particularly magnified in the context of transgender individuals. Anevident instance is the widespread hesitancy to accept a woman who transitions to a man and vice versa without difficulties. Compounding this are the universal societal curiosities about the physical and intimate dimensions of transgender lives. Questions about post-surgical sexual satisfaction and functionality manifest the society's inability to transcend surface-level fixations and recognise the deeper emotional and identity-based facets of transgender experiences.

Such invasions and curiosities pressure individuals to conform to perceived societal standards and perpetuate a broader community-wide insecurity. The transgender community constantly navigates these external judgments, striving to fit within these moulds, even as they grapple with their internal journey of self-acceptance and affirmation. Praveen's story is a powerful reminder of the terrible need for societal evolution, underlining the importance of empathy, understanding, and acceptance in a world that remains starkly divided on diverse identities.

The Kerala Transgender Policy 2015 marked a significant and progressive step in India's approach to transgender rights. This policy recognised the community's deep-seated discrimination and violence and laid a comprehensive framework to protect and advance their socio-economic and health rights. Emphasising education, skill development, and post-surgical care, the policy reflected Kerala's commitment to creating an inclusive environment where the transgender community feels valued and supported.

However, recent suicides among transgender individuals in Kerala highlight the profound chasm between policy formulation and its real-world implications. These tragic incidents underscore the persisting societal prejudices, mental health challenges, and systemic barriers that transgender individuals face daily. While the policy provides an institutional backbone for support, its effectiveness is undermined if not accompanied by societal change. The disturbing societal curiosity regarding personal lives, especially post-surgical experiences of transgender individuals, indicates the larger struggle to shift established mindsets.While the Kerala Transgender Policy signifies an important step toward recognising and safeguarding transgender rights, the recent suicides reveal the urgent need for robust implementation, accompanied by broader societal sensitisation and acceptance.

Incorporating Émile Durkheim's theory of suicide into the analysis is pivotal, as it lends insight into the societal structures potentially exacerbating feelings of despair within the transgender community in Kerala. Recognising this theoretical perspective not only accentuates the nuances of individual experiences but also underscores the broader societal forces at play, further enriching the study's depth and relevance.

Conclusion

The stark reality of the situation uncovers a pronounced gap between the outward appearances of societal advancement and the lived experiences of transsexual individuals. Historically celebrated as a torchbearer of social reform in India, Kerala seems to face shadows of discrimination that linger stubbornly. Despite its progressive frontage, recent events reveal that marginalised groups, especially transsexuals, are still ensnared in a web of entrenched prejudices. The painful suicides of transgender individuals in Kerala aren't mere isolated incidents but rather grim indicators. They emphasise an imperative to introspect and

challenge the deeply rooted binary gender notions that shape societal interactions.

As we envision a society that embraces diversity and fosters inclusivity, it becomes essential to ensure that every person's journey to self-affirmation is met with acceptance rather than solitude and despair. Transgender individuals, in their quest for self-recognition and authenticity, often see gender-affirming surgeries as a hugestep towards aligning their physical embodiment with their genuine gender identity. However, the way navigatedafter these surgeries is seldom laden with the anticipated elation and solace. The outcome of these surgical interventions will be physically tough. The nature of these procedures, inherently invasive, sometimes leads to unexpected complications. Persistent pain, unforeseen complications, or outcomes that fall short of their expectations spiral them into profound emotional distress.

However, this physical sufferingsimply scratches the surface of their challenges. Beyond the surgical transition, when they take transformative steps to harmonise their outer appearance with their inner gender identity, they are still at the mercy of societal biases. The digital age, while offering platforms to voice and share, often turns hostile. Cyberbullying, undue scrutiny, body shaming, and unwarranted interrogations about their personal choices further accentuate their emotional wounds. Digital platforms, instead of evolving into supportive communities, are frequently transformed into arenas of conflict where derogatory remarks, ridicule, and outright abuse are unleashed upon them. Compounding this are the haunting remnants of a lifetime spent battling genderincongruences, seeking validation, and striving to break free from societal discriminationchallenges that aren't magically obliterated post-surgery. Repeated online harassment and societal scepticism often serve as harrowing echoes of their pre-surgery tribulations.Within this, the emotional weight of their journey, compared with the financial implications of transitioning, will be daunting.The narrative surrounding transgender

individuals should evolve beyond the limited scope of surgical procedures. A comprehensive care framework that envelops physical recovery and emotional healing is imperative. Beyond medical interventions, there's an urgent call for heightened societal cognisance, broadened acceptance, and enforceable measures against cyberbullying. Only through such inclusive approaches will truly champion the welfare and dignity of transgender individuals.

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Ageing and Filial Factor: Quantitative Understanding of Filial Responsibility in The Context of Demographic Transitions in Kerala

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Abstract

With the multiplicity involved in the process of ageing, the associated factors like dependency, retirement, financial planning, etc. can be analysed and understood through different dimensions. Rather than viewing them as different kinds of aging, they may be regarded as viewpoints or lenses through which one can understand the importance of finance and planning with the process of aging. It is more significant in a state like Kerala, where the population distributions show a noticeable increase in the elderly population. Obviously, a 60-year-old person has the twin responsibility of taking care of at least one of his/her surviving parents(usually in their late 80's) and their own children. In this article, the researcher quantitatively demonstrates the subjective notion of filial responsibility using the term filial factor.

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Keywords: *Ageing, Family Ageing, Filial Responsibility, Financial Gerontology, Generational Ageing, Individual Ageing, Population Ageing.*

Introduction

As an interdisciplinary field, financial Gerontology focuses on explaining the process of ageing in different contexts- covering areas like retirement, planning, money, etc. Though serious research programmes and studies on financial gerontology originated and flourished in the West, especially among developed societies, it is equally important to Kerala society because of the changes that have been noticed in the demographic distribution and social structure.The relative rise in longevity and standard of living together with the popularity of concepts like 'adding life to years' prompted both the policymakers and scholars to rethink and reframe strategies, approaches, and programmes to deal with the issues and possibilities associated with the process of ageing. Add to this, the positive trend in life expectancy led to the creation of more and more families characterized by '60-year-old kids' staying with at least one of their parents. Here the 'kid' is a pensioner; but responsible for taking care of the needs of his/her old-old parent(s). It (Filial responsibility) describes the sense of personal obligation or duty that adult children feel for protecting, caring for, and supporting their aging parents (Schorr, 1980). It is evident in both attitudes and behaviors of adult children, not only assisting/helping them in meeting their daily needs but also enabling their parents to acquire new skills, seek novel and enriching life experiences, and disregard negative stereotypes about aging, and also allow their parents to speak for themselves, and respect their parents' self-determination in making decisions that affect their own lives (Seelbach, 1984).Such a filial responsibility took multiple dimensions if they have the twin responsibility of taking care of their own children on one side and the parent(s)on the other. It is more crucial to those who opted

for a late marriage due to personal/financial reasons. This article mainly centered on analyzing how the demographic transition influences the life of young-old population in Kerala and attempting to understand the subjective notion of care and support in a quantifiable way.

Materials and Methods

The paper here was based on a desktop survey and analyses of publicly available material regarding the data on the population in India and Kerala and was accessed mainly from the reports of theRegistrar General and Census Commissioner of India (Government of India Ministry of Home Affairs) and theMinistry of Health & Family Welfare, Government of India. It proceeds by narrating different viewpoints on ageing with the help of authentic statistical evidences and the researcher's own interpretations. Besides, it attempted to analyze quantitatively the qualitative relationship between old-old parents and their young-old son/daughter. The major questionthat came into my mind while attempting to study was: How the family ageing affect the responsibility of care and support to the old-old parents and in what way one could quantify such a subjective dimension? The quantification of such a subjective factor has been done with the help of calculating the filial factor using the formula:

FF = (a-b)/(c-d)

Filial fraction serves as a tool to measure above said qualitative relationships quantitatively. In statistical terms, it is the percentage of a middle-ager's adult life (in years) that an elder parent is alive (Cutler,2006). Here, the filial fraction is considered as a neutral measure. Even though the parent(s) is alive for years, that is in no way considered to be a burden to their 60+ year-old son/daughter. Nevertheless,the filial fraction offers us a tool that quantitatively measures the magnitude of the qualitative relationship between young-old son/daughter and their old-old

parent(s) and also helps to anticipate the additional extension of such care provided by the young-old kid. During calculation the numerator is the number of years that the parent is "old" – here, for the purpose of statistical procedure, it is fixed as older than age 75. Number of years that the young-old kid has been an adult (considering the age of 20 as the onset of adulthood).

Here, 'a' denotesthe age of the parent (dependent)

b= 75

c= age of the caregiver (son/daughter)

d= 20

Discussions

Aging through different focal points

As a discipline, gerontology pays attention to study the elderly population and more precisely; the dynamics associated with ageing, relationships, power, care, etc. involved in aging. To untangle and understand such dynamics associated with ageing, scholars often view the process through different focal points and make use of different paradigms while studying the phenomenon of ageing. These focal points can be split into four"lenses", viz. population ageing, individual ageing, generational ageing and family ageing through which we examine the interconnection between demographic transition and changing financial needs and responsibilities of an individual.

As a macro-societal profile of aging,the term "population ageing"(Cutler,2006) attempts to examine the existing pattern/ transition of population and periodically make comparisons between sub-population in a more precise way. Such a trend or transition is usually projected by statements like''greying of population'' or ''silver tsunami''. It has relevance with the process of budgeting since the state has to periodically raise the

expenditure incurred on social security funds for its seniors. Further, a population pyramid with a flattened top often prompts us to change the definition of the terms old, older, and oldest. It also points to reframe the upper age limit for applying to various government jobs and the age of superannuation. These are potential areas in gerontology and should be studied by encompassing the gender and relationship dynamics associated with it.

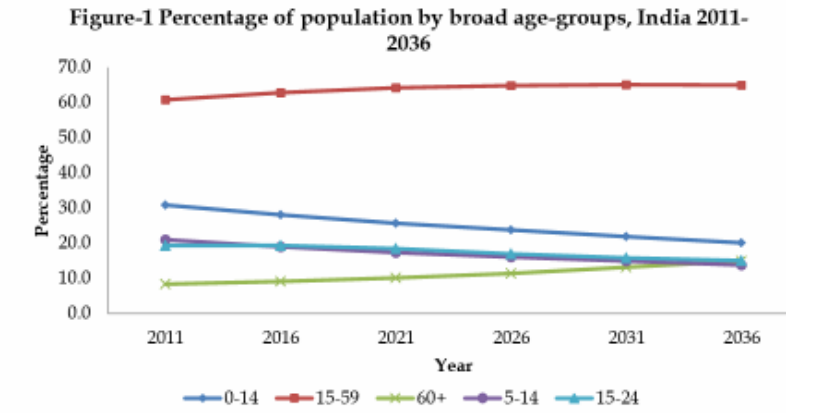
The process of ageing that has been happening to each individual is termed as "individual ageing"(Cutler,2006) that clearly demarcates and categorize certain age groups as infants, adolescents, youths, middle-aged, seniors, etc. Suchcategorization offers some form of legal sanction for an individual to express his voting rights, eligibility to apply for jobs, getting married, or living with a partner. Similar way it tries to mark an individual as senior or elder person and legally remind him about his retirement. In Kerala, the age of '56' is regarded as the age for superannuation, though there is variation that can be seen among public sector undertakings and state government companies.A clearer picture of individual ageing can be identified while analyzing the increase in life expectancy in our country. Table-1 shows age-wise comparison of population growth (in millions) in different census years. It shows that within all ages the '22.7 per cent' growth has been achieved during 1991-2001 and '17.7 percent' between 2001-2011. Interestingly, the growth that has been marked during the same period for the 60-99 age groupswas 35.4 per and'34.9 per cent respectively. Meanwhile, for 100+ yearscategory, the growth noticed accounted '500 percent' increase during the period between 2001 &2011 census years. Further, the figure, showing percentage of population (projection) by broad age-groups in India from 2011-2036, conveying the anticipated increase in the 60+ years category irrespective of the significant decrease among the other categories of population. The studyinitiated by Crimmins and coresearchers (1997)found that the increase in life expectancy

beyond the age of 65 seems to be comparatively healthy years if it is measured in terms of Health-Adjusted Life Expectancy. Nevertheless, such an advantage in decreasing the mortality rate among 60+ years category in India often resulted in an extended life span with increased risks of multiple morbidity (marginal increase in the prevalence of life style diseases) and health related expenses.

Table-1: Population of selected age groups India: 1991 to 2011 (in millions)

Age group (in years)	Census period		
	1991	2001	2011
All age groups	838.6	1028.6	1210.6
5-59	464.8	585.6	729.9
60-99	56.5	76.5	103.2
100+	0.2	0.1	0.6

Source: Census of India -2011, Age data highlights



Source: National Commission on Population, Ministry of Health & Family welfare, Government of India (2020)

While examining the "Generational aging" and the age factor in patterns of financial attitudes, Uhlenberg (1996)calculated the proportion of persons who (at various stages of life course) would have grandparents, spouses, siblings and children still living. Such a dynamics often creates an unprecedented potential for kinship ties at one side and an unprecedented urge for financial planning. In the words of Neal E. Cutler, (2008) "thedifferences in financial attitudesbetween a 70-year-old and one in his/her 30'scouldbe the result of forty years of maturational aging." This may be partly because of the influence of their social and cultural environments. The life circumstances and its correlation with financial (investment) decisions of people belongs to different age groups were studied by Khoo (2016) and reported that young people have more risk-taking capacity than elder. It further stated that the proportionate increase of dependents with respect to the increase in age often deter the elder people from risky investment decisions. While attempting to find out the prime age group of an investor, Cannivet (2019) concluded that people have an investment blind spot after the age of sixty resulting to take poor financial decisions.

Family Aging and Filial Responsibility

If we analyze the concept of "family ageing" either gerontological or sociological way, we come across with the different dimensions of care for the elderly. It is particularly relevant to our society since the family serves as the main institution for the care and support of elderly. As I mentioned earlier, today's families characterized with the presence of young-old kids and old-old parents. At one end the kids of these young-old kid's need some sort of financial support from their parents. At the other end these young-old kids supposed to take care of their old-old parents. The recent Report (2020) of the National Commission on Population, Ministry of Health & Family welfare, Government of India regarding population projections (2011 –

2036) for India and states, portrayed the significant increase in the total population and also the higher dependency ratio among 60+ years category. Unlike yesteryears, such changes often prompt the 60+ years category to opt for new vistas of financial/retirement planning to counteract the menace of higher dependency.

Table-2

Projected Population Characteristics As On 1st March : 2011 - 2036

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Indicator	2011	2016	2021	2026	2031	2036
1	2	3	4	5	6	7
Population (000')						
Total	33406	34578	35489	36207	36695	36949
Male	16027	16594	17043	17395	17638	17775
Female	17379	17984	18447	18812	19057	19174
Sex Ratio	1084	1084	1082	1081	1080	1079
Population Density (Sq. Km.)	860	890	913	932	944	951
Population by broad age-group (000')						
18 years and above	23955	25428	26708	27740	28526	29036
0-14	7839	7541	7247	6976	6746	6553
15-59	21340	22027	22390	22463	22295	21977
60+	4227	5011	5853	6767	7653	8418
Proportion (percent)						
0-14	23.5	21.8	20.4	19.3	18.4	17.7
15-59	63.9	63.7	63.1	62.0	60.8	59.5
15-49 (female population)	53.5	52.0	50.0	47.9	46.0	44.1
60+	12.7	14.5	16.5	18.7	20.9	22.8
Median age (years)	31.90	33.51	35.12	36.69	38.18	39.58
Dependency Ratio						
Young (0-14)	367	342	324	311	303	298
Old (60+)	198	227	261	301	343	383
Total (Young and old)	565	569	585	612	646	681

Source: National Commission on Population, Ministry of Health & Family welfare, Government of India (2020)

Filial fraction: quantitative understanding of filial responsibility

While analyzingthe patterns of marriage and family dynamics, we can see a notable increase in the age at marriage of both women and men in our society. Such a change in attitude has been attributed mainly to the priority given to education and career search. Such an emphasis on career related choices and development prompteddelayed marriages and in turn delayed conceiving. If we examine the trend, we can see that people belongs to the age group of 45-60 years married at leasttwo to three years later than their parents. It is more striking among the female population of Kerala while making a comparison with national averages (see Table-2). "It is not unusual for men in their late40s, 50s, and even 60s to become new fathers." (Wassel & Cutler, 2007). Such delayed marriages often deepen the financial liability of the young-old retirees with the responsibility of extending financial support to their married/un married children on one side and care to their parent(s) at the other.In such instances, there is relevance in assessing such a qualitative relationship in a quantifiable way.

Table-3: **Mean age at marriage (Female) in India and Kerala 2010 - 2017**

Area		2010	2011	2012	2013	2014	2015	2016	2017
Total	India	21.0	21.2	21.2	21.3	22.3	22.1	22.2	22.1
	Kerala	22.6	22.6	22.9	23.1	23.8	23.2	23.1	23.2
Rural	India	20.5	20.7	20.8	21.0	21.8	21.6	21.7	21.7
	Kerala	22.6	22.6	22.8	22.9	23.5	23.0	23.1	23.0
Urban	India	22.4	22.7	22.4	22.5	23.2	23.0	23.1	23.1
	Kerala	22.6	22.8	23.1	23.8	24.1	23.5	23.2	23.25

Source: - SRS, Registrar General & Census Commissioner, India

For illustrative purpose, let me present the case of a 59-year-old individual having 84-year-old mother staying with him. Calculations has been performed for obtaining the current filial fraction and compared it with the age of the individual and mother after 5 years (see Table-4).

Table-4: Age of respondents and filial factor

	Age of the individual under consideration (a)	Age of the living parent (b	Filial Fraction (a-75)/(b-20)
Present	59	84	25%
After 5 years	64	89	31%

From the table, the present filial fraction is 25%. It means that the individual selected herehas hadat least a dependentmother "around for 25% "of his adult life. More precisely, for a sizeable part of his adultlife hehas had the obligation to take care and support of hismother. If we look forward to 5 more years, the filial fraction will increase to 31%. That is, 31% on this person's adult life hehas had the dependent mother with him. Hence, an understanding like this is helpful to go for the right type of financial planning in the retirement life.

Conclusion

As I mentioned earlier, as a sub field of gerontology, financial gerontology began as adiscipline aimed to enhance knowledge associated with the financial realm of old age through the application of principles and practical tips in gerontology. In certain specific contexts (similar to the one in Kerala), researchers have the curiosity to analyze how aretiree effectively manages his/her retirement life considering the financial needs associated

with their lives. While considering the above said four kinds/ viewpoints of aging, it becomes clear that gerontology as an academic discipline and applied field best explains the dynamics of different categories of old age – say, young-old to old-old and to oldest-old. From a retiree's point of view, we definitely argue that young-old retirees are the more stressful group due to the dilemma associated with twin responsibility: while engaged in their own retirement planning, they are more likely to devote a major portion of their thought to their dependent parent for whom they have much obligations and responsibilities, including financial. The concept of family ageing will be useful for examining such a relationship in a deeper way. Besides, the tool that has been employed for a quantitative understanding of the qualitative relationship proved to be helpful in untangling the family aging dynamics and its financial implications. Regarding the future directions for research, I would like to mention certain potential areas like: how the gender and relationship dynamics associated with individual ageing and in what ways that affects one's career intentions after retirement; identifying the ways in which generational ageing affects the gender and relationship dynamics between reemployed retiree and their younger counterparts in today's organizations; familial ageing and its influence in post-retirement career intentions of reemployed retirees in Kerala.

Delimitations

In this article the researcher mainly focused on presenting the concept of filial responsibility and attempted to explain it in a quantifiable way. The case which has been illustrated here is only for demonstrative purpose and no intentions for generalizing the findings. However, the topic has the potential for further research by incorporating large data sets using surveys and other appropriate statistical methods.

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Sociological Insights into the Lives and Challenges Faced by Unmarried Tribal Mothers in Wayanad, Kerala

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Mamshida K **

Abstract

For decades, the socioeconomic challenges and life trajectories of unmarried tribal mothers in Wayanad, a district in Kerala, have remained a focal point of scholarly inquiry into the state's developmental landscape. According to the 2011 Census, the tribal population in India accounts for 8.9 percent of the total populace, with indigenous communities confronting systemic marginalization characterized by poverty, insecurity, illiteracy, inadequate healthcare access, political underrepresentation, and exploitation by dominant societal strata. Wayanad, hosting the largest tribal population in Kerala, has witnessed a concerning rise in the number of unwed tribal

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mothers, underscoring pervasive issues of abuse both within and beyond their communities. However, governmental records and systematic investigations addressing this phenomenon are conspicuously absent. This underscores the urgent need for comprehensive exploration of the exploitation faced by tribal women, the underlying causes of their insecurity, and the societal treatment of unwed tribal mothers. Given the paucity of recent and exhaustive quantitative data, the study adopts a case study methodology to elucidate these complexities. This approach integrates various qualitative techniques, including open discussions, in-depth interviews, face-to-face interactions, and non-participant observation, to provide rich narratives drawn from the experiences of five cases. Moreover, the research employs a hybrid methodology, combining quantitative and qualitative analyses, leveraging government statistics, newspaper reports, academic literature, and online resources to supplement primary data collection efforts.

Keywords: *Tribe, Indigenous Population, Unwed Mother, Poverty, Illiteracy, Unemployment, Exploitation, Sexual Exploitation*

Introduction

Wayanad is one of the hilly districts of Kerala state, located at the north-eastern border of the state, neighboring to Karnataka and Tamil Nadu.The hilly region of Wayanad, once the dwelling place of the tribal majority, is now home to more than 1600 unwed tribal mothers, who were enticed and left away mostly by non-tribal settlers. Wayanad has a population of around 700000 people and out of that 18% are the indigenous tribal people. Wayanad is rich with its cash crops economy like pepper, cardamom, and coffee plantations. Wayanad once the land of tribals has been encroached by the immigrants from the southern part of Kerala who had migrated to this virgin land immediately after the Second

World War. Tribals later become the casual laborers of the migrant population. Wayanad district, known for its wildlife sanctuaries and natural beauty, is also home to 2,000 unwed mothers, eking out a perilous existence in the shadow of shame. There are sexually abused and abandoned women in tribal hamlets all over Kerala, but this district, with its 17.1 percent tribal population, has the greatest number (Basheer 2003).

India has the second-largesttribal population in the world. According to the 2011 census, the tribal population constituted about 8.9 percent, which is 10.43 crores of the total population. There are 705 scheduled tribes identified by the constitution of India.89.9 percent of them in rural areas and the rest in urban areas. Tribes in Kerala constitute 484,839 (1.5 percent of the total state population) according to the 2011 census. Wayanad district with 151,443 tribal population contains Paniya, Irula, Kattunaikkan, and Adiyan the major communities among the tribal population. Poverty, illiteracy lack of social security, unemployment, lack of land ownership and exploitation from both government and society, lack of technological knowledge, and lack of political representation are dilemmas faced by tribal society. Other than this, among them, a tendency of the increasing number of unwed mothers have been witnessing. As per the census report given by Integrated Tribal Development Programme (ITDP), the number of tribal unwed mothers in Wayanad is 138 till 2016 (Tharuvana 2010).

The Integrated Tribal Development Programme reported statistical data on the prevalence of unwed mothers within the Wayanad district. As of 2016, a total of 138 cases were documented. Among these cases, 31 were recorded in Cheengery panchayath, 29 in Pulppally panchayath, 25 in Noolpuzha panchayath, 23 in Poothadi panchayath, 13 in Bathery panchayath, 7 in Thariod panchayath, 4 in Padinjarathara panchayath, while 3

cases each were reported in both Vengappally and Kottathara panchayaths, respectively (Basheer 2003).

The numbers have increased and there are cases that are not properly recorded by the government authorities. So many panchayats are not even in the list. The tribal promoters of majority of wards are unaware of the cases in their assigned area. These women are unfortunately getting misused both inside and outside of the community. The social injustice and insecurity faced by the tribal unwed mothers are yet to be addressed. The basic social causes which lead them to the hands of abusers and the reasons why these abusers are still protected are profoundly intervened.Understanding the social life and challengesfaced by the tribal unwed mothers in Wayanad andlocating the reasons behind the increasing number of unwed mothers in Wayanad are the major objectives analysed in this article.

Methodology

The research employs a blend of quantitative and qualitative methodologies to fulfill its objectives. During the data collection phase, alongside quantitative data sourced from secondary materials, five representative samples are selected from various areas within the Vellamunda, Thondarnadu, and Tariodu panchayats of the Wayanad district, employing the network sampling method (snowball sampling). As primary method,open discussion, face-to-face communication and in-depth interviews areused. Questions are semi-structured as it allows new ideas and extra information. The non-participant observation method is used in the process of data collection. As secondary data sources, articles, newspapers, and government statistics are used. By considering the demand of respondents, the pseudo names are used for them in narrations.

Research Gap Identified based on Review of Existing Literature

The scholarly discourse surrounding the sociological analysis of unmarried indigenous mothers in Wayanad, Kerala, has received considerable scholarly attention due to its multifaceted implications for individual agency, communal dynamics, and societal constructs. Previous research offers a robust groundwork for comprehending the challenges and encounters confronted by this demographic cohort, delineating numerous facets necessitating further exploration.

Primarily, extant scholarship underscores the socio-cultural determinants that underlie the prevalence of unwed motherhood among indigenous communities in Wayanad. Scholars elucidate the intersecting influences of entrenched cultural beliefs, familial structures, and communal norms in shaping the reproductive decisions and experiences of indigenous women. Moreover, historical marginalization and systemic disparities faced by indigenous populations are identified as pivotal factors heightening the vulnerability of unmarried mothers to social ostracization and economic deprivation.

Additionally, extant studies illuminate the distinctive impediments faced by unwed indigenous mothers in accessing essential healthcare, educational opportunities, and social support mechanisms. Challenges such as limited prenatal care availability, discriminatory encounters within healthcare settings, and inadequate governmental interventions are recognized as barriers to maternal and child well-being among this demographic. Furthermore, the compounding effects of gender, ethnicity, and socio-economic status accentuate the hurdles encountered by unwed indigenous mothers, perpetuating cycles of marginalization and disenfranchisement.

Furthermore, the psychological and emotional repercussions of unwed motherhood among indigenous women are scrutinized in the extant literature, emphasizing the imperative of comprehensive support frameworks and culturally attuned interventions. The research underscores the experiences of stigma, shame, and social isolation endured by unwed mothers, underscoring the necessity for community-driven initiatives fostering empowerment, resilience, and social integration.

Despite the breadth of scholarship on this subject, a dearth of research specifically targeting the experiences and challenges faced by unwed indigenous mothers in Wayanad, Kerala persists. Through a sociological inquiry informed by indigenous perspectives and grounded in the local context of Wayanad, this study endeavors to address this lacuna in the literature, contributing to a nuanced understanding of the intersecting determinants shaping the realities of unwed indigenous mothers. By means of empirical investigation and community collaboration, this research endeavors to yield insights informing policy formulation, social programming, and advocacy endeavors aimed at safeguarding the rights and well-being of this marginalized demographic.

In the context of domestic violence intersecting with low social status attributed to women from marginalized castes and economically disadvantaged backgrounds in India, several seminal sociological works provide valuable insights. The work titled "The Persistence of Patriarchy: Class, Caste, and Gender Inequality in Contemporary India" by Ramakrishnan, A.& Roy, S. 2017) examines the intricate interplay between class, caste, and gender dynamics in perpetuating patriarchal structures within Indian society. It delves into how intersecting identities of caste and economic status exacerbate the vulnerability of women to domestic violence, offering critical analysis and theoretical frameworks for understanding these complexities.

"Intersections of Gender, Caste, and Class: Theoretical Perspectives and Empirical Evidence" edited by Deshpande, A., & Newman, K. S. (2018): This edited volume provides a comprehensive overview of intersectionality theory within the Indian context, exploring how gender, caste, and class intersect to shape women's experiences of violence and oppression. It features contributions from leading scholars offering empirical insights and theoretical advancements in understanding the unique challenges faced by women from marginalized communities.

"Gendered Violence in India: Examining Domestic Violence Against Dalit Women" by Mohanty, M., & Joshi, S. (2020): Focusing specifically on domestic violence against Dalit women, this study offers a nuanced examination of how intersecting identities of gender, caste, and economic status intersect to perpetuate violence and discrimination. Through qualitative research methods, it highlights the lived experiences of Dalit women and provides a critical analysis of structural inequalities within Indian society.

"Violence Against Women in India: A Literature Review" by Sharma, S. (2019): This literature review synthesizes existing research on violence against women in India, including domestic violence within the context of caste and economic disparities. It provides a comprehensive overview of empirical findings, theoretical frameworks, and policy implications, shedding light on the multifaceted nature of gender-based violence and the intersecting factors that contribute to its perpetuation.

Incorporating insights from these seminal works into the research article titled "Sociological Examination of the Experiences and Obstacles Encountered by Unwed Indigenous Mothers in Wayanad, Kerala" would enrich the analysis by contextualizing the experiences of unwed indigenous mothers within broader socio-cultural and structural dynamics, including the intersecting axes of gender, caste, and economic status.

The Relief Actions and Results as per Gram Panchayat Records

Following media coverage highlighting the plight of unmarried mothers in Wayanad, several governmental agencies took proactive steps to address their legal and economic challenges. The Kerala Women's Commission, which has been advocating for the rights of unmarried mothers for decades, made significant progress in seeking justice for these women in Wayanad. By the end of 2012, the Commission had received a total of 278 complaints, with 207 originating from tribal women and 70 from marginalized Dalit communities across five specific panchayats: Thirunelli (104 cases), Pulpalli (78 cases), Muttil (28 cases), Panamaram (35 cases), and Mananthavadi (33 cases). Following an initial assessment of the complaints, the Commission initiated a DNA analysis process in select cases. DNA tests were conducted to determine the paternity of the children involved. Out of the 76 cases under review, 35 of the alleged fathers, who were called for blood tests, acknowledged their paternity without undergoing the tests. Among them, 29 expressed willingness to marry the victims, while the remaining individuals, already married, agreed to provide a monthly financial support. The Women's Commission, constrained by resources, prioritized DNA analysis in a limited number of cases. Out of the eighteen cases recommended for testing, paternity was successfully established in 10 instances, yielded negative results in six cases, and remains inconclusive in two cases. Apart from the DNA analysis initiative, the Women's Commission also instigated police investigations into 71 cases within the specified panchayats in recent years. More than 40 cases were resolved through out-of-court settlements prior to prosecution, while the remainder are either pending trial in courts or currently under investigation.

Table.1. Tribal Unwed Mothers of WayanadPetitions before Kerala Women's Commission

Thirunelli Panchayath	104
Pulpally panchayath	78
Muttil Panchayath	28
Panamaram Panchayath	35
MananthavadiMuncipality	33
Total Complaints	278

(Source: Gram Panchayat Records)

A significant achievement of the Kerala Women's Commission (KWC) is its success in holding government departments accountable and responsible for issues concerning the development of tribal women. According to KWC data, a majority of unmarried mothers experienced their first instance of sexual exploitation between the ages of 13 and 20. An intriguing observation is that many victims refrain from implicating their perpetrators, often influenced by their socio-cultural circumstances. In interviews conducted for this study, a substantial number of tribal women acknowledged the Women's Commission as pivotal in securing effective interventions, particularly because potential offenders feared legal repercussions.

Restoration of Indigenous Lands

The primary issue appears to be rooted in the progressive loss of their ancestral lands and diminishing traditional livelihoods, rendering tribal communities vulnerable to exploitation by external settlers. Their cultural heritage has not equipped them adequately to resist such exploitation. Over the years, these communities have faced an influx of outsiders who

have introduced detrimental practices such as alcohol addiction, land dispossession, and sexual abuse against their women. The proliferation of tourist resorts in Wayanad has further compounded these concerns. Once a predominant demographic in the hilly Wayanad region, Adivasis now constitute only 17 percent of the district's total population, as their habitats have been encroached upon and their traditional ways of life significantly disrupted. Since the initial settlement in the 1940s, there has been a continuous influx of settlers who have acquired local lands through both legitimate and illegitimate means. In 1976, a sub-committee commissioned by the state assembly conducted a survey in Wayanad to assess the extent of land alienation among the local population. Out of the 300 cases reviewed by the committee, 71 involved instances where tribal lands were forcibly seized. Compensation offered to 67 families was found to be inadequate, while 14 families were deceived into providing thumb impressions on blank documents under false pretenses.

Despite the enactment of several governmental statutes aimed at reclaiming tribal lands, implementation has been notably lacking. The 1972 Kerala Private Forests (Vesting and Assignment) Act mandates that 50 percent of privately owned forests acquired by the government be allocated to tribal communities. However, in Wayanad district, only a small portion of the 3,773 hectares acquired has been successfully transferred to *Adivasis.* Similarly, the Kerala Scheduled Tribes Act of 1975, applied retrospectively from 1960, invalidates all transactions involving tribal lands and directs their restoration to indigenous communities. Despite filing 2,127 petitions in court, *Adivasis* have seen minimal success, with only 103 cases resulting in court rulings affirming their rights. Nevertheless, settlers occupying these lands have resisted vacating, and law enforcement agencies have shown reluctance in enforcing court mandates.

A Kerala Legislative Assembly committee investigating the issue of unwed mothers presented its findings, proposing a series of measures to address the problem. These included initiatives such as reclaiming tribal lands that had been taken away and redistributing them under women's ownership. In 2002, the state government responded by introducing a relief package for unwed mothers, which encompassed provisions such as a one-acre plot of land, housing assistance, and a monthly pension of Rs. 1000.

A direct examination of revenue records across four panchayats and one municipality surveyed indicates limited progress in the allocation of land to tribal unwed mothers. The departments responsible for tribal welfare, social welfare, local governance, and revenue collaborated to execute the rehabilitation program. Despite receiving 256 applications for land distribution, only 14 women were granted plots under the scheme in these regions. Specifically, eight women received land in Thirunelli, four in Muttil, and two in Mananthavadi. However, Pulpalli and Panamaram did not report any achievements in this regard.

Table.2. Tribal Unwed Mothers of WayanadLand distribution to victims

Location received Land	Total applications	No. of Women
Thirunelli	92	8
Muttil	58	4
Panamaram	28	0
Pulpally	42	0
Mananthavadi	36	2
Total	256	14

(Source: Gram Panchayat Records)

Rehabilitation Programs for Housing and Job Skills

The majority of unmarried mothers reside with their parents and lack personal identity or autonomy. Tribal girls who become mothers before marriage are often marginalized within their families and left to fend for themselves, creating vulnerability to exploitation by outsiders. In response to this issue, the state government took action in 2000 by establishing a power-loom project near Thirunelli, known as Thrissilleri, aimed at rehabilitating unmarried mothers in Wayanad. Furthermore, an additional funding of Rs. 2.25 crore was allocated in 2008 to initiate a handloom unit within the project, expanding rehabilitation efforts to benefit 200 Adivasi women.Top of FormBottom of Form

Initially, a sum of 29 lakh rupees was allocated in 2008 for providing training to women, but this entire amount has been expended without the project achieving full implementation. The rehabilitation initiative for unmarried tribal mothers is conducted in collaboration with the Wayanad Handloom, Powerloom, and Multipurpose Industrial Cooperative. The project's aim is to transform a 13.40-acre area into a self-sustaining village for marginalized tribal women. Presently, only 28 women are employed within the project, and 11 women reside there with their children.

In addition, the state government of Kerala introduced a scheme offering a monthly pension of Rs. 1000 specifically for unwed tribal mothers. Across the five panchayats, authorities received 344 applications for the scheme. However, after evaluation by the tribal department, only 19 applicants were deemed eligible. Among them, 9 women from Thirunelli, and three each from Muttil, Pulpalli, and Manathavadi, along with one woman from Panamaram, currently receive the pension.Top of FormBottom of Form

Life Experiences from the Field

Illustration 1

Kamala, a thirty-year-old unmarried woman, resides with her parents, younger sister, and her three children (one daughter and two sons). She is illiterate and unemployed. Kamala became pregnant at the age of nineteen, a situation which elicited commentary from neighbors who observed her family's apparent lack of concern but continued normal behavior. The family frequently isolates themselves from others, with relatives also maintaining a distance. The father of the family is unemployed, resulting in a lack of visible income among household members. Neighbors harbor suspicions that Kamala may be involved in an extramarital affair with the tacit approval of her family, a notion substantiated by subsequent childbirths. Despite asserting that the father of Kamala's children passed away three years ago (with her youngest child being three and a half years old), the family has kept their marital status and the identity of the husband undisclosed to their community. Neighbors allege the presence of an unknown man (*Theeya*) visiting Kamala's residence intermittently for the past eight years. When questioned about their seemingly improved standard of living compared to other tribal families in the area, the family remains reticent. Kamala's eldest child, a daughter, faces continual harassment from men outside the household. However, they are hesitant to file complaints against individual perpetrators and lack awareness of their rights and legal protections. Kamala herself experiences persistent harassment, whether verbal or otherwise. She rationalizes this as a common experience for women, emphasizing avoidance as the sole recourse, stating, 'Every woman must endure such trials in her lifetime; avoiding such encounters is the only solution. I have been evading this for years; there is nothing to gain from lodging complaints against men.

Illustration 2

Saritha, a 28-year-old woman, is married to Vivek, who already has another spouse and two children. Saritha has been enduring Vivek's alcoholism and domestic violence for some time. He harbors suspicions about Saritha and subjects her to physical abuse as a result. Prior to her marriage, Saritha had a son at the age of nineteen. Her formal education only extends to the third standard. She had a romantic relationship with her childhood friend, who was also a neighbor and relative. Their bond developed during adolescence, facilitated by their long-standing friendship since childhood. Their social circle also included two male friends and one female friend, forming a close-knit group from an early age. As they matured, the boys introduced the girls to activities such as attending movies and local festivals, including the Valliyoorkav festival. Upon learning that the boys had tried alcohol, the girls expressed curiosity and eventually joined them in tasting it one afternoon in a rubber plantation. Saritha recalls, 'It was not to my taste, but it was exciting. We girls quickly became unsteady, and the boys may have also lost their inhibitions.' Saritha remembers engaging in intimate activities with her boyfriend, after which everything became a blur. She still feels shocked and ashamed to recount the incident. Upon regaining consciousness, Saritha found all five of them naked. Overcome with fear and guilt, she hastily dressed and fled, vomiting multiple times that day. Following the incident, Saritha severed ties with her friends and avoided eye contact with them. However, the most distressing realization for her was the cessation of her menstrual periods for two months. 'I consumed numerous papayas, stolen from others' plantations, in an attempt to induce a miscarriage before my pregnancy became apparent to others. What shattered me was being rejected by my boyfriend, who expressed doubts about paternity.' Saritha even contemplated suicide. Despite her family's initial shock and condemnation, they never abandoned her. She

ultimately gave birth to a son, who is now cared for by Saritha's parents. Her current marriage to Vivek was not of her choosing, undertaken to uphold family honor, and she continues to endure physical abuse at his hands.

Illustration 3

Sharada, is currently thirty- eight years old. She is the daughter of a five-member family where she lived with her two younger brothers and parents. Sharada did not attend any institutional-based education but as she quotes " life has taught enough". For the last fourteen years,she has been living with Jayan , who is another tribal man. Sharada gave birth to four childeren, three daugters from her marriage and the other one was carried by her when she was only seventeen.Sharada was not married at the time of the preganacy and she was never willing to reveal the father of her boy child. She was excluded and mentally tortured by the members of the clan. Even though her family was heart broken by the news they never abandoned her. Her child died at the age of three. Sharada started to isolate herself from the society due to continuous questions people raised towards her. Every stare was uncomfortable for her and she states "I became a hot news in everyones conversation, but nobody thought about what I have been going through".For sharada, she was forced to earn money because she was the eldest one in her family. Her father was an alcohol addict , so his income never met their needs. Whenever they raised their problems, he used to beat them up. So the only option left was to earn by herself at the age of sixteen. Ever since she started go for work, her father stoped working, her income became the only source to meet not only family needs but also was subjected to misuse by her father. So it became a huge burden for her. He forced her to go to work and forcefully took her money.This was the time one of the co-worker(a non-tribal man) offered her money for sexual relation. She first rejected him and kept a distance from him then after. But later on she realised it is

the only way to earn extra money so she can save it for herself without her fathers knowledge. She says, “it was not as easy as I thought”. After the first sexual inertcourse she was scared and decided not to do that again in her life not just because of the pain but the guilt she felt. Sharada was too late to realise the trap that and was forced to tolarate frequent balck mail from that man which stoped her from going to work. But her father never let her to quit the work which exposed her to continuous abuse. Sharada remember the days when her mother enquired about her menstrual cycle, and it was a big shock for her too.When her family realised she was pregnant , they asked her about the father of the child , so they can tie the knot between them. But she was so scared to tell them how it happened because “how can I tell them the money they ate and the alcohol my father drunk was actually the price of my body, even if I tell them , there is no doubt that I will be called as a sex worker, what else they call a women who is willing to have sex in exchange of money?”. After the death of the child, Sharada was mentally depressed. When she is in public, men started (mainly non tribal men)to misbehave towards her and even dared to publicly touch her. Sharada married Jayan at twenty three. It was the clan forced her to do that inorder to protect the pride and dignity of the clan. Jayan is an alcoholic addict who beats her and her children everyday. She is still insecure, and suffering to meet daily needs but not ready to go for work. She is also certain about educating her daughters but still scared of letting them go for work because she do not want her children to undergo the evil she underwent.

Illustration 4

Navya is currently 25 years old. Navya carried her first child when she was only seventeen but the child died within months of birth due to malnutrition. She have received education up to eight standard which make her one of the high educated in her colony. Navya was 15 when she had a relationship with a Christian man

who was a constuctor. He was an outsider. They met each other at the school where he came for work and she was a student. Before she knew she fell for him which was scary for her because she knew thereletionshipis never going to work out as she is a Paniya women. But he made her confident and promised they are going tohave a beautiful future together as soon as she become an adult.Navya received so many gifts such as chains, bangles , rings, bracelets and little toys and cards from him. She had a mobile phone so they continuosly called each other secretly. She was terrified in every moment of their relationship but she believed what they had was true love through his words and he treated her so well. She was continuosly worried about their age gap. She was only 15 and she believe he was above twenty eight. It was her birthday when he surprised her with gifts and went for a movie. She couldn't reject his request to have a sexual relationship because he did so much for her. She also was scared and curious about it at the same time. They had physical relationship more than once. She found herself in a weak position to say no to him. She was worried when she found out the abnormal gap in her mentrual cycle and talked about it to her cousin. The moment when she found out she was carrying all she could do is just cry.The most stressfull thing was facing her mother , a single parent who have been working hard to brought up her two girl children from a very young age. Navya had a elder sister who already was married . She faked her periods from her mother. She called her boy friend and told about her pregnancy, and the number was no longer existed after that call. She tried to committ suicide but was escaped by her mother. Her mother was emotionally broke but never abandon her child. She faced so much hatered from the people both inside and outside her community. Even though she had opportunity to get married again she believes it impossible to have family without forgetting her past. She was in so love with the man that she did not want to file a complaint againt him. Navya believes it was a blessing that the child died. She does not

believe she can be a good mother.Navya is sad about how the societal view changed towards her after that. So many people stop talking to her. The behaviour change of men have shocked her so many times. She experiences misbehaviuor often. Men outside the community asked her to be in relationship without marriage and forced her so many times. This experience made her to step back from public space. Navya feels uncomfortable when people stares at her. She lacks opinion in her own family.

Illustration 5

Anila , who is considered one of the brightest student in her school life, drop out in eight standrd. She has a good handwriting, painting skills and she won prices for poem writing competetions several times. Anila was a shy girl at school, who is tall. Her friends remember her as very attractive. People who knows Anila mentions her as a " girl with pretty smile". It was her teachers who enquired about her after she drop out. Anila's pregnancy was quite a shock for everyone. After her pregnancy, she negleted to speak to other people and found depressed. Her parents is so worried after her suicide attempt. A case was filed by the teachers themselves but Anila neglect to corperate. The family felt left out from the community for a while. All of them stoped working for few days because they were ashamed to face other . Her father was forced to talk about Anila'sincident. Anila was not ready to abort the child. When she was forced to do so, she cried and told them this is her fate. She never revealed the father of the child. In her mid fifteen, anila gave birth to a boy child. She seems to be very fond to the child and very protective. She is now only twenty one years old. She is afraid that what should she tell her child when he ask about his father?, even though she can lie that he died, what if people start to make fun of him and call him a 'bastard'. She thought about getting married to another person but she believes it is not going to change anything

for her son. Anila refuses to go out public because she says people directly ask her about the incident.

Data Analysis and Interpretation

The Causes and Consequences of Unmarried Motherhood

The causes and consequences of unmarried motherhood extend beyond the individual experiences of women to encompass broader implications for children's upbringing and societal development. Within the context of Wayanad, Kerala, unmarried tribal mothers encounter multifaceted challenges that intersect with various societal factors.From a sociological perspective, the causes of unmarried motherhood among tribal women in Wayanad may be rooted in systemic issues such as limited access to education, economic opportunities, and healthcare services. Structural inequalities, cultural norms, and traditional practices prevalent within tribal communities may also influence the prevalence of unmarried motherhood.

For unmarried tribal mothers themselves, the consequences can be profound. They may face social stigma, economic hardship, and limited support networks. The absence of a partner may place additional strain on their ability to provide for themselves and their children. Furthermore, unmarried mothers may experience psychological distress due to societal judgment and feelings of isolation.

However, the consequences of unmarried motherhood extend beyond the individual to impact children's upbringing and social development. Children born to unmarried mothers may face discrimination and stigma within their communities. They may also be at higher risk of experiencing poverty, inadequate access to education, and compromised healthcare. Moreover, the absence of a father figure in the household can have implications for children's emotional well-being and socialization.

From a broader societal perspective, the prevalence of unmarried motherhood among tribal communities can contribute to the perpetuation of social inequalities and the marginalization of already vulnerable populations. Addressing the challenges faced by unmarried tribal mothers requires a comprehensive approach that addresses structural barriers, promotes gender equality, and provides support systems for both women and children.

In conclusion, understanding the causes and consequences of unmarried motherhood among tribal women in Wayanad, Kerala, requires a nuanced examination of individual experiences, cultural dynamics, and societal factors. By recognizing the intersecting challenges faced by unmarried mothers and their children, policymakers and stakeholders can work towards creating more inclusive and supportive environments that promote the well-being of all members of society.

Alcohol Addiction and Sexual Exploitation:

In a patriarchal society, women experience pervasive vulnerability. Among the most marginalized are tribal women, subject to economic, political, educational, and social domination by more empowered segments of society. This lack of security renders them susceptible to exploitation, positioning them as among the most voiceless members of the population. Wayanad, encompassing 31.2 percent of the state's tribal population, exhibits stark disparities, with tribal women facing a literacy rate as low as 71 percent compared to the broader Kerala populace.

The inherent insecurity of tribal women extends beyond societal structures to their own households, where they often endure the consequences of male family members' alcoholism. Dependent on these men for essential provisions like food and shelter, tribal women find themselves trapped in a precarious balance, their lives disrupted by the erratic behavior and abuse stemming from addiction. Furthermore, despite their labor, tribal

workers in Wayanad are remunerated inadequately, exacerbating the strain on family resources.

The daily reality for tribal women involves navigating a hostile environment, where even basic sustenance is uncertain. Faced with sporadic employment opportunities dictated by male family members' whims, women are compelled to scavenge for sustenance, often resorting to foraging for leaves, bananas, or small aquatic creatures. This search for sustenance is fraught with danger, as women risk encountering sexual violence from predatory men, both within their own communities and from external sources who exploit their vulnerability. The cycle of exploitation perpetuated by patriarchal structures and exacerbated by addiction underscores the urgent need for comprehensive interventions to address the multifaceted challenges facing tribal women in Wayanad and similar marginalized communities

Legal Unawareness:

In some instances, male members of tribal families succumb to bribery from external parties aiming to maintain control over tribal women, ostensibly preserving their social standing. Limited understanding of physical relationships also contributes to teenage pregnancies, leaving these marginalized women with few options. Once subjected to sexual exploitation, the plight of tribal women exacerbates significantly. Their societal perception shifts from vulnerable individuals to sex workers, eradicating barriers to further exploitation and rendering their rejections futile. Consequently, this cycle perpetuates the proliferation of children born to different fathers within the same family unit. Over time, some of these women reluctantly turn to sex work as a means of financial sustenance, given the challenges faced by unwed tribal mothers in securing formal employment. Furthermore, victims of rape often refrain from pursuing legal recourse due to their unfamiliarity with legal provisions, while powerful exploiters manipulate the system to their advantage.

Unsafe Working Condition:

The unsafe working conditions faced by tribal women also warrant attention. Those employed in domestic roles are particularly vulnerable to sexual abuse by household members. Some individuals coerce these women into sex work and attempt to manipulate teenage girls into similar activities. Exploiters and members of society feel emboldened to harass tribal women due to the absence of evident consequences. Furthermore, government authorities have failed to conduct proper investigations to address the plight of tribal people. When questioned about such cases, tribal promoters often dismiss concerns by stating that 'the women involved are already married, so there is nothing to be concerned about.' Proper awareness, action, and security measures must be implemented by the responsible authorities to alleviate the ongoing misery faced by tribal women.

Failure of Government Programmes and Policies:

The government also plays a role in the plight of these marginalized individuals. Despite verbal declarations of development initiatives, practical implementation remains lacking. Many tribal communities still lack basic infrastructure, with women and girls often forced to traverse arduous paths to access water sources. Government-provided shelters are often poorly constructed, leading to rapid deterioration within a year. Systemic corruption further exacerbates the vulnerability of tribal populations, making them susceptible to external exploitation. There are numerous unreported cases where contractors and government officials attempt to sexually exploit tribal women under their authority. The pervasive backwardness across various sectors renders tribal individuals susceptible to exploitation by opportunistic abusers offering incentives. Another disturbing trend observed among unwed tribal mothers is the exploitation by men with *'Chovvadosham'* (a Hindu astrological belief indicating

unfavorable marriage prospects) who engage in sexual relationships with tribal women and secretly provide rewards to their families.

A study conducted by Tharuvana (2010) highlighted instances of unwanted pregnancies among tribal women working in ginger plantations in Coorg and resorts in Wayanad. The study also noted the common practice of enticing male workers with inexpensive country liquor to extract hard labor from them and sexually exploit female workers.

Conclusion and Observations

Wayanad district in India stands out for its high concentration of tribal population, comprising es extend to the education and social integration of tribal children. Fatherless upbringing due to absentee male figures results in societal stigmatization, with children often subjected to derogatory labels such as 'bastard.' This early exposure to societal disdain breeds resentment and impedes their educational progress, as they endure ridicule and ostracization from peers. Additionally, daughters of unwed tribal mothers face heightened risks of harassment, further deterring them from pursuing education beyond the primary level. The pervasive societal perception of sexually abused tribal women as accessible sex workers further isolates these marginalized individuals, compelling them to withdraw from public spaces to evade scrutiny and questioning.

Despite the prevalence of these injustices, there is a glaring absence of governmental intervention and legal protection for tribal women, particularly unwed mothers. Their plight remains largely undocumented in official statistics, leaving them vulnerable to continued exploitation and social marginalization. Addressing these systemic injustices requires a concerted effort from authorities to provide comprehensive protection and support to tribal women. These unwed mothers, victims of societal neglect

and prejudice, deserve recognition and redressal of their longstanding grievances through targeted interventions aimed at dismantling the barriers to their social and economic empowerment.

In summary, the implementation of developmental projects, relief efforts, and law enforcement measures has contributed to a notable reduction in cases involving unwed tribal mothers. Instances of abandoned mothers and children born out of wedlock have significantly dwindled, with fresh reports becoming rare. Notably, the proactive initiatives undertaken by the Kerala Women's Commission and Human Rights Commission to prosecute offenders have instilled a palpable sense of apprehension among perpetrators while fostering a greater sense of security among victims. However, the efficacy of these interventions varies depending on the specific circumstances of individual cases and the geographical context. Consequently, there is a pressing need for concerted, coordinated efforts aimed at enhancing the effectiveness and productivity of these projects and activities. Additional observations and recommendations are outlined below:

- The dispossession of tribal land represents a critical issue confronting indigenous communities in Wayanad and other regions of Kerala. It is imperative to develop a comprehensive strategy to restore these alienated lands.
- A holistic rehabilitation package that preserves the cultural and environmental contexts of tribal women should be devised.
- Effective inter-departmental coordination is essential for the successful implementation of development projects.
- The absence of fathers is a poignant reality faced by young children of unmarried mothers within the community. It

would be advantageous to establish a dedicated scheme to support their schooling and education.

- The lack of sensitivity among police and other officials concerning the rights of tribal women exacerbates the problem. It is essential to educate and sensitize law enforcement personnel on these issues.

Apart from the legal proceedings and DNA analysis efforts led by the Kerala Women's Commission (KWC), all other initiatives addressing unmarried motherhood were carried out through decentralized local bodies like gram panchayats or block panchayats. The effectiveness of panchayat administration and officials played a crucial role in the success of these initiatives. Notably, Thirunelli and Muttil panchayats, which demonstrated relatively better performance in distributing land to tribal women (see Table 2), had dedicated task forces for the development of tribal women. To enhance the implementation of relief projects, it is suggested to establish a separate Standing Committee for Destitute Tribal Women in panchayats with a significant tribal population.

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Work from Home and Gender Divide: Nuances of Patriarchy found in the context of IT Profession

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Abstract

Work from home means one can work sitting from anywhere other than an office space. The mode of work from home has gained momentum during the COVID-19 pandemic times. Considering the IT sector, work from home was implemented way back due to its nature of work. The prime challenge posed by work from home is that the domestic and professional domains got mixed up; it imposed the burden especially on women thrice the times compared to the pre-pandemic times. However, the work that women do in the family is not highly paid or culturally important, despite the important role it plays in maintaining the economic system. Work-family conflict also got exacerbated due

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to work from home. The major reason behind the stress experienced by women is due to the dominant patriarchal norms and gender stereotypes. Across India, gender inequality plays out in different ways, affecting the lives of men and women, but females are particularly vulnerable. During any crisis, women are the ones in peril because they are considered submissive and also due to the deeply ingrained gender inequality in our society. In this paper, an attempt is made to unveil what are the regressive factors affecting women IT professionals while they undertake work from home as a part of their profession.

Keywords: *Work from Home, Gender Divide, Patriarchy, Gender Stereotypes, Regressive Factors.*

Introduction

The pandemic and the pandemic-induced lockdown have changed every aspect of our lives, including the way we work. Work from home is a major technological advancement. But the experience of work from home may not be the same for everyone. The mode of remote working gained momentum during the pandemic times. Considering the IT sector, work from home was implemented way back due to its nature of work, but many other sectors administered WFH during the pandemic. There is a preconceived notion that working from home would be much more flexible, but it is not completely true. Especially married women professionals consider it difficult to manage their paid work together with unpaid domestic work because of the dominant patriarchal norms. In this paper, an attempt is made to unveil how far patriarchal norms are relaxed or pronounced while women work from home.

Sylvia Walby (1990) defines patriarchy as "a system of social structures and practices in which men dominate, oppress, and exploit women". In the patriarchal system, men hold the supreme power, and they control the women and children in the

family. The property and titles are inherited through the male's lineage. Patriarchy can be termed as an ideology in which men dominate women and find women inferior, and the decision-making power is vested in the hands of men (Bhasin, 2006). Patriarchal norms can be seen in every realm of society, from family to workplace. One dominant form of the patriarchal norm which is still followed is the custom of a woman moving to her husband's house after marriage. Similarly, children are given the name of their father's family. Patriarchy and gender stereotypes can be termed as two sides of the same coin. Gender stereotyping is a set of norms ascribed to women and men, like how they should behave and what roles they should perform. Gender stereotyping has more negative effects on women than men. For instance, a woman must be submissive and nurturing, and these stereotypes are foisted on women to follow such ascribed qualities (Levesque, 2011).

Men consider themselves as the master of the house and view that decision-making is a monopoly of men, and women should obey men for the smooth running of the family. In patriarchy, masculinity is praised for power and femininity for weakness. Man finds it a discredit to his masculinity to abdicate his gender roles pre-assigned by society. So, in the patriarchal society, the role of women is simply looking after the husband, household duties, and child-bearing. Women lack property rights and freedom to choose a career; generally, men are valued more than women. The gender gap in working at home shares many of the characteristics of an already existing gender gap and also several new factors. First, women lead the way with a large preponderance because they leave work much faster than men. The driving force behind this difference appears to be the heavier load that women often carry at home. Among working adults with children, women are three times more likely than men to be the primary caregiver (Works, 2023). During and after the COVID-

19 pandemic times too, women were negatively affected in terms of their health, career, financial stability and their empowerment.

An unequal burden

According to Gaskell's (2023) survey, across the board, the respondents reported an increase in interruptions since the pandemic began, but the nature of these interruptions had changed significantly. The responsibility for interruptions was unevenly distributed, with women reporting higher levels of all types of non-work interruptions. This suggests that women experience a greater degree of fragmented time compared to men. Even when both partners work remotely, women bear the majority of household burdens, resulting in a heightened level of interruptions for them. This situation was already present before the pandemic but has been further intensified during the pandemic period. While the interruptions for family-related reasons could be predicted to a certain extent, women also reported suffering from more interruptions from colleagues and managers when they worked from home.

Methodology

The paper addresses the positive and negative impacts of work from home on the lives of women IT employees. Appropriate theoretical perspectives are availed that lead to the inquiry towards enlightening pathways. Different aspects of the topic, such as the challenges of work of home with respect to gender and how far patriarchal norms affect women inthe IT sector who undertake work from home, are discussed from a holistic perspective; highlighting the importance of bridging the gender divide induced by social inequalities. The data used for the study is exclusively from secondary sources such as books, journals and online research portals.

Theoretical Framework

Emile Durkheim defined 'Anomie' in his book 'Division of Labour in Society' (1893) as a state of inability due to the collapse of the normal society. Due to the outbreak of the COVID-19 pandemic, the normalcy of society has been affected (Serpa & Ferreira, 2018). The daily lives of the people changed upside down. Thus, the way of working was also altered.

Even in this 21st century, our world is a place of dominant patriarchal notions. Sylvia Walby's work on "Gender, Class, and Stratification" (1986) highlights how women's labour is seldom rewarded. She argues that women do not constitute a distinct class. Rather, women across all classes share common experiences. Domestic duties are not regarded as real work, rendering women's difficult housework invisible. When work-from-home policies were suddenly implemented, it placed an extra burden on female household members. Nowadays, many women are employed. While this improves their social standing, it also increases their workload.

Feminism and Gender Stereotypes: Third-wave feminism seeks to examine gender structures and women's experiences in different areas of the gendered social order where men and women intersect (Budgeon, 2012). The new wave of feminist theory seeks to understand the current situation of women in different organizations and organizational systems in various social, economic, cultural and religious contexts (Tabassum& Nayak, 2021).

Impact of patriarchal norms and gender stereotypes on women working from home

The COVID-19 pandemic has dramatically changed the views on Work from home (WFH). Women were more likely to want WFH than men, and they had a harder time doing so. The

working hours increased, and meetings and conferences started to happen, which contributed to a negative impact. The work-life balance became almost non-existent due to working from home. For women, WFH can be considered a boon and curse at the same time because it exacerbated the deeply ingrained gender inequality in our society (Molla, 2021).

Due to the COVID-19 pandemic and the implementation of WFH, the lives of working women changed tremendously and caused turmoil. The status of women professionals with high educational qualifications with high profile jobs are usually considered as empowered and independent, but taking into account their in-world (family space), they are still facing discrimination and their contribution is considered negligible (Jasrotia, Meena, 2021). Thus, it is evident that the status of women has changed in modern times, but still, patriarchal norms are dominant, so women are yet labelled for doing household chores and men as breadwinners and women are accounted for doing more than 75 per cent of household duties, according to Silva and Carvalho (2021). The stereotypes got strong during the pandemic. The household duties are not shared equally between the partners. Sociologists described women's household work as 'second shift', where after completing the paid work, she enters into another shift of work called domestic duties, which is unpaid (Hochschild & Machung,1989).

Before the allocation of work from home, women were more comfortable with their work. As working women used to complete their household duties before leaving for office and do the same when returning from office. But, due to working from home, they find it difficult to manage their time, contributing reasonably to professional duties and household chores. They are even working on weekends; and earlier, there were fixed timings for meetings and calls, but due to work from home, the meetings and calls can happen any time throughout the day and even on Sundays, which

once happened to be holidays. Therefore, switching between professional and personal space is difficult to manage. From answering a calling bell to caring for the elderly in the home, the duties are supposed to be performed by women. Preparing food, washing dishes, taking care of the child, and sitting with the children for their online classes, along with the paid job, is a herculean task. In society, household responsibilities and housework are the onus of the women in the family. So, before the arrival of COVID-19 and the lockdown, women were at least having some support in terms of domestic servants, but the change emerged with the complete shutdown, and it affected the quantum of work of women, though it did not affect men's working arrangements in the same way (Del Boca et al., 2020). Even after the crisis, many IT companies offered complete work from home for their employees as they found the method profitable.

For many women, working at the office and talking to their colleagues was a stress reliever. Due to WFH, the employees lost their social circle, thus alleviating stress and loneliness. Women were not able to find time for themselves. The situation is not different, even in the case of women working in executive positions in a company, because the cultural and structural systems are both shaped against women. Women undergo difficulties in playing their different roles like wife, mother, and daughter-in-law (Andrew et al., 2020) and are more likely to feel burned out than men, and that has negatively affected their experience working from home. Seventy-nine per cent of men said they had had a positive work-from-home experience during the pandemic, compared with just 37 per cent of women, according to Stachenfeld & Alexander (2022) report on COVID-19's impact on women's employment. Women with children are found to experience more stress than ones without children. A crying toddler makes an appearance on the Zoom call of a mother, not on the father. While both women and men are working from home,

still women are more involved in looking after a child than men (Del Boca et al., 2020).

Therefore, men show a positive attitude towards work from home while working women, especially women with children, find it difficult to manage their paid work and caregiving to children, so two out of three women choose motherhood over the profession. Hence, women quit their jobs. There is a sharp decrease in the women workforce during the pandemic times (ILO, 2021).

Domestic violence intensified during the pandemic times. According to the UN (n.d), one in three women experience sexual or physical violence by their intimate partner. Due to the lockdown, there has been a rise in domestic violence incidents as people are confined to their homes for prolonged periods. The COVID-19 pandemic has further aggravated the situation, caused financial difficulties, and made it difficult for victims to access basic needs like food and housing, thereby exacerbating the problem of intimate partner violence. Other reasons range from alcohol abuse, issues between in-laws and married women, conflicts related to relationships, etc. The cases are still on a hike even after the pandemic.

Even WFH is not safer for women, as sexual harassment has found its place even virtually. Berating someone in front of colleagues in the office, video calls, and virtual meetings facilitate private conversations that can become toxic on a personal level as they create the illusion of privacy and turn someone off or on at the touch of a button. Virtual workplace bullying can take many forms. It could be a manager excessively putting someone on the spot to exert pressure on them in front of colleagues. Pressuring individuals to appear on video against their will or criticizing their appearance and the condition of their surroundings can create a distressing situation. Women have unfortunately experienced unsuitable text messages, voice recordings, images, and even

deliberate disrespectful conduct during video conferences. The cyberbullying took a toll on the mental and physical health of the employees. Individuals may also encounter feelings of diminished self-worth and engage in thoughts or actions related to self-harm or suicide (Bollestad et al., 2022).

Role of Patriarchal norms

Patriarchy is a social system. In a patriarchal society, a man holds supreme power. The patriarchal system designates the male as the head of the family. The decision-making powers will be vested in the hands of a husband or father or an elderly man in the family. Gender stereotyping is a set of norms ascribed to women and men, like how they should behave and what roles they should perform. Gender stereotyping has more negative effects on women than men. For example, a woman must be submissive and nurturing, and these stereotypes are foisted on women to follow such ascribed qualities. Men consider themselves as the master of the house and view that decision-making is a monopoly of men, and women should obey men for the smooth running of the family. In patriarchy, masculinity is praised for power and femininity for weakness. Man finds it a discredit to his masculinity to abdicate his gender roles pre-assigned by society. So, in the patriarchal society, the role of women is simply looking after the husband, household duties, and child-bearing. Women lack property rights and freedom to choose a career, and men are valued more than women. Women were considered weaker, and they were devoid of the rights and privileges enjoyed by men. In the technological era, the condition is the same. The COVID-19 pandemic outbreak and the lockdown became a beneficiary contributor to the stereotypes. The lockdown helped to unite the family members under one roof, but it reinforced the stereotype that women are responsible for household chores and that their place is in the kitchen.

The mental health of working women is exacerbated due to patriarchal norms. The household chores and caring for children and the elderly became the duties of the women in the home. The duties were not shared equally. According to OECD (2021), Women work for two hours more than men in unpaid or domestic work. Before the pandemic, the professional and personal spaces were different. Working women complete their work before the office, and in the office space, she receive acquaintanceship, and thus, the social circle makes her relieved, but due to working from home, the status of women again turned back just like the traditional old days. The loss of jobs for women made them submissive to their husbands as they lost their financial stability. The dependency of women on their male counterparts paved the way for the deepening of patriarchal norms. Domestic violence cases got lifted during the pandemic. The lockdown and quarantine minimized the movement of people outside their houses, thus increasing abuse. The pandemic has saved women from abusers outside, but the times revealed that women experience abuse and sexual harassment mostly from their intimate partners. Women in abusive relationships find it difficult to come out of the relationship due to the lockdown and the risk of infection. They suffer more as they come in close contact with their partners and family members, thus increasing domestic violence.

Emotional violence is an unaddressed term. Emotional abuse, just like physical abuse, is a form of violence. Yelling at women, verbal assault, humiliating, threatening, excluding, and insulting are emotional abuse. The male-dominated society that considers women as inferior shows a higher rate of emotional violence against women. The husband employs emotional abuse towards his wife in order to assert his position of dominance. Women's psychological stability is at stake due to emotional abuse. Insulting the woman for not taking care of the child, for not doing household chores, and forcing her to quit her job to

look after the family are the common emotional abuses against women.

The woman is working hard for the satisfaction of other people —-it is what patriarchy teaches her to do. Thus, self-satisfaction became less important and that eventually increased the frequency of toll on their mental health. Gender roles and expectations are the major reasons for depression among married women. Even in developed countries, gender equality is a neglected topic. No country has attained complete gender equality yet.

Bridging the Gender Divide during Work from Home

During a tough time like COVID-19 pandemic, gendered social roles have emerged as a function that suits power positions in the patriarchal set-up. Hence, women were not able to cope with their careers and domestic duties. But considering the situation of a crisis, WFH was a better option that safeguarded people from getting the infection, and also, they can perform both personal and professional work while sitting in their comfort zone. Hence, the technological advancements can be considered as a boon during tough times.

WFH can be used effectively as a catalyst to retain women in the workforce. Change must start from the familial space. Promoting equal share of work in the household, looking after children, and everything else must be two-tier. The gender roles and expectations around must be changed. From the end of the organizational set-up- paid parental leaves, equal compensation and promotion for performing the same job for both men and women, focus on their productivity and not the extra hours (Molla, 2021).

More flexibility needed

The husbands could significantly help their wives when they work from home by performing more household tasks, especially when their wives have a more rigid work schedule. With the increasing blurring of boundaries between personal and professional lives, the chances of conflict among dual-earner couples also rise. Although having both partners working from home may result in increased productivity, it also intensifies the feeling of inter-role conflict. This conflict leads to psychological disengagement from work and even a sense of guilt towards the employer. Managers should form realistic expectations about how much work their remote working employees can effectively handle and show more understanding of the home working situations of dual-earner couples (Gaskell, 2023). Hence, WFH can be made effective and outgoing for women professionals.

Conclusion

The COVID-19 pandemic has brought about a crisis that is prompting us to re-examine and reconsider the existing disparities in our society. These disparities, which manifest in different ways, such as social class, race, ethnicity, and gender, have been further highlighted during this challenging period. Particularly, the pandemic has shed light on the deeply ingrained and gender-biased social dynamics within family structures. Consequently, this period has introduced additional complexities to the already existing and ongoing challenges related to gender within families. The mother's working hours are significantly burdened by family responsibilities and childcare, more so than their fathers. Consequently, it is essential to cultivate a positive home environment in order to restore a sense of normalcy (Hjálmsdóttir and Bjarnadóttir, 2021). Therefore, it is essential for the family to function as a cohesive unit and reduce gender-based stereotypes associated with work roles.

Working women have to prioritize their home life, professional situations and their physical and mental well-being, which needs constant motivation and support from family members. Along with motivating women to work and be independent, it is also necessary to encourage men to help their partners with household chores. Both men and women are equally responsible in every situation, whether it is working on a project in the workplace or taking care of the household chores. Therefore, everyone should have an idea to bring about a revolutionary change in their thinking. Commit to women and accept them as equal participants in the country's development (Sapna Sah, 2014). Working from home is, therefore, a narrow response to gender inequality in the workplace. The possibility of work from home does not by itself sufficiently change the organization of paid and unpaid work in a way that would promote a more sustainable transition towards gender equality at home and at work. Flexible work arrangements, such as individual behavioural changes, are important. But, these small adjustments are completely insufficient to effectively solve a structural problem that requires a large-scale solution (Is Working from Home a Solution to Gender Inequality, 2020). Therefore, the problem requires a wide-reaching plan to make the world a much better and safer place for women.

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Gender in Sex Work: A Probe among Sex Workers of Thiruvananthapuram

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Abstract

Sex work is a depraved activity where the worker is despised. Sex workers are the ones who receive money or gifts in exchange for performing sexual acts or providing sexual services either regularly or irregularly. Though the perceptions on sex work differ across societies, it is usually perceived as a moral transgression.There exists a skewed attitude towards men, who are usually the clients, and a hostile attitude towards women, the service providers. Even the system of law and order treats them as such, ridiculing women's legal and constitutional rights (Adelman, 2008). The present study focuses on thestructural imbalancesof gender insex workusing case studies, selected through snowball sampling. Sex work is highly gendered where masculinity and patriarchy are most explicit. While men dominate

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sex work with undue power and control over women, the latter are pushed to submissive roles, mostly confined to performance of sex acts. The men who manage the business choose the customers, decide time and venues and even the price of services pushing women into passive roles. Thus, sex workers constitute an excluded section that badly needs social acceptance and legal protection.

Keywords: *Gender,Sex work, Exclusion, Patriarchy, Masculinity*

Introduction

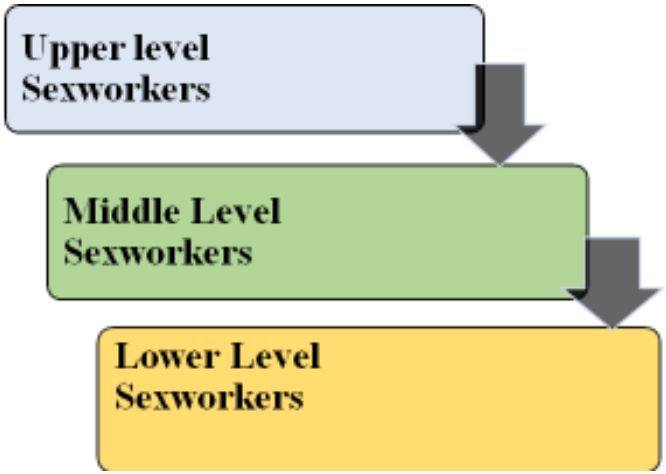
The sex industry employs sex workers including gays, transexuals, lesbians, and homosexuals. Prostitution is another name for sex employment, one of the oldest and most enduring issues in any society. There are various definitions of "sex." It can specify human physical activity, such as sexual activity or the distinction of biological differences between men and women. Here, "Sex" refers to sexual behaviour and acts.A sex worker is someone who works in this field (Anthias, 2013). Sex workers suffer exclusion and marginalisation not only from others but also from their community of co-workers. They face several disparities and discriminations in the environment to which they belong.

Sex work can be divided into three levels based on its operation: lower, middle, and upper. Lower level includes those who work on the streets. They wander in the streets or stay at a particular point where they can find their clients bysoliciting them mostly through non-verbal communication like gestures. Middle level work is based in lodge/homes and the number of both workers and clients may vary from single to multiple. Either the clients approach the workersor the middlemen solicit the clients. The play of middlemen makes it exploitative. It is more of a conventional manner of sex work. The higher-levelsex work is amore organised commercialengagement involvinghigh-

classworkers and clients for a considerable payment. Ordinary people cannot afford their services as it is costly and specifically designed for the elites.

There are also classes and classifications among sex workers. Financial assets, physique and appearance, sexual performance, age, colour etc are among the defining factors of type and level of a sex worker. Sex workers of the lower levels face several disparities and deprivations that can be seen in every aspect of their lives and work making their lives vulnerable.

Figure-1 Levels of Sex Work



Source: Own formation

Review of Literature

Sex work has existed since the dawn of humanity, and the idea that there is a culture solely dedicated to it is a sociological fallacy(Brents and Sanders, 2010).A man or woman who performs sexual services for pay, reward, or personal gratification is called a "sex worker." Sex workers include women who perform sexual

favours for either men or women. Sex labour is viewed as a voluntary choice. While 'sex work'presents a positive outlook of the profession, prostitution has negative legal and moral ramifications (Cecil,1937).

Different forms of commercial sex include brothels, call girls, escorts, Devadasi system, sex tourism, and virtual sex.The term "brothels" or "pillow homes" refer to places where sex workers meet their clients in quiet cabins or private rooms. The customers pay the brothel operator for the service. These brothels are protected by gangs-pimpsnexus. Part-time sex workers include "call girls," who are in a better position than prostitutes(Brents and Sanders, 2010).

Literature has identified a variety of routes leading to sex employment depending on its nature. Financial factors are important in pushing people into sex industry. Sex industry is thought to be valued at about £534 million annually(Angew and Robert, 2007).

In brothels, there are owners, managers, and sex workers (Brentand Sanders, 2010).

Different sex workers confront varying levels of risk and suffer varying degrees of health effects. Non-contact sex work and stripping are two sex jobs that are less likely to result in health issues. The activities with reduced risk are not mentioned becausemost sex work literature focuses on practices that put both sex workers and customers at greater risk(Harcourt and Donovan, 2005).

A considerable number of women sex workers have a tumultuous family life. Economic pressures, failed love affairs, poor marital life, marital breakdowns, sexual illiteracy, porn addiction, exploratory tendencies, desire for novelty etc., can influence people to engage in sexual conductthat is deviating from

societal norms. Uncomfortable situations at home, primarily due to poverty, alcohol and substance addiction, and frequent family quarrels, are all motivating elements that lead people to a life of deviance. Sex workers are often excluded and are subjected to misconceptions.(BrentsandSanders, 2010).

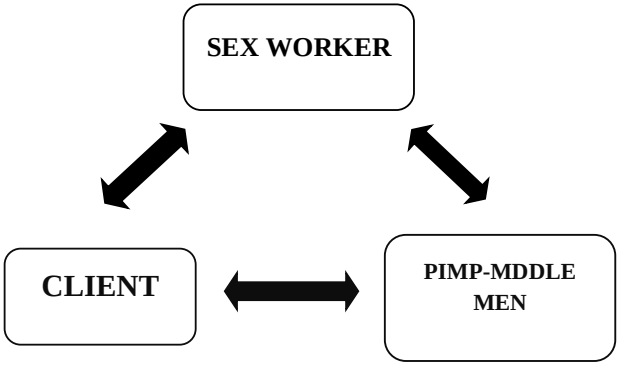
Methodology

The study is exploratory research using case study method. Data were collected through snowball sampling. The street based or low-level sex workers of Thiruvananthapuram district are the population of the study. Primary data were collected through case studies using in-depth interviews. Secondary data were collected from books, journals, reports, online resources, etc.

Conceptual Framework

Sex trade is usually dominated by men, who hold important roles and positions of power and authority. In sex work, while men are active partners controlling almost every task, women appear to be passive partners. In sex work, gender norms and power structures are most visible. The study mainly focuses on skewed gender roles and exclusion of women in sex work.

Figure 2: Tripartite in Sex Work.



Source: Own formulation

There is a Tripartite relationship between the sex worker, pimp/local patron, and client. They are interrelated and interdependent. Though due to exploitation, street sex workers try to find customers alone, they do not succeed as the pimps/ middlemen use their power and influence to create barriers. Thus, they act as an oppressive regime towards sex workers.

Social Class and Exclusion

Sex work has a sharp class distinction. Those who stand at the top of socio-economic hierarchy often believe that sex work is particular to the oppressed and lower layers of society. Society constructs a hierarchy of discrimination and power relations with regard to sex workers resulting their facing of several threats from both men and women. In every aspect of sex workdo they experience power hierarchy and social exclusions. In sexual encounters,men exert unequal power instead of lovemaking, taking undue advantage in terms ofpaying for the service. Males have a misconception that'if I pay, I am the master, and you are the slave', that is interestingly absent in othercustomer-service provider situations. Such misconceptions lead to toxic power relations and hierarchy in sex work.

People engaged in some jobs are looked down up on over others in traditional societies resulting in their exclusion from the mainstream. Even in this modern world consider sex workas an evil and sinful profession and sex workers as sinners or even criminals. Even women instruct their children not to even talk to sex workers. Sex workers and those related to them are excluded from social functions, job opportunities, marital alliances, and other social spheres. Authorities like police consider sex workers as nuisance. At the same time, many of them either hire or exploit sex workers. Similarly, religion and belief systems contribute much to the social exclusion of sex workers. Their texts and scriptures preach that sex work, masturbation, and transgender interactions are sinful practices attracting the wrath of God.

Sex workers are often at the receiving end of stereotype perceptions and misogynistic attitudes of society.

Ms. Sofia (pseudo name), 37 years sex worker, said

> *"Police come to me whenever I stay on the street, asking questions. Most of the time, I lie to escape those interrogations. Whenever I try to solicit clients, the cops or others question me like a thief. We do not commit any crime like theft, but they all see us as abomination."*

Her words show the stereotypical perception of society toward sex workers. As it is illegal to perform sex work in the state, the police ensure that it does not happen. However, there is a discrimination as they always target the lowest class among them. There are high profile sex workers who run their business hassle free in luxury hotels and resorts. Due to their upper-class advantage, police and others do not exploit or disturb them. Nevertheless, the plight of the street-based sex workers is the opposite. They are one of the most vulnerable sections, suffering exploitation and hardships from all quarters.

The lower-level sex workers mostly entered this job unwillingly; their familial, economic, and problems led them to this. Besides, sexual assault and sexual exploitation are also crucial in their entry. The community often perceives that divorce happens due to the grave mistakes of women. Also there exists a perception that if a woman loses her virginity, she loses everything. Such kinds of patriarchal judgments, attitudes and stigmas are instrumental in pushing women into sex work.

Ms. Sandhya (pseudo name), 30 years, said:

> *When I went to a street for work, a man yelled at me.*
>
> *"You are sluts, shamelessly selling your bodies. You are all a disgrace to our society and culture."*

People usually place a prejudicetowards the sex workers, that is less likely to change. The media,like films and print media make slut-shaming, body-shaming, objectification, and other ingredients to make their contents more poetic. They also characterise sex workers as low class in society. They express hate and disgust towards them.

Gender rolesand Hierarchy

Except a few who do not work alone, sex work is carried out through a network of houses or brothels with pimps and procures.There areseveral players who exertpower over sex workers and eat on their earnings.Sex work is not socially accepted except in Bombay Red Street, Sonagachi etc. Because of the stereotyping and other problems, sex work is performed secretly and planned. The upper-level workers constitute a powerful business, often combing economic and political powers together, so that they are capable of overcoming any adverse move from police and the like using their power and influence. There are both male and female leaders and pimps in the industry.

There also exists a hierarchical power structure in the business. The males are more in number and have more control. They mobilise clients and make all logistics, including the custom made that cater to the specific needs of the clients, for which they get a share from both the customers and the workers. Though there are a few pimps who take their share only from the clients. most of them claim it from both. The pimps are crucial in finding clients. The street sex workers often succeed in finding only one or two cases daily whereas pimps have more contacts and communications with several clients. They can arrange any customer to any worker and coordinate time and space efficiently. Since they have more power and influence, they exploit the vulnerable workers.

Ms. Leela (pseudo name), 32 years, said:

> *"Per day, I get between Rs. 2000-3000, but it needs to be divided among the pimps, police, local patrons, etc. After all the deductions, I get Rs. 1000 to 2000. If there is not any problem, I can earn up to Rs. 25,000 per month, which has its own purpose."*

This account shows the exploitation of sex workers by the stakeholders. She is forced to give a share of her earnings to everyone she enlisted. Police, pimps, and local patrons are the key playersin the skewed power relations. Sex workers need to pay to these players to avoid the trouble that might otherwise cause. The police often abuse authority to illegally control and extort the sex workers and most often the lowest segment. The other men, including clients and pimps too overpower and exploit them.

Ms. Leela (pseudo name), 32 years, said:

> *"Most of my clients force me to do acts that I do not like to do, like anal sex,oral sex, etc. However, when I resist, they physically force me to do it. Also, if they in intercourse, they blame me, as if it is my fault"*

This statement shows the skewed power relations in sex work. Sex workers are subject to constant exploitation by all the male stakeholders. Though they are very often exploited financially, sexual exploitation is also there. Being the mediator between the sex worker and the client, pimps take money from clients, often without the knowledge of workers besides from worker. When sex workers oppose it, pimps use even physical power to suppress them. Since pimps have more connections with clients, they can easily dominate the workers. Power relations of workers differ across social situations like intercourse and financial transactions. The men use both physical and nonphysical power to dominate the female sex workers and forcefully make themcommit or omit things against her free will.

Individuals have their likes, dislikes and fantasies in doing sex. While acts like oral sex, blowjob, doggy style, etc. give pleasure to some, they make others quite uncomfortable. The male clients by virtue of being buyers of service demand the workers to do whatever they like. If the sex worker cannot do an act as demanded, she does some alternatives to make the client feel good, to keep the business on track. Most of the time, the low-level workers have to press the clients for payment who in turn make lame excuses on the quality of the service renderedto slash the amount. Clients also resort to body shaming to justify reduce the agreed pay. They sometimes even threaten the workers to reveal their identity before their local community. Thus, men exert power over sex workers in various ways.

The street workers are unable to resist and suffer all these atrocities as they do not have legal protection. Since they cannot find alternative livelihood than selling their bodiesdue to social exclusion and stigma, they do not resist. The stigma of their work and the consequent exclusion remain even after they leave their work.

A group of men keep an eye on a share of the earning of sex worker, being insensitive to them. Men appear to be a parasitic regime exploiting the major chunk of the earning of the helpless sex workers.

Some of them conduct these business-like corporates. The worker has to connect with several pimps or intermediaries to get customers. The workers usually are in a lower position in the negotiation with pimps and clients for their share of earning. This is a defining feature of lower-level sex workers. The middlemen charge considerable portion of earning from the clientsand instruct them not to disclose to the worker the actual amount charged.

There is a Tripartite relationship between the sex worker, pimp/local patron and client. They are interrelated and

interdependent. Though due to exploitation, street sex workers try to find customers alone, they do not succeed as the pimps/ middlemen use their power and influence to create barriers. Thus, they act as an oppressive regime towards sex workers.

Conclusion

Sex workers fall in three classes namely lower, middle and upper with differential experiences of power domination. The female sex workers are in continuous negotiations with the male stake holders for their work and share of income. The male stakeholders utilise their power to put them in constant uncertainty and subjugation. The male clients try their level best toslash the pay as low as possible. Sex workers are forced to perform the sex acts that they do not like against their free will. Thus, domination of the males work on the female sex workers in multitude forms. Sex work involves male dominance not just in the intercourse but also in other aspect of the business. Though women are the providers of sexual service, men decide almost everything including financial transactions, clients, time, and space with the workers having no voice. Thus, the men in sex work constitute an exploitative and oppressive regime that is insensitive to the sex workers.

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Journey Within: Exploring the Correlation between Personal Beliefs and Young Adults' Perspectives in Thiruvananthapuram, Kerala

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Abstract

Young adulthood is a period during which individuals focus on making choices related to friendship, occupation, values and lifestyle. They also contemplate matters of love, sex, and gender, seeking bold and liberating answers,such as pornography, premarital sex, the significance of marriage, and the influence of

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religion and spirituality in their lives. The purpose of the present study is to gain insights into the impact of spirituality and religiosity on the behaviour andchoices of young adults. A total of 371 young adults aged 20–40 years from Thiruvananthapuram district, Kerala were selected using a purposive sampling procedure and were asked to complete a self-administered questionnaire that included opinions regarding spirituality, religiosity, and the influencing factors related to behaviour change. The participants were male and female, indicating that 58.8 per cent of them identified as religious and spiritual and had never contemplated ending their lives. In contrast, only 25 per cent of respondents reported being satisfied with their lives, and this satisfaction increased by 9.4 per cent among those who were not religious or spiritual. 60.4 per cent of the participants found forgiveness to be challenging. When it came to watching pornographic content, 42.5 per cent reported watching porn videos more than once, and 14.8 per cent (55) had no reservations about engaging in premarital sex. The educational background of the respondents included 41.7 per cent undergraduates, 40.9 per cent postgraduates, and 59.3 per cent working individuals. The results of this study indicate that young adults exhibit a declining interest in religious affiliation and are less likely to perceive spirituality as an integral aspect of their lives.

Keywords:*Spiritual, Religious, Anger Management, Premarital Sex, Forgiveness, Pornography*

Introduction

Thiruvananthapuram, the capital of the state and its southernmost district, is a prime location because of its abundant natural resources. It is a hub for many government and non-governmental institutions and is home to one of the largest IT hubs in Asia (Reghunathan & R. Anilkumar, 2014). However, according to the State Human Rights Commission (SHRC), Thiruvananthapuram has the highest number of suicides,

particularly among teenagers, which is a cause for concern rates ("140 Suicides by Teenagers in 6 Months: SHRC Seeks Report from Kerala Government on Prevention Measures," 2020). Furthermore, Thiruvananthapuram is also a region with a variety of religions and many spiritual centres that promote religiosity and spirituality from childhood. The capital city boasts of several renowned religious centers, including the Swami Padmanabhaswamy Temple, Beemapally Mosque, and Madre De Deus Church, which are a testimony to the peaceful coexistence and mutual respect among the locals.During the 64th birthday festivities of spiritual leader Mata Amritanandamayi, the President of India, Ram Nath Kovind, acknowledged Kerala's role as a prominent spiritual center in the country and its inclusive society. According to Kovind, Kerala has been a beacon of spiritualism for thousands of years and has played a significant role in unifying the country through its shared spiritual values. Kerala has been instrumental in advocating crucial social reforms. However, recently, it has been observed that young adults are losing interest in religious centres to see them as power centres to build life, resulting in a decrease in membership. Many young people believe that religious teachings fail to keep their promises and to connect preaching with practice. The present study also agrees with the trends of youth. Young adults often have a tendency towards liberal thinking and a desire to deviate from conventional constraints. This study aimed to highlight the impact of religiosity and spirituality on behaviourchange in young adults. During early adulthood, a person undergoes many changes in their personality. This period is marked by both biological and physiological development as well as emotional and intellectual maturity. It is also time to adjust to the new patterns of life and societal expectations. According to Erik Erikson's stages of psychosocial development, young adulthood spans 20–40 years of age (Staff Writer, 2022). This study focused on individuals aged 20-40 studying or working in Thiruvananthapuram.

Review of Literature

The term "spirituality" has its origins in the Latin word "spiritus," which means "breath of life"(Hsiao et al., 2010., Fatima, 2019). In the 19th century, the term was not commonly used, and "spiritualism" referred to communication with spirits and psychic phenomena (Nelson, 2009,). However, in the 21st century, spirituality has become a significant topic in various fields including psychology, sociology, social work, nursing, education, and trauma care(Brown, 2008).While there is no universal definition of spirituality, none can fully capture its essence (Zeenat & Husain, 2019). According to Baldacchina, as cited by Fatima (2019, p. 10), spirituality is a unifying force that encompasses biological, physiological, and social aspects.

According to Nelson, (2009), who cited Shannon (2000, p.47) and Vergot (2003), spirituality involves the pursuit of higher values, inner freedom, and meaningful experiences. A recent study conducted by(George et al., 2022)among nursing students at a college attached to a medical hospital in Ernakulum District, Kerala, showed that spirituality is an integral component of holistic care. The study further revealed that nurses were receptive to providing spiritual care as part of their nursing responsibilities. However, the study also found that nursing education has not paid adequate attention to incorporating spirituality into the nursing curriculum.

In Meenakshi's (2020) view, science without spirituality is not only incomplete but also vulnerable. Science is more likely to be misused and exploited by vested interests. It works for only those who pay for it. There is a growing body of evidence that people positively benefit from being spiritual and following spiritual practices. To ignore the spiritual aspects of a person's life is a serious error (Zastrow, 1999). According to Glenn's definition in 1962, religion is a part of human culture that is shared by a group. Religious beliefs and practices are taught to individuals

from birth and involve revering or fearing supernatural entities. Religion is a human creation, and its practices are learned intentionally and unintentionally. This included learning how to participate in religious activities, communicating with divine beings, and performing prescribed rituals and ceremonies (Glenn, 1962). According to Ajala (2013) and F. Karakas (2010), spirituality is different from organized religion as it is a personal, all-encompassing, non-sectarian, and universal human emotion, rather than following the doctrines, customs, or regulations of a particular religious institution or tradition.

Hsiao et al. (2010) shed light on a study conducted by Hammermeister and Peterson (2001), which found that university students with higher spiritual health had better self-esteem, lower hopelessness, less loneliness, and were less likely to use marijuana and alcohol compared to those in the lower spiritual health group.As per research (Seaward, 2008), human spirituality is often likened to emotions such as love, self-esteem, and faith, among other traits that are seemingly connected to it. It encompasses meaningful connections with others, well-defined personal value systems, and a sense of purpose in life. Unlike religions that have established frameworks, human spirituality is not governed by any set of rules, dogma, or agenda.

Shibasingh, (2023)highlights that pornography can significantly hinder spiritual development by focusing on immediate sexual gratification rather than addressing emotions and life experiences in a healthy manner. While it may provide a temporary escape from life challenges, fixation on sexual arousal impedes individuals' ability to undergo transformative growth. Critics point out that pornography perpetuates negative stereotypes, contributes to relationship problems, and can lead to addiction or desensitization. Moreover, forgiveness, a key aspect of many spiritual practices, becomes challenging when consuming explicit content that contradicts spiritual beliefs, leading to

overwhelming guilt and shame. This can obstruct the journey towards inner peace, self-acceptance, and forgiveness, hindering spiritual growth and fulfillment. Hayward, (2019)examined the relationship between religiosity and premarital sexual behaviour among adolescents. The study found that religious youths were more likely to believe that sex should be reserved for marriage, to become sexually active at later ages, to pledge abstinence until marriage, and to have fewer sexual partners.According to Parker and Fernandes (2023), there is a correlation between higher levels of religiosity and lower levels of sexual behaviour. They also referenced the research of Agustus et al. (2017), who found that insufficient knowledge about sex and lack of communication can contribute to sexual dysfunction (Parker & Fernandes, 2023).

According to Denton, (2015), religion has long been a significant factor in shaping personal beliefs and influencing how people live their lives. Research has demonstrated a correlation between religious beliefs and likelihood of engaging in premarital sex. Studies have found that more religious individuals are less likely to have had sexual partners outside of marriage, while less religious individuals are more likely to have had multiple sexual partners and engage in sexual activities with people they have known for a shorter period of time (Lefkowitz, Gillen, Shearer, & Boone, 2004; Barkan, 2006). It is essential to recognize that statistical data on religion and premarital sex can be challenged and debated. While studies indicate that religious people are less likely to engage in premarital sex, it is important to note that highly religious attitudes do not guarantee sexual abstinence before marriage. Nevertheless, the probability of engaging in premarital sex is lower for more religious individuals than for less religious ones. And, pornography, defined as sexually explicit images or videos created by professionals or users who intend to arouse viewers, has experienced increased consumption during the COVID-19 pandemic, particularly due to lockdowns and social distancing measures (Jhe et al., 2023).

Objectives

1. To understand the considerations related to spirituality and religiosity among young adults.

2. To understand young adults' opinions on anger management, premarital sex, pornography, and forgiveness.

Methodology

Variables

The variables of the study were Premarital sex, Pornography, Anger management, Forgiveness, Spirituality, Religiosity Personal beliefs.

Premarital sex

Premarital sexual activity refers to sexual relations between individuals who are not married. In the context of India, this behaviour emphasizes the significance of abstaining from sex before marriage and the value placed on chastity. Various factors, including increased levels of education, economic independence, exposure to media, modernization, urbanization, exposure to Western cultural influences, and shifting social norms, have been linked to a shift in attitudes towards more liberal views on sexuality.

Pornography

Pornography typically refers to the act of engaging with or viewing sexually explicit materials, including videos, images, literature, or other media, with the intention of achieving sexual arousal or gratification. These materials are created and consumed specifically for sexual arousal or gratification. It is important to recognize that the definition of pornography is subjective and can differ based on cultural, legal, and personal variables.

Anger management

Anger management refers to the process of acknowledging, comprehending, and productively managing one's feelings of anger in a positive and beneficial manner. The objective of anger management is to reduce the frequency, intensity, and duration of angry outbursts, enhance interpersonal connections, and promote overall emotional health and happiness.

Forgiveness

Forgiveness is a personal choice that can lead to emotional liberation, inner peace, and the ability to move forward with life. It involves letting go of the negative emotions associated with the offense, fostering understanding/empathy towards the offender, and moving towards a state of acceptance, peace, and emotional healing.

Spirituality

Spirituality is a deeply personal and subjective experience that can differ significantly from one individual to another as it is shaped by an array of beliefs, personal experiences, and cultural backgrounds. It is often viewed as an inward journey that entails self-awareness, introspection, and exploration of one's position within the cosmos. During this journey, individuals frequently seek meaningful connections with various external aspects of existence such as the universe, other people, and themselves.

Religiosity

Religion is the creation of human beings, and its customs are learned either consciously or unconsciously. In most cases, religious belief systems include a deity and their rites, ceremonies, and rituals revolve around this central figure. The pursuit of spiritual fulfillment is often a consequence of religious practices that encompass the dogmas, rites, and customs of a particular

religion or religious organization. The sense of belonging to a community of believers is frequently associated with religiosity.

Personal Beliefs

Personal beliefs encompass the convictions and values of the participants, including spirituality and religiosity, which individuals hold true and significant. These beliefs frequently influence an individual's perspective of anger management, premarital sex, pornography, and forgiveness.

Procedure

The 5-point Likert psychometric scale was used to obtain the respondents' opinions and views related to the topic. The questionnaire was prepared on a Google sheet and distributed randomly in college classrooms, seminar halls, college libraries, and fellowship groups. The ten questions required participants to select the most options, including 'strongly agree', 'agree', 'neutral', 'disagree', and 'strongly disagree'. The questions were set into two parts. The first part contained questions such as, I am spiritual and I am religious, I am religious and not spiritual. I am not religious but spiritual, I am not religious and I am not spiritual. The second part includes six questions: I am happy with my life, I can manage my anger, I watch pornography, I agree with sex before marriage, I forgive others in their wrongdoing, and I thought of ending my life. All the questions were answered voluntarily by 371 respondents. The Statistical Package for Social Sciences was used for the analysis in this study.

Purposive sampling was employed to align with the research objectives and to derive meaningful insights from a specific group of participants aged 20–40, consisting of young adults with diverse backgrounds who were either studying or employed in the Thiruvananthapuram district. Furthermore, the unavailability of a publicly accessible sampling frame for the Thiruvananthapuram

District necessitated this approach. This method aimed to capture a wide spectrum of perspectives and views among participants. Purposive sampling was used to gather rich and detailed information while working within resource constraints (Patton, 2002), and to identify individuals who possess knowledge and experience relevant to the phenomenon of interest(Cresswel & Clark, 2011). This approach represents a nonprobability sampling method chosen for its specific benefits in this context.

Participants

The study included both men and women between the ages of 20 and 40 years who were either working or studying in Thiruvananthapuram district, Kerala. Erikson's psychosocial theory outlines eight stages of development, from infancy to late adulthood, each with its own crisis or task that must be resolved. In this study, the participants belonged to the young adulthood stage, aged between 20 and 40 years, and faced a conflict of intimacy versus isolation. According to Erik Erikson's psychosocial development theory, one of the essential parts of the intimacy versus isolation stage is learning to be open and to share with others. Participation in the study was voluntary, and the identities of the participants were kept anonymous. A total of 371 participants studying or working in Thiruvananthapuram both men and women fulfilled these criteria.

Data Analysis and Interpretation

Table 1:Levels of spirituality and religiosity among young adults

Opinion on religiosity and spirituality	Frequency	Percent
I am religious, I am spiritual	218	58.8
I am religious, I am not spiritual	49	13.2
I am spiritual, I am not religious	69	18.6
I am not religious, I am not spiritual	35	9.4
Total	371	100.0

Based on the data presented, 58.5 per cent of the 371 respondents considered themselves to be religious and spiritual. Thirteen percent were identified as religious, but not spiritual; 18.6per cent as spiritual, but not religious; and 9.4 percent as either.

Most respondents identified themselves as religious and spiritual, while approximately half of the population fell into other categories. This suggests that some individuals do not consider religiosity to be relevant, whereas others do not prioritize spirituality in their lives or choose not to participate in religious or spiritual practices.

Table 2: Education and its relationship between religiosity and spirituality

Relationship between religiosity and spirituality	I am religious, I am spiritual	I am religious, I am not spiritual	I am spiritual I am not religious	I am not religious, I am not spiritual	Total
Under graduation	122	31	40	18	211
Post-graduation	60	11	22	12	105
Doctoral degree	14	4	3	2	23
Working	22	3	4	3	32
Total	218	49	69	35	371

This study focused on 371 participants who identified as male and female. Of the total population, 211 were undergraduates. Of these, 122 participants (57.8 per cent) were identified as both religious and spiritual, 31 (14.6per cent) as religious but not spiritual, and 40 (18.9per cent) as spiritual but not religious. Additionally, 18 (8.5 per cent) undergraduate students stated that they were neither religious nor spiritual. Of the total population, 105 were post-graduates. Of these, 60 (57 per cent) were identified as both religious and spiritual, 11 (10.4per cent) as religious but not spiritual, and 22 (20.9per cent) as spiritual but not religious. Furthermore, 12 postgraduates (11.4 per cent) stated that they were neither religious nor spiritual.

Of the total population of 371 participants, 23 belonged to the category of doctoraldegree. Among them, 14 (60.8per cent) stated that they were both religious and spiritual. Four participants (17.3per cent) claimed to be religious but not spiritual, and three (13per cent) indicated that they were spiritual but not religious. Only two participants (8.6per cent) responded that they were neither religious nor spiritual. Out of 371 participants in the

working-class category, 32 belonged to it. Among them, 22 (68.7per cent) stated that they were both religious and spiritual. Three participants (9.3per cent) claimed to be religious but not spiritual, and four (12.5per cent) indicated that they were spiritual but not religious. Three participants (9.3per cent) said that they were neither religious nor spiritual. According to this study, interestingly, while the thoughts of undergraduate, postgraduate, and doctoral degree participants on this subject seemed to fluctuate, the working class remained steady in their religiosity and spirituality.

Table 3: The level of happiness

Happy with my life	Frequency	Percent
Strongly agree	93	25.1
Agree	166	44.7
Neutral	94	25.3
Disagree	11	3.0
Strongly disagree	7	1.9
Total	371	100.0

According to the data, 44.7per cent of participants agreed that they were happy with their lives. 25per cent of them strongly agreed, while 25.3per cent remained neutral and neither agreed nor disagreed. Only 3per cent of the respondents disagreed that they were happy with their lives, and 1.9per cent strongly disagreed with this statement. The majority of the participants 69.8per cent (259), supported the statement that they were content with life, while others had varying opinions. The analysis shows that, despite having everything at their fingertips, today's generation is not satisfied with material possessions and desires a fulfilling life.According to Dr. Francoise Adan, being happy improves

overall health and encourages healthier habits such as better eating, increased activity, and improved sleep(*How Happiness Affects Health | American Heart Association*, 2020). The data investigates what we seek if not happiness, and what prevents contentment.

Table 4: The relationship between age and happiness levels

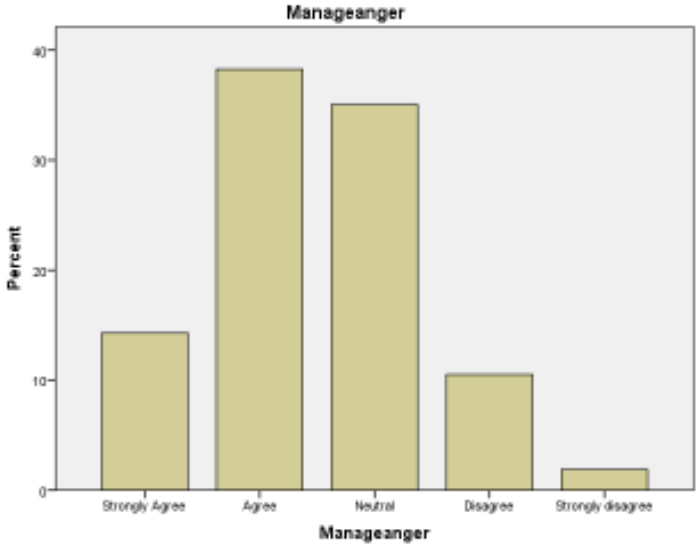
	Happy with life					Total
	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	
Age 20-25	32	52	50	6	5	145
26-30	53	105	40	5	2	205
31-35	8	9	4	0	0	21
Total	93	166	94	11	7	371

After analysing the data provided, it was found that among the 145 participants aged between 20 and 25, 32 strongly agreed that they were happy with their lives, while 52 agreed with the statement. On the other hand, 50 individuals remained neutral, six disagreed, and five strongly disagreed with the notion of being content with their lives.

When examining the provided data, it was discovered that out of 205 participants between the ages of 26 and 30, 53 strongly agreed that they were satisfied with their lives, while 105 simply agreed. Conversely, 40 participants remained neutral, five disagreed, and two strongly disagreed with the idea of contentment in life. Of the 21 participants between the ages of 31 and 35, eight strongly agreed that they were happy with their lives, while nine agreed with the statement. In contrast, four participants remained neutral, and none disagreed or strongly disagreed with the notion of life satisfaction. Interestingly, the data indicate that

individuals between the ages of 31 and 35 experience more happiness in life than those in the 20–30 age categories.

Figure 1: The levels of anger management



This bar chart shows the anger management levels of the 371 participants. Only 53 participants strongly agreed that they could manage their anger. A total of 142 respondents agreed that they could manage their anger, while 130 had a neutral opinion. 39 respondents disagree that they can manage their anger and seven strongly disagree with their ability to manage their anger.

Managing emotions is a sign of good mental health and has the ability to maintain relationships.

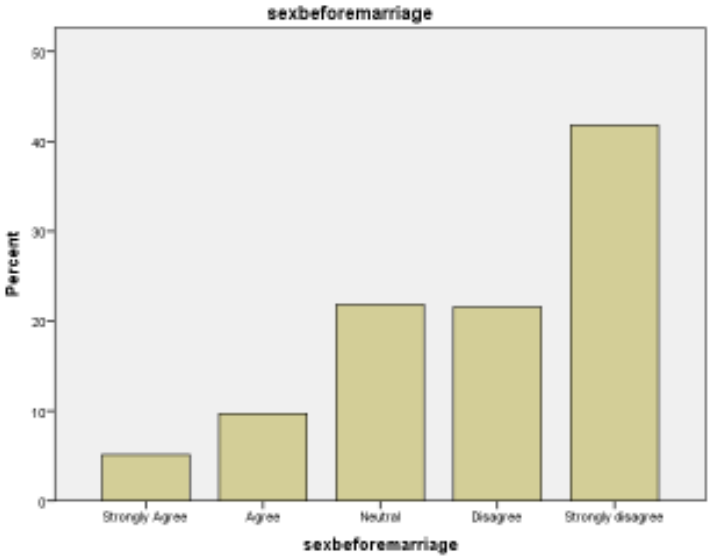
Table 5: Interest in watching pornography

Watching pornography	Never	rarely	sometimes	Always	Often	Total
Under graduation	123	47	35	3	3	211
Post-graduation	61	24	16	2	1	105
Doctoral degree	15	6	1	1	0	23
Working	13	9	9	0	1	32
Total	212	86	61	6	5	371

The above data reveals the respondents' interest in watching pornography. Out of 371 respondents 212 (57.1 per cent) of them never watched pornography, while 86 (23.2 per cent) of young adults rarely watch porn videos, 61 (16.4 per cent) of them sometimes watch the porn videos, 6 (1.6 per cent) participants of the study watch porn videos always and 5 (1.3 per cent) often watch pornography. Based on the present study, 158 respondents (42.5 per cent), including undergraduate and postgraduate students, often and always watched pornography.

The topic of pornography is generally considered taboo in Indian culture and often goes unacknowledged. However, statistics from popular pornographic websites reveal that India is the third largest consumer of pornography, with 70per cent of viewers being men. Excessive viewing of pornography can create negative thoughts and emotions about one's physical appearance, sexual abilities, and desires, which can be particularly harmful for adolescents and young adults (Kallahalla & Asokan, 2023).

Figure 2: People's views on the subject of premarital sex



According to the current analysis, 19 individuals (5.1 per cent) strongly believed in having sex before marriage, whereas 36 (9.7 per cent) agreed with the statement advocating for premarital sex. The majority of the population, which included 235 individuals (63.3 per cent), either disagreed or strongly disagreed with the idea of premarital sex. In addition, 81 (21.8 per cent) respondents remained neutral and did not express a clear opinion.

Table 6: Opinions on premarital sex, categorized by education and occupation

Premarital sex	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	Total
Education Under	13	21	41	46	90	211
Graduation	3	13	28	23	38	105
Post-graduation	1	1	5	2	14	23
Doctoral degree	2	1	7	9	13	32
Working						
Total	19	36	81	80	155	371

The data presented above reflect the opinions of the participants on the topic of sex before marriage. Of the 211 undergraduate participants, 90 (42.6 per cent) strongly disagreed with having sex before marriage, while 46 (21.8 per cent) disagreed. 41 (19.4 per cent) participants remained neutral, 13 (6 per cent) agreed with the idea, and 21 (9.9 per cent) strongly agreed with having sex before marriage. Of the 105 postgraduate participants, 38 (36 per cent) strongly disagreed with having sex before marriage, whereas 23 (21.9 per cent) disagreed. Five (21.7 per cent) remained neutral, 13 (6 per cent) agreed, and only three (2.8 per cent) strongly agreed. In the case of 23 doctoral degree students, 14 (60.8 per cent) strongly disagreed with having sex before marriage, while 2 (8.6 per cent) disagreed. 28 (26.6 per cent) remained neutral, one (4.3 per cent) agreed, and one (4.3 per cent) strongly agreed. Finally, 13 (40.6 per cent) of the 32 working respondents strongly disagreed with having sex before

marriage and 9 (28 per cent) disagreed. Seven (21.8 per cent) remained neutral, one (3 per cent) agreed, and two (6.2 per cent) strongly agreed. The majority 63 per cent (235) of the participants did not support having sex before marriage. Whereas 14.8 per cent (55) of the respondents agreed with the statement, meaning they did not see any issues with having sex before marriage, 21.8 per cent (81) remained neutral.

Sociocultural factors have a significant impact on the increase in premarital sex. Women are more susceptible to sexually transmitted diseases, such as HIV/AIDS, due to engaging in premarital sex than men. Those who engage in sexual activity before marriage or at a young age face serious health risks such as unplanned pregnancy, which can result in unsafe abortion (U. Das & Rout, 2023).

Table 6: Opinions on premarital sex, categorized by religiosity and spirituality

Premarital sex	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	Total
I am religious, I am spiritual	3	12	34	55	114	218
I am religious, I am not spiritual	4	6	15	9	15	49
I am spiritual I am not religious	6	9	24	12	18	69
I am not religious, I am not spiritual	6	9	8	4	8	35
Total	19	36	81	80	155	371

According to the data analysis, of those who identified as both religious and spiritual, only 1.3 per cent (n = 3) strongly agreed with the acceptance of premarital sex. 5.5 per cent (n=12) agreed to have sex before marriage, while 15.5 per cent (n=34) held neutral opinions. A majority of 25 per cent (n=55) disagreed with premarital sex, and 52 per cent (n=114) strongly disagreed with having sex before marriage.

Table 7: Individuals' opinions on the act of forgiving others for their misdeeds

Forgive others for their wrong doings		Frequency	Percent
Valid	Never	18	4.9
	Occasionally	59	18.6
	Some times	137	36.9
	Often	107	28.8
	Always	40	10.8
	Total	371	100.0

According to the presented data, the opinions of 371 participants regarding forgiving others for their wrongdoings were gathered. Of these, only 40 (10.8per cent) agreed that they always forgave others. 107 (28.8per cent) participants stated that they often forgive others' limitations, while 137 (36.9per cent) said that they sometimes forgive others' flaws but not always. 69 (18.6per cent) of the respondents claimed that they forgave occasionally, and 18 (4.9per cent) of the respondents reported that they never forgave others' flaws.Long et al., (2020) found through their research that forgiveness is linked to better psychosocial and mental health outcomes.

Table 8: Individuals who have considered ending their own lives

Having thought about ending life	never	occasionally	some times	often	Always	Total
I am religious, I am spiritual	128	30	52	3	5	218
I am religious, I am not spiritual	23	7	15	4	0	49
I am spiritual I am not religious	39	11	16	2	1	69
I am not religious, I am not spiritual	18	4	8	2	3	35
Total	2018	52	91	11	9	371

According to the current study, 218 out of 371 respondents were identified as both religious and spiritual. Of these 218, 128 (58.7 per cent) reported never having suicidal thoughts. Among those identified as religious but not spiritual, 23 (46.9 per cent) reported never having suicidal thoughts. Of the 69 (56.5 per cent) respondents identified as spiritual but not religious, the majority reported never having suicidal thoughts. Finally, 18 (51.4 per cent) respondents who were not religious or spiritual reported that they had never had suicidal thoughts.The current statistics indicate that approximately one-third of respondents (29.9 per cent) contemplated ending their own lives on multiple occasions.

Discussions

The study's objectives are reflected in the findings. Initially, the aim was to investigate the religious and spiritual beliefs of young adults. The data analysis revealed that 58.5% of respondents identified themselves as both religious and spiritual, while 9.4% did not follow any religious or spiritual practices. Moreover, a substantial portion of the younger generation, constituting 28%, do not place significant importance on religion, while 77% value spirituality without adhering to any particular religious doctrine or affiliation. Conversely, the World Value Survey Report (2010-2014) indicated that 67.1% of individuals in India considered religion to be extremely important, 24.2% considered it to be somewhat important, and only 1.8% believed it to be non-essential. Additionally, a mere 2.8% of Indians reported not believing in God, while 96.4% professed their belief ("WVS Database," 2010-2014). This suggests a significant change in the perspectives of young Indians towards religiosity and spirituality over the past decade, away from the traditional values and practices passed down through generations.

The findings of this study reveal a concerning trend among individuals aged 20-30, as only 24% of respondents within this age group strongly agreed that they were content with their lives. Furthermore, it is alarming to note that 30% of respondents did not report feeling happy. These statistics are consistent with the World Health Organization's (2018-2019) labelling of India as one of the most depressed countries in the world. Additionally, the National Mental Health Survey of India (2015-2016) reported that a significant percentage (83 %) of individuals struggling with mental health issues did not receive necessary treatment. The current study supports previous academic research on this topic (T. Das, 2021).

The present research revealed that only 14 percent of individuals strongly concur that they possess effective anger management skills, while 35 percent remain neutral on the issue. It is widely recognized that an inability to manage one's emotions can have detrimental effects on both mental and relational health. Uncontrolled anger, similar to a slow-acting poison, triggers the release of adrenaline and cortisol hormones, which can lead to unfavourable outcomes.

Additionally, 39.6 per cent claimed that they could always forgive others' flaws, while 60.4 per cent found it difficult to do so. Recently forgiveness, as noted by Acharya (2024), is a key aspect of spirituality that can purge one's heart, mind, and soul from negativity, including grudges, hurt, hatred, jealousy, and sorrow. By contrast, failing to forgive can result in becoming trapped and overwhelmed by feelings such as ego, hatred, pride, and hurt (Acharya, 2024).

Among the participants aged 20-40, a significant portion, 57.1% (n=212) had never viewed pornographic material, whereas 42.5% had watched such content multiple times. Research indicates that exposure to pornography can lead to the development of unrealistic beliefs and attitudes toward sex. Adolescents in particular may anticipate real-life sexual encounters to mirror what they witness in pornography (Jhe et al., 2023). Regarding premarital sex, 14.8 per cent of the respondents supported it. Interestingly, 58.7 per cent of those who identified as "religious and spiritual" never considered ending their lives, indicating a potential link between religiosity, spirituality, and mental well-being. These study findings are in line with existing research including studies by George et al., 2022.,Parker & Fernandes, 2023. However, it is essential to note that the larger and more diverse samples are needed to strengthen the validity of these findings.

Conclusion

This paper concluded an analysis encompassing religiosity and spirituality, happiness, anger management, views on premarital sex, forgiveness, and pornography consumption within the context of a personal journey. The initial examination focused on happiness levels and their association with education and employment. Of the 371 respondents, a significant majority of 212 identified as both religious and spiritual, whereas 35 did not. Kerala, with its diverse religious and communal backgrounds, is notable; however the 2011 census indicates that 99.72 per cent of the population is affiliated with a religion, with only 0.28 per cent having no religionaffiliation (Census, 2011). This study highlights the diverse perspectives of young adults in Kerala regarding religion and spirituality.Interestingly, despite the world's high level ofadvancement and digitalization, with material abundance readilyaccessible, the current study unveiled that not all respondents reported experiencing happiness in life. Many individuals grappled with emotional challenges, including struggles in forgiving other's limitations, difficulties in anger management, engagement with pornography, and even contemplation of suicide.

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Rights at Wrong End: Labour Rights Under Kafala in the Gulf Cooperation Council Countries

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Abstract

In the Gulf Cooperation Council (GCC) countries, the employment relationship between foreign workers and their employers operates under the Kafala system. GCC countries contains a higher foreign population than the nationals. Due to this scenario, the migrant labour laws or employment laws are very stringent there. In this arrangement, the state grants sponsorship permits to local people or businesses so they can hire foreign workers. The legislative processes of each of these countries ensure the welfare of their citizens while keeping a separate legal framework for the migrant workers, excluding them from mainstream society. This is not limited to the employment sectors only. The social welfare and standard of living of foreign labourers are neglected here. Such discriminatory practices are visible in various occupational groups across GCC. This system has been a subject of controversy and criticism for long.

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The GCC region contains the highest number of Malayalee migrant workers in various occupational groups under the kafala system. The majority of them are unskilled labourers, mostly working in construction and allied sectors. Under these circumstances, they have been exploited by others under the kafala system.The current study examines the variation in this system among GCC countries based on the experiences of the GCC migrants from Kerala who have worked in a variety of occupational groups for a long time. The emigrants from Kerala to GCC countries constituted the population of this study. Based on trends in global migration, two districts Malappuram and Thiruvananthapuram were chosen. According to the study, there are differences in the rigidity and character of the Kafala system among various occupational categories. In addition, it was discovered that the experience of different generations of migrants based on their year of migration found that the rigidity of the system has been slightly reduced. But the core of this system is still remaining intact.

Keywords: *Kafala system, Labour Rights, Emigrant, GCC, Labour Laws, Migration*

Introduction

The phenomenon of migration has been indispensable in human history, cultures, and civilizations. It is a multifaceted issue affecting many elements of our everyday lives in a world where connections are becoming increasingly important, including social, economic, and security. It features a range of actions and scenarios with individuals from various backgrounds and spheres of life. Due to globalization, migration affects all countries and individuals today (IOM, 2018). The India-Gulf region is the world's second-big international migration corridor, opened in the 1970s. Of the 31 million non-resident Indians (NRIs), an estimated 8.5 million work in the Gulf (MEA, 2018). In the Gulf States, where the percentage of non-natives the working

population is highest in the world, Indians make up more than 30 percent of the foreign labour force in GCC (ILO, 2019). The History of Kerala's migration to Gulf countries started in the 1970s after the oil boom. This represents the most complex chapters in Kerala's migration history (Panicker, 2018). Migration has become a way of life for Keralites, and its density is now intertwined with the fortunes of the Gulf Boom (George, 2013). The six Gulf nations of the United Arab Emirates, Saudi Arabia, Qatar, Bahrain, Oman, and Kuwait are home to most Malayalee immigrants. Malappuram (4.06 lakh) has the most number of GCC migrants among the districts of Kerala, followed by Kannur (2.49 lakh), Thrissur (2.41 lakh), and Kollam (2.40 lakh) (Economic Review, 2019).With 5,73,289 Malayalee immigrants, the United Arab Emirates leads the GCC, followed by Saudi Arabia (4,50,299) and Qatar (1,25,503) (Department of Economics and Statistics & NORKA, 2013). In this scenario, it is very important to look into the labour laws of these countries. Given that migrant worker safety is a shared responsibility of sending and receiving nations, it is a crucial migration component. Therefore, the migration process faces complex legal constraints in countries of origin and destination. The regulations in the origin country can be more easily administered as the aspiring migrants are aware of them. They can use the support of family members, friends, and other resources to overcome issues. But in the destinations, the situation is different and the immigrants are often ignorant of the legal frameworks of the land. It takes time to learn about the legal system and their rights. Lack of awareness may lead to crimes, or the fear of them may result in their marginalization.

The countries of the GCC have established a legislative framework that routinely denies rights to migrant labourers while providing substantial and profitable benefits for citizens. The Gulf countries look sophisticated, modern, and cosmopolitan from the outside (Hamza, 2015). But, the prevailing legal regime, has worsened the lives of the migrant communities in their

destinations. However, the system has grown more divisive in recent years, and it is becoming increasingly obvious that it is replete with abuse. Low pay, unfavourable working conditions, and mistreatment of employees are frequently the outcomes of migrant workers' rights not being protected. Both gender-based violence and racial prejudice are pervasive. The shortcomings of the Kafala system have been made public by international anti-racism demonstrations, the coronavirus epidemic, and preparations for Qatar's 2022 FIFA World Cup, although it is still unclear how reform initiatives will go (Robinson, 2021).

Review of Literature

The word Kafala traces back to Islamic jurisprudence on legal guardianship and other matters (Robinson, 2021). This system has been in place in the Gulf Cooperation Council (GCC) nations of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates since it was developed in the 1950s to control the connection between employers and migrant workers. These countries sought foreign workers for their large infrastructural projects at that time. The inadequacy of the native working population and indifference to do manual jobs were the reasons behind this immigration. The additional temporary workers came during periods of brisk growth of the economy and left when it weakened.

The economic goal of the Kafala system was to supply transient, revolving labour that could be quickly imported into the country during economic booms and exported during less prosperous periods. This system legally binds the worker to an employer for their contract period. The sponsor decides their transportation, transfer of employment, and leaving the country. If the migrant workers quit their jobs, the sponsor must notify the immigration authorities and make arrangements for the worker's departure from the country at the expiration of their contract,

including the cost of their return airfare. (Migrant Forum, 2012). This is a form of modern slavery which is legitimized.

In Kafala, the workers are temporary contract labour/guest workers or expatriate manpower (ILO, 2017). Therefore, even if the worker is present for a long time, she or he does not acquire the rights of citizenship or any other benefits. The restrictive nature of immigration policies under the Kafala system has limited the stay of overseas workers to the duration of their contract. The foreigners working under Kafala in the host countries come from all nationalities, economic classes, and professions. Most of these workers come from Africa and South Asia. They often take up occupations that nationals find undesirable for financial or cultural reasons, such as construction, domestic work, or service industries, which can involve long hours, low pay, and poor working conditions (Robinson, 2021). They also earn much less than locals. Despite the potential for exploitation, most of the workers accept the jobs under Kafala because they get comparatively higher pay than in their home country.

Methodology

The study used both qualitative and quantitative methods. It also used primary and secondary sources of data. Primary data were collected using structured interview schedule and in-depth interviews. Besides, case studies were also conducted to have a deeper understanding of the issues under discussion. A total of 600 samples were collected from Malappuram and Thiruvananthapuram Districts. The emigrants from Kerala to GCC countries constituted the population of this study.

Kafala across GCC

Various forms of Kafala Systems exist across GCC (Diop, 2018). There are differences in the rules regarding how migrants can leave the country during their contract period. One of the main differences between the different Kafala systems is the

requirement for an exit visa for migrants to leave their employers and the country (Montague, 2013).The countries with the Kafala system have established rules against collecting any fee from companies from immigrant workers in exchange for a work permit. However, sponsors often need to pay more attention to these laws and collect fees from immigrant workers. The workers who cannot pay the fee may lend money, which will ultimately put them into debt that takes years to repay, during which they are at the mercy of the debtor. Unfortunately, intermediaries like recruitment agencies often charge such fees to foreign workers in the Kafala systems. Indemnities for delays in registration are also often billed to workers. Similarly, some Kafeels partially withhold final payments to foreign workers to recover some of the recruitment costs. Also, many Kafeels exploit the workers by leasing their Kafala against payments (Khan, 2014). Although Kafeels behaving this way remains a minority, their victims are much more.

As per rules, migrant workers must sign contracts with their sponsors before they begin their travels and work in the host country. However, this is only sometimes the reality; many are not given contracts in their home country. In other cases, there are contracts, but they are either not signed by the migrants themselves, or they do not know the terms of the contract (Robinson, 2021). In some cases, although work agreements are stated and signed before departure, they rarely provide human rights protection and are often changed or ignored upon their arrival in their host country. Recruitment agents in home countries often substitute contracts drawn up in the destination countries with different terms and conditions. Such malpractices involving contract substitution occur in destinations, too. The disputes within GCC countries on the contracts are admissible only if they are in Arabic. This makes the workers unable to sign the contract, as most migrant workers do not speak or read Arabic (United Nations, 2021), or the sponsor has to change the language and terms of the

Arabic contract. Despite attempts to streamline contracts through a standard form, it has not come into force.

Migrant workers in the Kafala System are subjected to several human rights violations. They are often tied to their contracts, with restricted freedom of movement, and have unfavourable work and living conditions (Migrant Forum, 2012). Thus, employers make immigrant workers work long hours without days off (Boundless, 2022). In some cases, workers are "loaned out" to others, who make them do more work that is largely unpaid. As mentioned, they often need to be more informed about salary figures, and many do not get paid on time. Immigrant workers are often cut off from their families back home, as their employers often restrict them to calling back home, making their physical separation even graver.

In most of the Kafala systems, a migrant worker needs an exit visa to leave the country except in Qatar and Saudi Arabia (Human Rights Watch, 2020); (Government of India, 2022). In these countries, if an employer does not grant the visa, the immigrant cannot leave; besides, although against the law, the sponsors also constrain travel by holding their passports. This puts the migrants at the complete mercy of their sponsor, as they cannot legally leave if their sponsor does not give back their documents. Governments forbid the retention of passports and acknowledge ex-pat workers' right to register complaints and recover their passports. However, workers know such a move that if they were, their employers would turn hostile, resulting in punishments, reductions in wages, non-renewal of contracts, false accusations, etc. and ultimately deportation. In extreme cases, Kafeel exchanges passports for workers to declare that they have received their dues, especially end-of-service payments and wage arrears (Khan, 2014).

In all countries except Qatar and Saudi Arabia, the Kafala system offers different options for leaving a job and the country.

But regardless, most of these systems do not offer complete freedom of movement, which is a human rights violation. Adding to this, because it only allows workers to move to a better job or leave the country with approval, the system conflicts with labour mobility. So, workers have to obey their sponsors. Thus, under the system, migrant workers may be identified as 'guest workers' but are often treated as disposable economic commodities at the mercy of sponsors.

Under Article 3 of Kuwait's Private Sector Labour Law, an expatriate worker must obtain a work permit issued by the Ministry of Social Affairs and Labour under the Kafala of a Kuwaiti entity—i.e., individual or organization. The law also states that a release is required from the current entity for an employee's work permit to be transferred to the Kafala of another one (State of Kuwait, 2010). In Oman, a migrant cannot work for another employer without the current employer's permission.

In the prevailing conditions, migrant workers cannot run away from their current employer, as running away poses additional challenges. First, countries in the GCC view running away from a Kafala agreement as a criminal offense (Migrant Forum, 2012). This leads them to be arrested and jailed. Second, once a contract is breached pre-term, the sponsor may file a case of absconding with the police, which leads to deportation repayment of the recruitment fees and other costs the sponsor bears. Even if they can escape and contact their embassy, the lengthy process may leave them at risk for months. An exit visa is still required to leave the country.

Another interesting situation is that migrant workers fear that any challenge to the existing norms of the Kafala system might cause them to lose their opportunity to work abroad. They fear they could be easily replaced by those from other countries ready to work unconditionally. Thus, it is difficult for migrants to advocate for their rights due to the chance of losing their

opportunities. The Middle Eastern countries are now pushing to reform their current Kafala system. While activists advocate complete reform (or the abolishment of the Kafala), and some countries have been more willing to change Kafala rules in recent years, others maintain the system as such.

Table 1:Protection of Workers Under Kafala Across GCC

Country	Join unions	Change job or quit without permission	Leave country without permission	Minimum wage	workers included under labour law	Standard contract for all workers
Bahrain	Yes	After 1 Year	Yes	No	In some cases	No
Kuwait	Yes	After 1 Year	Yes	No	No	No
Oman	Yes	No	Yes	No	No	No
Qatar	In some cases	No	In most cases	No	No	No
Saudi Arabia	No	No	No	No	No	No
UAE	No	No	Yes	No	No	Yes

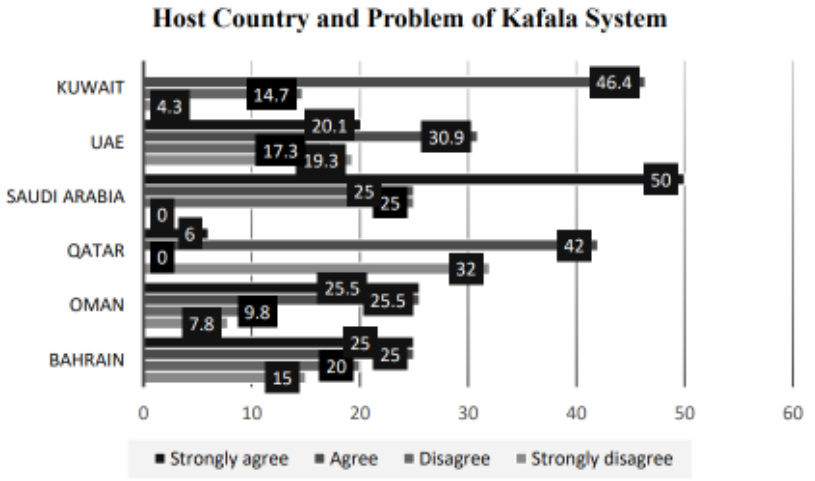
Source; Council on Foreign Relations, 2020.

Table 1 explains the protection of workers under the Kafala system across the GCC. When looking into the various aspects of the Kafala system, like organisational freedom, occupational mobility, wages, etc. it is found that there is no uniformity in this system across the GCC. It is found that Saudi Arabia has a comparatively more strict Kafala system than others. It does not even provide minimum wage security and occupational mobility.

Figure 1 shows the primary data in connection with the problem of the Kafala system across GCC. Among the total respondents, the majority feel the negative impacts of this system. But there is visible variation in this problem in different

destinations. Among the six GCC countries, Saudi Arabia ranks first in terms of the rigidity of this system. In Saudi Arabia, three-fourths of respondents (75 percent) are concerned about this issue. It is also found that more than half of the respondents from all GCC countries except Qatar are facing issues in connection with the Kafala system.

Figure 1 Host Country and Problem of Kafala System



Source: Primary Data

Kafala- The Problem

Because of the power disparity between sponsors and workers and the sponsors' legal impunity, the practice is known as modern slavery worldwide. It is a fact that a considerable share of the global workforce still works under this system. In 2019, there were 35 million international migrant workers in the GCC countries (UNDESA, 2019). This system also violates global employment laws and conventions. Regarding ratifying international accords that safeguard workers, the GCC must catch up to other areas. For instance, the ILO's Domestic Workers

Convention, which binds signatories to a minimum wage, the abolition of forced labour, and the provision of decent working conditions, among other rights, has yet to be approved by any host nation (Robinson, 2021).

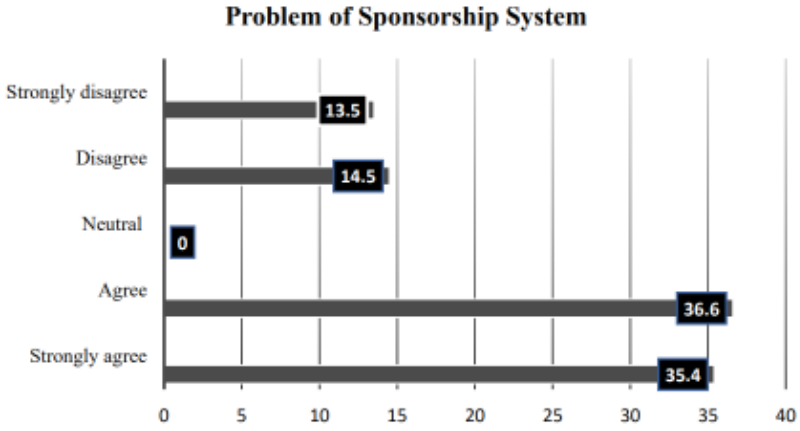
Because of this, migrant workers are subject to a variety of abuses under the system, including limitations on their freedom of movement and communication, debt bondage, forced labour, irregular residency status, and more. Migrant status, race, and ethnicity are also factors that contribute to worker abuse. For instance, in Qatar, foreign employees of all income levels stated that their pay was determined by their home countries, and some migrant workers, even with professional degrees, claimed to be forced into low-paying positions that were typically associated with and held by members of their racial or ethnic group (United Nations, 2020).

On the other hand, the GCC has a high prevalence of discrimination based on gender. In this case, domestic workers, usually women, face the most abuse, including sexual exploitation and violence. However, victims frequently choose not to report due to fear of loss of a job or being charged with a crime as retaliation. Certain countries, such as Kuwait and Qatar, have imprisoned female workers for extramarital sex in the cases of them being raped. The gendered abuses of the Kafala system are especially worrisome given that in some countries, such as Lebanon, women compose the majority of Kafala workers (Robinson, 2021).

Most of the GCC countries changed their stringent and exploitation labour laws. Figure 2 shows the opinion of the respondents regarding the problem of the Kafala system in the GCC. While, more than half (72 percent) agreed that this was a problem,only 14.5 percent disagreed with this issue and 13.5 strongly disagreed. The majority of the Keralites living in the

GCC are undergoing the ill effects of Kafala system. The intensity of the Kafala system is determined by the job of the respondents.

Figure 2 Opinion of the Respondents – Kafala System as a Problem



Source: Primary Data

In connection with this, Mr. Jamal (pseudonym) a 52-year-old male from Vengara, Malappuram, working in Saudi Arabia stated,

"The so-called Kafala system is indirectly integrated with the legal system of each GCC country and its major problem is, it gives full powers to the employer for controlling the labour. It also prescribes some responsibilities to employer; providing adequate wage, good shelter, medical insurance coverage, etc. After 2011, the GCC countries have made some efforts to pull out this system due to the protests came from all over the globe. But they still practice this abusive system towards us."

This is very evident that the GCC governments have created their legal system that systematically denies rights to migrant workers while safeguarding the interests of the employers.

From table 2, it is visible that all the occupational groups are affected by the problem of Kafala. More than half of the respondents from each occupational group agreed with this. The workers in construction sector (89.0 percent) suffer the most.Thus, all employment categories of workers in the GCC are suffering from this system including the government sector.

Table 2: Occupation and Problem of Kafala System

Occupation	Problem of Kafala System				Total
	Strongly agree	Agree	Disagree	Strongly disagree	
Government Sector	0.0%	66.7%	16.7%	16.7%	100.0%
Private Sector	32.0 %	37.0%	15.5%	15.5%	100.0%
Self Employed	27.3 %	40.0%	24.2%	8.4%	100.0%
Service Sector	38.9%	37.9%	8.7%	14.6%	100.0%
Construction Sector	58.4%	30.6%	8.3%	2.8%	100.0%
Agricultural Sector	33.3%	33.3%	33.3%	0.0%	100.0%
Technical Jobs	37.5%	30.6%	8.3%	23.6%	100.0%
Domestic Works	16.7%	50.0%	16.7%	16.7%	100.0%
Professional Jobs	29.0%	34.2%	21.1%	15.8%	100.0%
Construction related sector	16.6%	50.0%	16.7%	16.7%	100.0%
Academic Sector	0.0%	66.7%	33.3%	0.0%	100.0%
Total	35.4 %	36.6%	14.5%	13.5%	100.0%

Source: Primary Data

The study also found that the migrants were forced to work under dangerous conditions in their workplaces across the GCC. The working conditions may vary according to the type of occupation, skills, education, and experience. This is so evident from the words of Mr. Abdul Salam (pseudonym) a 40-year-old emigrant from Edava (Trivandrum) who worked in Saudi Arabia.

"I worked in both industrial and non-industrial sectors in different countries in GCC, some sectors forced workers to work in the inhuman conditions who live in isolated areas that the outside world is not much aware of. I am also a victim of some abuses as a cleaning staff of oil tank at a refinery. Though it is off the record, most of the workers work more than 12 hours a day, 7 days a week without any holiday. Although the governments do not allow the emigrant workers to work in open spaces when temperature exceeds, this rule is very often violated as they are forced to work outside at higher temperature levels. The migrants are not able to secure protection against hazards, organize themselves to obtain fair wages, ask for compensation in case of injury or illness, or have any employment security."

Reform of Kafala

The realpolitik of labour migration to the Middle East suggests the need to be strategic and precise in the action needed to reform the Kafala system (Khan and Travel, 2011). But it is a challenging task for the GCC administration as it is rooted deeply. Though they cannot terminate the system as a whole, some changes are brought in. In Bahrain, the Minister of Labour announced that the Kafala would be dismantled in 2009 so that the government-run Labour Market Regulatory Authority (LMRA) would be responsible for sponsoring migrant workers rather than employers. However, the change is yet to materialize since the LMRA continues to regulate only the work process, post-recruitment, and thus, not replace the Kafala. With the passing of

"Decision No. (79) for 2009, regarding the mobility of foreign employee from one employer to another" from the Ministry of Labour, Bahrain has, nonetheless, eased one constraint of the Kafala, i.e., by allowing foreign employees to change employers without the consent of their current employer (Migrant Forum, 2012). This was hailed internationally as a significant step forward in reforming the Kafala, allowing mobility of labour and better protecting the rights of migrant workers against abuse and exploitation.

However, in 2011, the government further stipulated in Law 15/2011 that the migrant worker needs to wait one year before being legally allowed to change employers (ILO, 2011). Such a move shows the government's lack of political will to reform Kafala. Bahrain now also permits migrant workers, who give advance notice that their contract is ending, a period of one month to look for new employment (Labour Market Regulatory Authority, 2022). Thus, it helped break the strong correlation between employment and residence under the Kafala system. Bahrain is the first in the region to dismantle the Kafala with the advice from ILO.

In Kuwait, the Minister of Social Affairs and Labour announced in 2010 the government's decision to mark the 20thanniversary of Kuwait's liberation during the first Gulf War by abolishing the Kafala in February 2011(Migrant Forum, 2012). The Minister did not provide specificities on an alternative law nor the mechanisms for abolishing the current one. After that announcement, an Under Secretary from the same ministry explained that the government would not cancel the system but only amend it to make it easier for migrant workers to transfer sponsors. Kuwait continues to receive technical assistance from the ILO to improve its management of labour migration (Ibid, 2012).

Oman, introduced a law in 2003 that forbid employers from loaning their immigrant workers to work for other employers (Khan and Traval, 2011). Through this was described as a first step towards eliminating incidences of human trafficking and forced labour there was no further steps to change the Kafala to protect the migrant workers.

In 2010, Qatar attempted to ensure the financial security of migrant workers by requiring private companies to provide monthly salary details (Human Rights Watch, 2022). This would allow the authorities to ensure that workers are paid on time without unlawful deductions (Migrant Forum, 2012)and help identify workers who have not been paid. However, this has not yet been implemented. Strangely, Qatar later announced that it had no intention to abolish the system or to follow other Arab countries in this regard, arguing that each country has its own specificity and sovereignty. Qatar recruited millions of additional migrants to build the massive infrastructure for the World Cup in 2022 (Whiteside, 2022), and this has triggered widespread campaigning on the oppressive regime of kafala in Qatar (Migrant Forum, 2012). There were numerous stories of abuse of migrant workers and violation of their human rights.

Earlier, Saudi Arabia had no intention of changing the Kafala (Khan and Travel, 2011). However, later (in 2020), it took steps to eliminate the system so that foreign workers in Saudi Arabia can now switch jobs without their employers' permission (Aljazeera, 2021). Now, workers are exempted from exit authorisation so that they can travel indefinitely without their employers' permission (Ramzan, 2021).

Future of Kafala

On account of its gross violation of human rights, human rights and labour activists have called for abolishing all forms of Kafala, stating that the Kafala directly contradicts labour laws.

While the laws try to bring about a balance, in terms of rights and obligations, between the employer and the employee, the Kafala confers too much power in the hands of the employer/sponsor. The employer can dictate the recruitment process and working conditions. The paradox is that Kafala is not a law but a tradition that seems to precede labour laws. This is at the root of abuses of workers' rights. Though Saudi Arabia thought of reforming the system in 2012, it later stepped back (Sequiram'sSounsar, 2014).

The system is quite unfair for migrants as it allows sponsors to use and abuse workers. Therefore, it is essential that the Kafala system should be terminated and the migrant workers should be given full human rights. They shall be ensured that they do not have to pay for travel documents, they are paid what their contract calls for, and are provided safe working conditions, and can leave their employer and/or the country without problems. Over and above ending the System, the origin and host countries shall work together to ensure that migrant workers are protected throughout the entire process. This includes implementing and enforcing laws that protect migrant workers, providing support services, and promoting awareness of migrant workers' rights.

Conclusion

The kafala system, a sponsorship-based labour framework primarily used in Middle Eastern countries, has been a subject of significant concern and controversy for several reasons. While it has existed for decades, its flaws and negative consequences have become increasingly apparent, leading to widespread calls for reform or abolition. Exploitation and abuse, lack of freedom and autonomy, human rights violations, inequality and discrimination are the core issues of this system. However, due to the differences in the legal frameworks of the nations, the intensity of these problems may vary. However, no one is entirely free from the system. Considering kafala as a system of governance of migrant

labour ultimately failed to ensure the welfare of the immigrant labourers. Occupation is one of the critical factors in determining the intensity of the issues posed by the kafala system. Those in the contrition sector are more vulnerable than those in other sectors. Many advocacy groups and international organizations have called for reform or abolition of the system. Some countries have taken steps to address its most egregious abuses, but comprehensive change remains a challenge. Addressing the kafala system's issues requires a concerted effort to protect the rights and dignity of all workers, regardless of their nationality, and to create a fair and just system that benefits both host countries and the migrants who contribute to their economies.

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Gender Sensitivity of the Political Decision-Making Mechanisms: Opportunities and Challenges to Women's Political Participation in Governance

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Abstract

Political decision-making is an essential aspect of any society. It is inevitable to reflect citizens' voices while making decisions, hence gender sensitivity occupies a significant role. Women contribute to being prominent change-makers in leadership and good practices. The right to vote and to be eligible for elections, the right to participate in the creation and execution of public policy, and the right to join organizations related to public and political life are basic aspects of civic life. New understandings emerged on gender, public life, and political participation over the years. The present paper analyses women's role in a decision-making mechanism and reflects on the opportunities and challenges they experience as a legislator using descriptive research scheme. The study further focuses on the concept of representation using the factors influencing substantive

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representation with particular reference to woman's roles. According to the study, an increase in the proportion of female voters does not always translate into a growth in the representation of women equally at all levels of government that make decisions. The paper identifies the socio-cultural barriers, facilitating factors and barriers that impact women's participation in public debate. The paper submits the supposition that the contribution of women in the political decision is essential and, therefore, requires substantive representation, of women leaders to influence the administrative arrangement. The need for collective action and gender sensitive policy reforms towards an inclusive and participatory approach to political participation is the vision to be realized as a long-term goal.

Keywords: *Decision-Making, Gender Mainstreaming, Gender Sensitivity, Leadership, Women's Political Participation, Participatory Decision-Making*

Introduction

Women's political participation has been significant with the access to participate in public debate. Women have had a significant part in bringing about significant changes to the policies and conventions that govern society. Despite being denied the opportunity to engage in politics, women are now coming forward with the intention of influencing governments and thereby decision making. The obstacles preventing women from effectively participating are not new (UNHRSR, 2014). The capacity to engage in political activities and exercise leadership is of primary importance to ensure equality in participation. Women have established their position at higher decision-making levels, but the growth rate is not uniform. A strong criticism concerning political participation is the lack of gender perspective in it and need to be sensitized about the mainstreaming of gender concerns, particularly in decision-making. A conscious effort has been made

through reservations to bring women from marginalized communities like Dalits, tribes, and minorities into mainstream politics so that their interests are voiced (Chaudhary, 2012). India was among the pioneer countries that introduced constitutional amendments to reserve seats for women in local governance (Ministry of Law and Justice, Government of India). The Government of India, in the declaration derived from the Beijing conference of 1995, stated 'women's empowerment and full participation based on equality in all spheres of society including participation in the decision-making process and their access to power is fundamental for achieving equality development and peace' (UN Women, 1995). The Indian women's group and other countries' interest groups emphasized the need for women to actively engage in politics.With the provision of reservation, women's standing is increasing, which can be seen as encouraging. According to Christy Carol, as countries become more developed, the woman gets increasingly integrated into all the spears of public life (Corol, 1987). This integration could include the political sphere, development, and cultural factors that connect to the presence of women. While development assesses development in its entirety, sociocultural elements evaluate women's status in relation to men's. These factorial analyses provide more insights into the relationship between multiple variables in the system. Political socialization of understanding women's role in politics is stressed in the study by Richard E Matland. It is also suggested that the level of interest articulation also determines the participation of women in politics to make them present in the system (Matland, 1998). This decides the degree to which women participate in political life. While women have made significant strides in political representation in recent decades, they continue to be underrepresented in legislative bodies across the globe. Addressing this gender gap is essential for achieving gender equality, promoting inclusive decision-making, and ensuring that the diverse perspectives and experiences of women are reflected

in the legislative process. Women continue to face obstacles such as gender-based violence, harassment, and discrimination in politics, which deter many from entering or staying in political office. Additionally, cultural and societal expectations regarding women's roles and responsibilities often limit their opportunities for political leadership. It is inevitable to unearth the underlying factors in their way hindering progress into an efficient representative.

Statement of the problem

Despite the progress made over these years by the suffragist movement, there is still tension between the descriptive representation of women and their substantive impact. Though, women mark their position at decision-making levels; the ratio in terms of representation is few. What are the reasons for this situation of women being under-represented? Why they are not heard? What are the possible ways through which the participation and representation of women candidates can be increased? How can we ensure the probability of women being elected and adequately represented in the governing bodies? These are the questions that need to be addressed if we need to bring more women to the forefront. Women are availed for campaigning and as sloganers, but they do not become the actual decision-maker. This is one of the primary reasons why unequal representation is still there! It is essential to understand women's role in political activity. How are they important? What is their role in bringing change rather than depending on making decisions by a particular group of people? The present study is a conceptual inquiry into gender sensitivity in the democratic decision-making process by analyzing women's role in the decision-making mechanisms and reflects on the opportunities and challenges in representation. The substantial representation in governance is to be analysed to see whether there is an adequate level of representation for women after becoming the representatives.

Literature review

Political participation and representation are the most appropriate way citizens can participate in the decision-making process. The public-private dichotomy has resulted in women being marginalized in all spheres of activity, including social, economic, and, more specifically, political (Sahay, 1988). The equal rights to participate in the electoral competition have been guaranteed by the constitution of India through Universal suffrage. However, the male predominance and the public-private divide, created the most significant barrier to the active participation of women. The 'glass ceiling' in the system prevents women from entering important positions and decision-making (Rai, 2011). Even the topmost position of the decision-making institutions was monopolized by men (Ghatak, 2010). The involvement of women in decision-making has been Low-key. Anuradha Bhoite commented on the vast chasm between the De jure and De facto perspectives. The fundamental right of equality and equal right to vote brought women to par with men in the legal or De jure sense. They cast their vote and participate in all campaigns and protests along being slogners but lag in enjoying positions of power and decision making. In the de facto sense or what exist in reality, they are far below their male counterparts. (Bhoite, 1988). In political decision-making women's status has been subordinate to that of men. Only a small section of women who belonged to or were supported by affluent and influential families managed to enter the political mainstream (Kondreddy, 2000).

The role of women's representation is of crucial importance; hence their status is crucial in any society that claims to be equal. The pre-independence era of the country showed a significant number of women participating actively in the struggle. They were considered inevitable for the success of a movement (Sethi, 1988). Women's participation also depends on social, cultural and economic aspects where, Political equality, education, and

employment are interlinked. Women's political participation after independence cannot be viewed in the same sense it was viewed before. There was a decline in the representation of women in decision-making institutions since there was low participation. The 73rd and 74th Constitutional Amendment Acts has established two significant local laws pertaining to women's participation in decision-making and development plan formulation. A requirement of this Amendment is that at least one-third of the members and chairpersons of Panchayats must be women (State Election Commission, 2024). The most crucial way to promote socioeconomic development is through grassroots community involvement and it can be started from Panchayati Raj Institutions. In the past 20 years, there has been a greater focus on empowering women by boosting their involvement in political institutions. Political empowerment is acknowledged as a possible outcome of affirmative action. Though a large number of women voters are there, participation and representation in power or decision making is not yet fulfilled. Many 'invisible' and 'marginalized' women have yet to find leadership space (Pandit, 2010). The need for qualitative participation rather than quantitative that indicates an increased number of women voters and a lower presence in decision-making is not a sustainable means of development. Lack of training, low level of awareness, poor socio-economic background, and ignorance about one's rights and responsibilities are some of the reasons for poor or low representation of women in leadership. The patriarchal orientations are challenging to overcome but necessary (Khanna, 2009). Therefore, the vitals of 'disempowerment' should be checked on time to ensure a more inclusive system (Pandit, 2010).

Women's presence in politics, as evident from the literatures is nearly 'symbolic' rather than 'real' power wielding (Kaushik, 1993). Thus, an independent women candidate stands on a weaker platform. The intersecting axes of gender, caste, class, religion,

and region influences and impact women's experiences of political participation in India (Nivedita S & Priyanka S, 2021). The effectiveness of affirmative action measures like reservation policies in fostering women's political leadership at the grassroots level needs a critical appraisal time to time (Patel, 2019). It examines the outcomes, challenges, and implications of reservation policies for women's empowerment. Women can introduce a more significant number of policies if they are given opportunities. The evolving patterns of women's electoral participation, shifts in public attitudes towards women leaders, the duties and responsibilities, needs to be checked to address persistent barriers to women's political empowerment (Rashmi et al., 2023). The existing literatures suggests that the participation of women in political activity is inevitable. However, the systemic factors in society needs to be addressed wherein women are still treated as subordinates or lower than their male counterparts. The existing studies and reports show an upward trend with increasing women's political participation as leaders over the years.

Objectives

- To identify the role of women as political leaders and the substantive impact on policies.
- To reflect on the existing literatures on women's substantive representation.
- To understand the opportunities and challenges in decision-making process influencing women's political participation.
- To suggest the factors to maintain the participation of women and identify the measures to impart substantive representation.

Methodology

To understand the topic in a detailed manner, the researcher has thoroughly gone through the theme's relevance and mainly studied women's political participation. The study uses content analysis under the qualitative framework for navigating the problem under study. It is significant to have a qualitative understanding of the participation of women as political leaders to delineate the underlying factors of challenges and opportunities in representation. From a descriptive-conceptual paradigm, the present study is piloted using content analysis, secondary data sources and information gathered from books, articles, and reports from the existing literature on the relevant theme of the study. This helped the researcher conceptualize scenario of women's political participation and thematically understand the problem under study.

Results and discussion

Historical Context of Women in Leadership

Across the world, there are various models of women's political engagement and historical transition. The struggle for women's suffrage and political rights in the 19th and early 20th centuries marked a significant turning point in women's history. Women's rights activists and suffragists campaigned tirelessly for the right to vote and participate in political life, paving the way for greater opportunities for women's leadership. The term homemaker has been applied to women in a permanent way since the adult franchise was established and became a legal requirement. The impact was diverse, both in the Indian and international contexts. For women, gaining the ability to take part in the voting process and make decisions was by no means simple. Following the 73rd and 74th amendments to the Indian Constitution, the proportion of women voting increased. The mandatory provision to include women in decision-making bodies

guaranteed the necessity to include them, even though there were socio-cultural and systemic barriers.

Descriptive and Substantive Representation: Theoretical Insights

The term 'Representation' received a different connotation through the influential work 'The Concept of Representation' by Hannah Pitkin. The term Descriptive representation, as conceptualized by political theorist, refers to a form of representation where representatives share similar socio-demographic characteristics or traits with the constituents they represent. Pitkin contrasts descriptive representation with substantive representation. Substantive representation that connotes 'acting for' the interest of the people they represent in a way responsive to them. Here the representatives act in the best interests of their constituents by advocating for their policy preferences and advancing their interests, even if the representatives do not share the same demographic characteristics as their constituents. Substantive representation is essential for effective democratic governance because it ensures that constituents' interests are adequately addressed, regardless of whether their representatives share their socio-demographic characteristics. Representatives who engage in substantive representation are expected to understand their constituents' needs, concerns, and preferences and to act on their behalf within the political process (Pitkin 1967). When women are voting at higher rates, it means that there is a rise in women's political participation, however, an increase in the number of female voters does not mean that women are equally represented at different levels of government, where decisions are made (IACHR, 2011). In decision-making and governance, the role of women needs to be prioritized that they can effectively engage and participate in a responsive manner. Therefore, it is important to convert the descriptive representation into substantive representation, to ensure the active role of women in decision-making.

Women's political participation and effectiveness in governance.

Figure 1: Factors affecting the effective political participation of women

(Source: Self formulation)

Social and Cultural Factors

Even though women may be allowed to vote by the constitution, there are situations in which cultural or familial constraints prohibit them from exercising their right to vote. Traditional gender roles dictate that women should prioritize family and household duties over career aspirations. Women who choose to pursue political careers willingly may face resistance from family members and society, who view their involvement in politics as deviating from expected gender roles. The cultural barriers along with these stereotypes can deter women from entering politics or seeking leadership positions, fearing social

backlash and scrutiny. Women from marginalized castes or minority communities may face additional barriers due to intersecting forms of discrimination based on gender, caste, and religion. The lack of resources such as education, support, financial possessions can hinder their ability to contest elections, campaign effectively, and navigate the complexities of political power dynamics. When historical background of women in political leadership positions are tracked, it can be evidently seen that there are few or nominal women leaders to point out compared to men. So, without adequate representation, women further struggle to envision themselves as political leaders and lack the necessary mentorship and support networks.

Opportunities and Challenges

There are facilitators such as better opportunities, grassroot involvement, broader political awareness, policy interventions, recognitions of women's rights, vision on development, acting in favor of women, and there are barriers including socio-cultural norms, economic disparities, and institutional biases. The existing inequality in opportunities caters a cycle of gender inequality that deteriorates the efforts of women to attain higher positions. Women encounter resistance and lack of support from family members and without encouragement and backing from their social networks, women feel discouraged or unable to enter the political arena. Women's experiences imply that they feel caught between responsibility and societal expectations. In this situation, where women require assistance in juggling their many obligations, systemic support is highly relevant. When women have sufficient support from the institution, it becomes possible to ensure their equitable involvement in the decision-making processes. The role of media in portraying women also influences their public image. Media can either reflects and reinforces gender stereotypes, influencing women's access to political leadership positions or highlight and address the issues that the women in

leadership position experience. For the substantive representation to happen, it is necessary to focus on the facilitators and include more gender sensitive policy interventions and awareness. Thus, institutions and agencies play a crucial role in exhibiting opportunities and challenges existing for women and promote the relevance of women's political participation in society.

Policy Interventions

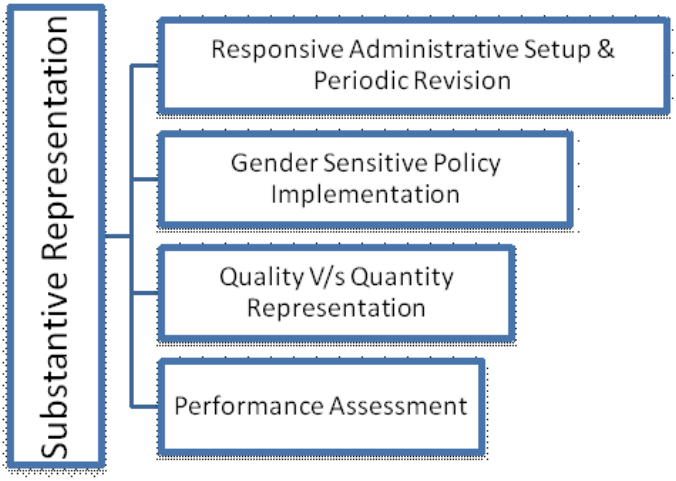
Interventions in policies contribute to the participation of women in leadership and decision-making. Quotas are implemented at various levels of government, including national, regional, and local, to ensure that women have equal opportunities to participate in decision-making processes. Along with that it is important to provide capacity-building programs, leadership training, and mentorship opportunities for women interested in politics that can enhance their skills, confidence, and readiness to participate in governance. These programs should focus on political campaigning, public speaking, policy analysis, and other relevant skills. The reflections from analysing the different factors also suggest the need to boost the confidence of women in public speaking and civic engagement. Highlighting the achievements and contributions of women in governance can challenge gender stereotypes and inspire other women to pursue political careers. Strengthening institutional mechanisms for gender mainstreaming and ensuring the inclusion of gender perspectives in policy-making processes can help institutionalize gender equality in governance. This involves establishing gender-responsive budgeting mechanisms, creating gender-sensitive administrative setup, and integrating gender analysis into policy evaluation frameworks.

Substantive Representation in Women's Political Participation

It is inevitable to ensure good measures in place to keep a qualitative number of women in the organizational or administrative structure. The prevailing practices kept women out

of mainstream decision-making by assigning them to allied roles, but it is the right time to bring and make necessary changes in the participation and performance of women in decision-making mechanism. First aspect in this is the 'qualitative v/s quantitative' representation, (figure 2) where the task is to delineate the difference between these two. For a democratic system to be efficient and responsive, both descriptive (quantity) and substantive (quality) representation is required. Having a large number of women does not always reflect in participatory decision-making, unless there is actual and inclusive role for women in governance. For the substantive representation to be effective, descriptive representation should be maintained, so that the constituents realise their voices are heard. This can convey the concrete meaning of 'representation' and recognise the shortcomings, forecast future trends in the participation of women.

Figure 2: Facilitators of Women's Substantive Representation



(Source: Self formulation)

The mainstream decision-making also involves the Gender sensitive policy formulation which is the second crucial aspect to include in the actualisation of women's political participation. It requires inclusive and supportive environment that recognizes and addresses the unique needs, perspectives, and experiences of women in leadership positions. Creating opportunities for women leaders to actively participate in decision-making processes, ensuring that their voices are heard, valued, and respected is significant part of it. This may involve providing training and capacity-building support for women leaders, facilitating networking and mentorship opportunities, and addressing barriers to women's participation, such as discrimination and bias. The support in work-life balance while managing caregiving responsibilities and other obligations can help women to better perform in decision-making roles, especially in governance. Therefore, soliciting their input, feedback, and recommendations while considering policy formulations and implementations can offer better need-based policies. Third crucial aspect in addressing the political participation of women is their performance assessment. The participation of women in governing bodies will only be converted to representation when their performance is considered for periodic checks and necessary changes are made. The performance appraisal of representatives can help understand their contributions as a people's representative during the tenure and critically evaluate the significance of their role.The significant contribution that women take to the implementation of legislation and welfare programs that support the elderly, women, and children in a community is crucial to reaching out to all segments of the population. An effective way to prepare for the public sphere is to encourage more women to run for office by allocating financial resources for initiatives that promote their growth rather than discouraging them. This will reduce the inactive, and lopsided functioning of the administrative setup.

These three factors will be effective only when another important aspect is planned and arranged; that is responsive administrative setup and periodic revision of existing mechanisms and frameworks. The administrative setup shapes the implementation of policies and programs that affect women's political participation and leadership. Periodic revisions to administrative structures and procedures offer opportunities to introduce gender-responsive policies, such as quotas for women's representation, gender-sensitive budgeting, and gender mainstreaming initiatives, to promote women's leadership roles in governance. Periodic revisions to administrative structures can address barriers to women's access to financial resources, information, networks, and infrastructure, enabling them to overcome systemic challenges and compete on an equal footing with their male counterparts. Measures to combat gender-based discrimination and violence, and promote women's empowerment in political and public life is necessary to impart the gender-equal participation.

Thus, numerous insights can be gained from the growing patterns of women's political engagement in important institutions of decision-making. The administrative system clearly displays the descriptive representation of women, but substantive representation is an area that demands further academic attention. The active and complete participation of the legislator in any given system is what representation envisages to induce. The participation of women in public discourse and leadership roles serves as a foundation for achieving gender equality and civic responsibilities. The increasing participation of women in leadership roles shows progressive rate as it accepts and recognises the role of women in exercising their opinion as a decision maker. Along with the number of persons elected to leadership positions, what matters most is the type of policies and initiatives that the individual has started during his or her tenure. The substantiveness of decision-making is important, since it has the potential to

significantly alter how the mechanisms for making decisions operate as a whole.

Conclusion

Political participation and representation of women are inevitable parts of a democratic setting. Women make up approximately half of the population, and their participation in politics ensures that diverse perspectives and interests are represented in policymaking. Women's political engagement must begin with the election of women to public office, but once they are in government, it is crucial to guarantee that they have a voice. Women's political participation enhances the legitimacy of democratic institutions by ensuring that they are accountable. Utilizing the critical mass in elected bodies is essential to guaranteeing that women have a powerful voice. Instilling the values of equality among people requires gender awareness in the decision-making processes. Developing strategies for women's political mobilization is essential and some of these strategies include socialization, civic engagement, networking, and bolstering the infrastructure for active political participation. Ensuring women's participation is integral to the overall development of the society where equality is envisioned. The ideal representation of women leaders would combine substantive and descriptive elements.

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Maternal and Child Health Programmes in India after Seventy - Five Years of Independence : An Overview

Pratibha Baburao Desai *

Abstract

Health and well - being of citizens are the most valuable asset for any country, and their care is the most sacred commitment of any government. The standard of health care delivery services, both generally and specifically for mothers and children, can serve as a barometer for any society's level of progress. Maternal and child health (MCH) refers to the care of substantially more susceptible infants and children from malnutrition, infectious diseases, etc., as well as the health of women throughout pregnancy, childbirth, postpartum care, etc (Sayeed & Devo Bhava, 2014).

The health and well - being of children and mothers are of great concern in developing countries, particularly India. Many national and international reproductive health agenda continuouosly focus to improve the health status of children and

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mothers. One of the most significant moments in the history of women's reproductive health and rights was the 1994 International Conference on Population and Development (ICPD). It gives importance and placed emphasis on giving women's reproductive rights, family planning, and sexual and reproductive health services universal access (Dehury, 2016). Maternal Health Policies and Programmes have their long history and they are stressed from British Colonial rule. Hence present study had made an attempt to highlight the maternal and child health programmes after seventy - five years of Independence.

Keywords: *Maternal and Child Health, Well - being, Pregnancy, Childbirth, Postpartum Care, Reproductive Rights, Family Planning*

Introduction

Maternal health is a key indicator of women's health and status. Also, it is a major public issue and an important indicator showing the level of social development. The definition of women's health differed along with variations of policies. Historically, it was the State's emphasis on maternity health that focused attention on women's health issues.

In the narrow sense, it is the care of her newborn infant and the maintenance of lactation. It is the upkeep of breastfeeding and the caring of her recently born child. In a broader sense, it starts much earlier with initiatives meant to advance the health and welfare of young individuals who may become parents, support them in creating the best family structure, and put off family planning (Qadeer, 1998).

Maternal health is a major public health issue and an important indicator showing the level of social development and women's status in society. Reducing maternal mortality by two - thirds is one of the millennium development goals. Various efforts

for reducing the Maternal Mortality Ratio (MMR) have been initiated by focusing on thrust areas at different points of maternal health services inclluding antenatal care, delivery care and postnatal care (Saxena et al., 1998).

The National Health Mission and the colonial administration promoted the expansion of institutionalized maternity care. India has led the world in medical advances since gaining independence because of its excellent private medical facilities and medical education system. It currently boasts some of the world's most highly qualified and talented medical professionals and is a significant provider of health services. The present research paper highlights maternal and child health since from colonial to after 75 years of independence. It is very important to know about how these programmes are benefitted for the mothers and children. How colonial efforts differ from programmes after independence. Hence present study is going to present the scenario of maternal and child health programmes in India after seventy - five years of independence.

A nation's ability to develop depends heavily on the health of its children. Any nation's ability to grow depends on its ability to produce healthy people resources. Ensuring the health of children is critical as they are the future generation's most valuable resource. In India, one in three children is undernourished. In relation to the MDG, infant and child mortality rates are still relatively high. Infants and children under five are especially susceptible to malnourishment, mortality, and other ailments that are easily treatable or prevented. However, the health of children in India is in jeopardy. Anemia affects three out of every four children, and the fight to eradicate polio is really regressing. Many programmes are implemented for the improvement of child health after independence. Hence present study also highlights najor child health programmes launched by the government of India.

Objectives of the Study

i) To know maternity Care Services in British India.

ii) To understand the development of Maternity and Child Welfare Programmes in India after independence.

Research Methodology

The present research paper is based on the review of published and unpublished work concerned with the theme and is based purely on secondary data.

Historical Background of Material and Child Health Programmes in India :

The health and well - being of citizens are the most valuable assets for any country and their care is the most sacred commitment of any government. The goal of many national and international reproductive health agendas is to constantly enhance mom's and children's health. One of the most significant moments in the history of women's reproductive health and rights was the 1994 International Conference on Population and Development (ICPD). It prioritized giving women's reproductive rights, family planning, and sexual and reproductive health services universal access (Dehury, 2016). Maternal Health Policies and Programmes have a long history. They have been stressed since British Colonial rule.

Maternity Care Services in British India :

Maternity health of women was rooted not only in the poor state of maternity health of native women. The evolution of general health services was the outcome of the interest of the British army and the political interests of the colonial government. British administration was very far with maternal health services of women. Along with these administrative officers and wives of the administrative army governor general took interest in the health

of women. Wives who came to India along with viceroys and officers got involved in social work not on a professional basis but rather purely on a humanitarian basis and provided their services in British India. Even at the end of the nineteenth century, one - third of the 343 women doctors with British degrees in British India were from overseas. (Sayeed, 2014). Due to patriarchy in overseas countries, the medical women professionals are not getting the chance to provide the medical services in their own countries and they started to provide maternity services in India. So, overtime traditional dais (India's traditional birth attendants) whose role was very important at the time of delivery declined and people started to take services from medical professional women from overseas rather than these traditional dais. Emphasizing the importance of the role of traditional dais, these women Missionaries fro Britain started to train these indigenous. These British missionaries, who emphasize the value of traditional dais began preparing these traditional dais for the practice of higher standards of midwifery than those customarily followed. The Women Missionaries from Britain attempted to instruct the traditional dais in better midwifery practices than the customary ones that were in place before the motion was introduced. Miss Hewlett of the Church of England Zenana Mission made the first attempt in this approach in 1866. Allopathic system of medicine became popular. The services of these medical women were limited to only to upper class. The majority of lower - class women and middle class were left out of this preview. To provide services to all of them, funds from different sources would be collected and some males and females who got training in medical started the private practice (Qadeer, 1998).

In 1885, the Dufferin Fund Committee was established with the objective of providing medical aid to the women of India through women doctors. The Dufferin Fund came into existence due to the interest and initiatives of a missionary doctor, Ms. Bielby, who came to India in 1875 and opened a dispensary, and

then a small hospital in Lucknow. In 1881, when Ms. Bielby was going to England for her higher studies, the Maharaja of Poona (now called Pune) requested her to visit her old patient, the Maharani of Pune. During the visit, the Maharani gave her a gold chain with a locket. Inside the locket, there was a note stating the sufferings and complications faced by the Indian women at the time of childbirth. Ms. Bielby was asked to deliver the chain personally to the Queen of England. On receiving the message, the Queen asked many questions and enquired about the conditions and sufferings of the Indian women. When Lady Dufferin came to India in 1883, the Queen ordered her to arrange for medical aid for the women of India. This paved the way for the creation of the Dufferin Fund (Qadeer, 2011).

The Dufferin Fund along with a little financial support from the Government of India opened the Lady Reading Health School in 1918 in Delhi for the training of health visitors for providing public health services, MCH services and to supervise Auxiliary Nurse Midwives (ANMs).

Women missionaries from the US, Britain, and Canada came in to open dispensaries, hospitals, and training schools for miswives and nurses. By 1888, fifty female missionary doctors were working in India and constituted two - thirds of all women doctors. This trend further increased and was supported by Indians with British education who considered medical intervention necessary. The Lady Duffer in Fund established a control committee with independent branches in West Bengal, Bombay, Madras, Berar, Burma, Central Provinces, Punjab, Mysore & North West Province. The Dufferin got less government financial support and its patrons were Queen Viceroy, the Governor and their wives, and the fund was also collected through donations for its work. In British India, Public health policies were influenced by British administrations.

The colonial government thus encouraged the growth of institutionalized maternity care through British women professionals who were permitted to practice and run the hospitals and dispensaries. These institutionalized maternity services created an opportunity for Western women professionals, who were findings it difficult to get a break in the male - dominated profession in their own countries as well as the means of entry into the medical schools, to become eminent practitioners by showing their work experiences gained in India. However, their work was purely projected as philanthropic activity, and thus, health remained an external arena of the health policies of the colonial rule. Although maternity services provided through charity organizations under the aegis of qualified British women catered to the needs of upper - middle - class women, the majority of the women (depended) on the marginalized and untrained traditional dais. The number of deliveries performed by traditional dais was more in comparison to institutionalized deliveries. Later, these institutions started discrediting the traditional systems and practices of the traditional dais (India's traditional birth attendants) and portrayed them as being ignorant, vicious and careless, and thus they were able to establish the superiority of allopathic maternity practices. The colonial government instead of preserving the strength of traditional practices followed by traditional dais (India's traditional birth attendants), introduced training programmes, based entirely on British curriculum. Apart from discrediting the traditional dais, the patrons of the Lady Dufferrin Fund also blamed the 'purdah system' as a retrogressive practice of an inferior culture for their poor health. Studies on health services in British India reveal that the evolution of general health services was the outcome of the interests of the British army and, later the political interests of the colonial government (Jeffrey, 1988).

The National Planning Committee was appointed in 1938 and began its work early in 1939 with 29 sub - committees and into eight groups under the chairmanship of Col. S. S. Sokhey. The Committee was divided into 29 sub - committees, formed into eight groups to deal with all dynamics of health, life and work with a predetermined plan. In 1930, under the aegis Red Cross Society, a 'Maternal and Child Welfare Bureau' was established with the objective of promoting maternity and child welfare work throughout the couontry. The next milestone was the establishment of a training curriculum in the All - India Institute to Hygiene and Public Health, Calcutta (Kolkata), in 1933, which qualified women doctors for a diploma in maternity and child welfare. Finally, in 1942, a National Committee was set up to examine health issues in India.

Personnel and Infrastructural Deficit

In 1943, according to the Bhore Committee report, there were 5,000 practicing midwives in the country with an increment of only 300 qualified professionals annually. However, for a total of probably 10 million births each year in British India, nearly 100,000 midwives were required for making a huge gap on the basis of one midwife for every 100 births.

The total number of health visitors in the same period was 700 - 750. The qualification of these health workers ranges from third standard from Anglo - vernacular school to as high as matriculation differing from state to state. There were seven training centres located at Delhi, Lucknow, Calcutta (Kolkata), Madras (Chennai), Poona (Pune), Bombay (Mumbai) and Nagpur providing training for 6 - 18 months and generating 60 professionally qualified health visitors annually. The role of the health visitors was to supervise the work of five midwives, thus making a deficit of 17,500 health visitors to control the work of 100,000 midwives. There is only about a dozen medical graduates

and about 50 or 60 licentiates were the total number of women with special training.

Before independence, in most parts of the country, maternity and child welfare centres were run by health visitors but Madras and Delhi were the only provinces where women doctors were employed in both rural and urban areas. In 1942, Madras was the first province to initiate a programme to organize the existing maternity and child welfare work in a systematic manner. Committee was set up to examine health issues in India before independence.

Development of Maternity and Child Welfare Programmes in India after Independence

India has led the world in medical advances since gaining independence thanks to its excellent private medical facilities and medical education system. It now ranks among the top providers of healthcare services, with some of the most highly qualified professionals globally recognized medical professionals. However, many underdeveloped areas of India still lack access to high - quality healthcare. For instance, it's projected that there are just 18 hospital beds available per 100,000 residents in rural towns. Public hospitals are usually understaffed and under - stocked, even in cases where medical care is provided. The only access to healthcare for the impoverished is through overworked, filthy facilities. Five Year Plans served as its foundation.

(i) Maternal and Child Health and Five - Year Plans :

On the basis of the recommendations and suggestions, different programmes and policies were framed through five - year plans, which give us a picture of the efforts taken by India for development of the health of its citizens. Different initiatives were taken with respect to the mother and child health rights from the initiation itself. The report of this committee was delayed

because of imprisonment of Jawaharlal Nehru and the Second World War and lastly, it was published in 1948. This report had many drawbacks, such as it does not contain detailed analysis of the existing health situation from another committee. Ms. Rani Laxshmibai Rajwade, one of the committee members, who was in charge of different aspects of maternal and child welfare services, claimed that material and child welfare services might well be thought to have a primary claim on public funds, but unfortunately, it was not what happened.

Government of India constituted major health committees and the names of these committees are Sokhey Committee, Bhore Committee, Dasgupta Committee, Model Public Health Act Committee, Mudaliar Committee, Shah Committee, Jungalwala Kartar Singh Committee, Shrivastav Committee, Hati Committee, Small Family Norm Committee, ICSSR and ICMR Study Group and Bajaj Committee. These committees made direct and indirect suggestions for the improvement maternal and child health programmes directly & indirectly. One of important committee 'Dasgupta Committee' also known as Environmental Hygiene Committee was appointed under the chairmanship of Dr. B. C. Gupta, who was also a member of the Bhore Committee, focused on housing water supply, general sanitation and drainage systems, waste disposal vector control etc.

The first two Five - Year Plans (1951 - 61) made their allocations to implement the Bhore Committee recommendations, especially related to building up the primary bedrock for health services in the country. On the basis of the recommendations of Mudaliar Committee, special attention was given to MCH on the basis of the recommendations of Mudaliar Committee. At the end of the Second Plan, the number of primary health units increased to 2,800 as against 725 units during the First - Plan period. Also, there were 4,500 maternity and child welfare centers across the country during the period. The third five - year plan

gave less attention to maternal health, whereas the fourth plan gave importance to family planning. The Fifth Five - Year Plan (1974 - 79) highlighted the problems of malnutrition and anemia and their implications for MCH. At the end of the fifth plan, maternal health was seen as an essential component of child development and hence, pre - and post - natal services were included in the different initiatives.

Minimum Need Programme :

The importance of primary health care to the rural population was again recognized during the Plan period with the Minimum Need Programme. The Sixth Plan was dissatisfied with the existing plan, and it also emphasised that existing health care facilities, hospitals, specialized and super - specialized hospitals, with trained doctors which is availed only to the well - to - do classes and depriving the rural areas and poor people of the benefits of good health and medical services. The National Health Policy of 1983 was formulated in the Sixth Plan Period which became a milestone.

Seventh Plan (1984 - 89) emphasized the health needs of women in the reproductive age group and of children below the age of five years and it also provided contraceptives and family planning services. This plan also gave importance to The Universal Immunization Programme and Oral Rehydration Therapy (ORT) which help curb the mortality and morbidity among infants and young children. The Sixth and the Seventh Plans gave more importance to maternal and child health rather than other earlier plans.

At the period of Eight Five Year Plan (1992 - 97), the country went through a massive plan. Nothing new was happening during this plan. The Eighth Plan adopted a new slogan instead of 'Health for all by 2000 A - D'. The plan emphasized a community - based system covering about 3000 people as the basic unit of the primary

health care system. Major developments took place during this plan. These include the establishment of the education Commission for Health Sciences and the setting up of Health Universities by some states. The first phase of the Reproductive and Child Health (RCH) programme was also launched in 1997 by integrating all ongoing fertility regulation and MCH schemes of the Ministry under a single umbrella, adopting a holistic target free approach which was as Family Welfare Programme. During this plan, an expert committee on the public health system was set up to review the public health programmes. The Ninth Plan followed the recommendations of the eighth planning committee and this plan also proposed a horozontal integration of all vertical programmes at the district level to increase their effectiveness and also to facilitate allocate efficiencies.

The Tenth Plan (2002 - 07) witnessed a major transition in the implementation of health policy nd health programmes such as the formulation of a second health policy and implementation of NRHM in 2005 which are responsible for strenghtening the public health care system. The Eleventh Plan (2007 - 12) focuses on the good health of poor, especially the poor and the under - privileged with individual health care, public health sanitation, clean drinking water, access to food and knowledge of hygiene and feeding practices and it also focuses on infant mortality rate and gave importance to institutional delivery. This plan reviewed the Maternity Benefit Act by increasing the length of leave for women employed in factories, mines, plantations, shops and so on with its trust area.

ii) Family Planning Programmes

To control the growing population, India is the first country in the world to formulate a National Family Planning Programme in 1952, with the objective of reducing the birth rate to the extent that is necessary to stabilize the population at a level consistent

with the requirement of the national Economy. Family Planning Programmes (EPPs) initially followed a clinical approach, but after the 1962 census, which showed a continuous rise with population growth of 21.5 per cent, the central government decided to adopt the demographic goal to reach a crude birth rate of 25 by the year 1972. In 1966, a UN Advisory Mission visiting India strongly recommended that the directorate (health and family planning) should be relieved from other responsibilities such as maternal and child health and nutrition (U. N. Advisory Mission, 1961)

iii) National Health Policies and Maternal and Child Health

To avoid increasing maternal health inequality towards particular groups and gender equality is very important. So, National Health Policies are working towards this. There are four important principles of National Health Policy viz time - bound programmes, health training volunteers to acquire knowledge and skills and access necessary technology, well - organized referral system and integrated network of specialty and super - specialty services.

a. First National Health Policy, 1983

On the basis of Alma - Ata Declaration government of India had formulated the First National Health Policy to sustain primary health care as a part of the national health system. Thus, the Indian government came up with the National Health Policy in the light of the Directive Principles of the Constitution of India, which focuses and recommends 'universal, comprehensive primary health care services.

b. National Health Policy, 2002

This was the second National Health Policy implemented in 2002 and this policy is completely based on the National

Population Policy of 2000 and mostly affected by the process of globalization, privatization and liberalization. It says goodbye to 'Health for all' and 'Health is Fundamental Human Right'. It focused urban, specialist - based helth care and it also gave importance to the proposed privatization of secondary and tertiary - level care, ignoring public hospitals. It made provision for user fees in public hospitals.

iv) Maternal Mortality and Child Mortality

Maternal mortality is not only a public health challenge but also an indicator that reflects the low and vulnerable status of women. Maternal Mortality Ratio (MMR) measures the number of women aged 15 - 49 years dying due to maternal causes per 100,000 live births. The World Health Organization (WHO) estimates that, of 536,000 maternal deaths occuring globally each year, 136,000 take place in India. Millennium Development Goals (MDGs) set a target of reducing three - fourths of maternal mortality by 2015 from the level prevailing in 1995. India's maternal mortality rate reduced from 212 deaths per 100,000 live births in 2007 to 178 deaths in 2012. Maternal death is preventable and interventions aimed at improving maternal health have acknowledged that the efforts would contribute to human development in a significant way (Akram, 2014).

The implication of maternal loss at all levels from family, community to nation was recognized and drew the attention of policymakers and researchers, leading to an understanding that the objective of poverty alleviation was contingent on better maternal health. Thus, Alma Ata Declaration in 1978 focused on health equity and community participation so that health care could be delivered according to the community needs. Maternal mortality can be prevented at the primary level (by prevention of pregnancy), secondary level (by preventing obstetric complications) and tertiary level (by preventing maternal death).

The Safe Motherhood initiative had redefined maternal health from a disease - specific approach aimed at quick solutions as in the primary care approach to a broader health system approach. CSSM focused on establishing First Referral Units to support safe motherhood initiatives since skilled care has to be backed by adequate and appropriate facilities and attempted to universalize ANC services.

The International Conference on Population and Development in 1994 (ICPD) was a major break throough that shaped the orientation towards maternal health. ICPD gave a great impetus for the creation of new policy initiatives and strategies for improving maternal health.

Globally, an estimated 287000 maternal deaths occured in 2010, a decline of 47% from the level in 1990. India is leading in the number pf maternal deaths (56,000) and contributes nearly 20% of total maternal deaths worldwide followed by Nigeria with 14% (40,000). According to the Millennium Development Goals, globally maternal mortality ratio is expected to reduce from 400 to 100 by 2015. The current 212 MMR indicates that achieving MDG goal is a long way away. Besides the slow improvement in maternal health, factors such as regional differences in relative risk of maternal mortality are important. Nearly 99% of all maternal deaths occur in developing countries. Half of all maternal deaths in developing countries occur in African countries and the one - third in South Asian countries; together they account for nearly 85% of all maternal deaths (Akram, 2014).

vi) MDGs (Millennium Development Goals) and Maternal and Child Health

MDGs are the specific goals of social transformation designed for the entire World at the beginning of the twenty - first century. MDGs are a set of numerical and time - bouond targets to measure achievements in human and social development and

originated from the Millennium Declaration out - lined to poverty and preventable diseases, promoting equitable, development and protecting the earth's environment with eight goals including direct and indirect goals related to maternal and child health (Akram, 2014).

Assessment Studies of Maternal and Child Health :

Some studies also focused on maternal and child health programmes and tries to assess these programmes. Some of them are as follows

Husain Zakir's (2011) paper titled 'Health of the National Rural Health Mission' is based on the findings of evaluation studies undertaken by the Planning Commission, the Ministry of Health and independent authorities. The study concluded that NRHM has implemented to strengthen the issue of public health at the top of the government agenda and had positive impact on several health indicators like immunization, institutional deliveries and antenatal care and it got huge success. But, for further improvement it should focus on the complexities of Indian rural societies.

Eble Alex's (2012) paper on 'Incentives, Women, and Children : How the ASHA Programme Can Reduce Child Mortality in Rural India', tries to find out how this programme made an attempt to the role of ASHA in preventing child mortality. This report found that, the health status of villagers would not improve if suitable incentives are not offered to the ASHA. So ASHA system represents the best option for lowering child mortality in rural regions.

Roy Somnath's (1985) paper on 'Primary Health Care in India' gave a detailed account of primary health care in India. This study concluded that there is an urgent need that the people working at different levels in the field of health and other related

socio - economic development sectors should be properly oriented and motivated to develop the proper scope of primary health care & public health priorities. The study also concluded that the rile of primary health care in maternal and child health is very important. So it is very important to strengthen the primary health care for the improvement of maternal and child health in India.

Mohammad Akram's (2014) study titled "Maternal Health in India : An Overview" tries to take a comprehensive approach by including the socio - cultural, political - administrative and macro - environmental determinants of maternal health. This study tries to highlight the state of maternal health in India after six decades of planned change and health interventions. On the basis of data provided by the National Family 74 Health Survey (NFHS), Sample Registration system (SRS), MDG - India Country, Report (MDG - ICR) and other authentic sources, the paper tries to locate the achievements in maternal health in India.

Sayeed & Devo Bhava's (2014) study titled "Contextualizing Maternal and Child Health in India : From Colonial Era to Globalized Era" highlights the development of Maternal and Child Health (MCH) programmes from colonial periods to after independence. This study focuses on relationship between maternal and child health that they are very natural process and related to each other. This study also focuses on the colonial era, which was marked by more individual voluntary efforts that lacked organized planning pertaining to MCH. India, on attaining independence, embarked upon the 'socialist pattern' of planned development and the health services, as 'the foundation of all things' found key attention for the socio - economic development process.

Nidu Siddiqui (2017) paper titled with "Child and Maternal Health in Uttar Pradesh : A Study on Impact of ASHA" addresses community health workers ASHAs in Uttar Pradesh. This study

starts with role community health workers most countries have largely relied on females as Community Health Workers (CHWs). This paper highlights the eligibility, roles, responsibilities, selection procedure by gram sabha, community mobilization process and training provided, and her major contribution. The study concluded that ASHAs scheme is playing an important role in the improvement of maternal and child health and it is a ray of hope for maternal and child health in India.

Study titled with "An Overview of MCH Services in Idukki district based on MCTS and Client's Satisfaction" by Sreeranjini, A. A. T. C., and Anil Kumar (2016) focuses on Child Tracking System (MCTS) launched in 2009 in the improvement of maternal and child health. The present study also focuses on the utilization of health care facilities of MCH Services in Idukki district of Kerala, for appraising the reliability of MCTS data and assessing the utilization of the service delivery from the health facilities by comparing MCTS data from the portal and coverage of MCH services at the beneficiary level and client satisfaction, regarding maternal and child health services, is also assessed under the PHC areas selected for the study. The study also found that majority of the beneficiaries opted for government facilities for ante - natal and post - natal services. Majority of the beneficiaries did not feel any discomfort in the timing and accessibility of the health facility in their area.

T S Syamala's (2016) study title "Distance Barrier in Institutional Delivery in Rural India" shows the relationship between institutional delivery and reduction in maternal and infant deaths. So, the promotion of institutional delivery is an important strategy for reducing maternal and infant deaths. Physical accessibility appears to be a major barrier for women in opting for institutional delivery. There is an inverse relationship between distance and institutional deliveries, so the probability of women going for institutional delivery declines drastically when the

distance increases, even after controlling for other socio - economic variables. If a woman stays within 1 - 5 km away from the health facility, she is 44 percent less likely to go in for institutional delivery compared to a woman who has a health facility within the village. Although institutional delivery increases with an increase in the education of women, at each educational category the probability of women going for institutional delivery declines with an increase in distance to health facilities. Although the introducing of ASHAs under the NRHM, JSY and JSSK programmes helped in improving MCH services, many women, especially from the poorer sections are yet to receive adequate MCH services. Further, the distance from the health facility is still an important determinant of MCH services, although emergency ambulance services in the form of 108 services and free transport under the JSSK scheme are aimed specifically at addressing these issues. This study also shows that the institutional delivery proportion increases if the village is connected by aal - weather roads and also when the households owns a motor vehicle.

"Impact of Public Health Programmes on Maternal and Child Health Services and Health Outcomes in India : A Systematic Review Study" by Abinash Singh, Sukumar Vellakkal highlighted the various public health programme inititives on maternal and child health outcomes. On the basis of the summary of the literature, published during 2000 - 2019 on the maternal and child health services and the related - health outcomes in India. The study found that most studies assessed the impact on the short - term and intermediate outcome of various maternal and child health services rather on the long - term outcome of improvement in health.

Major Maternal and Child Health Programmes

Maternal and child health programmes play important roles in reducing maternal, infant and child morbidity and mortality of the population.

a) Child Survival and Safe Motherhood Program (CSSM) during the period of 1992 - 1997 :

The CSSM programme aimed at training of medical officers and traditional birth attendants for safe delivery practices, provision of aseptic delivery kits, expansion of rural health services including facilities for institutional deliveries and provision of other essential things for emergency obstetric care. This programme aimed at improving antenatal coverage and intended to increase the proportion of deliveries overseen by skilled medical attendants. (Dadhich & Paul, 2004).

b) Strategies in RCH - I for improving maternal health

As a signatory to ICPD in 1994, the Indian government tried reorient its family welfare program from a contraceptive - oriented approach and to target a free approach and community need - based approach. Decentralized planning, monitoring at local levels, partnership and involvement of the community, and inter - sectoral convergence became the main elements of the Reproductive and Child Health project. The strategies adopted were to make both permanent and temporary methods of contraception available and expand MTP (Medical Termination of Pregnancy) services for eliminating unwanted pregnancies. The National Maternity Benefit Scheme (NMBS) was also launched on 15 August 1995, aiming to provide maternal care in the form of a better diet to expectant mothers. This scheme provided financial assistance of Rs. 500 per birth for the first two births to all the pregnant women who attained 19 years of age and belonged to Below Poverty Line (BPL) households (MoHFW : 1996).

c) Strategies in RCH - II and NRHM

In RCH - II (in 2005, it became National Rural Health Mission (NRHM)), priority was given to the strengthening of the health system for the provision of obstetric services. The highest priority was given to making all PHCs and CHCs an EmoC centers and all FRUs as CmoC centers. Unfortunately, there is little evidence that maternity has become significantly safer in India over the last 20 years, despite the safe motherhood policies and programmatic initiatives at the national level. National Rural Health Mission is aiming towards safe motherhood by reducing maternal mortality and promoting institutional delivery.

d) National Rural Health Mission (NRHM) :

National Rural Health Mission MHC gave the first preference to maternal and child health. Accredited Social Health Activists is one of important component of NRHM to improve maternal and child health. She has given performance incentives, not have a fixed remuneration and she is performing multiple tasks. She would act as a bridge between the ANM and the village, accountable to the village panchayat and an important link worker in JSY. The major objectives of NRHM are to strengthen the public health care system, improve maternal and child health and increase primary care utilization. NRHM creates hope for the healthcare delivery system in India.

e) Public Private Partnership (PPP model)

Policy encouragement for health sector reforms was inevitable to improve health service delivery, and the policy dialogues supported the idea of 'reforms in the health sector' through public - private participation, which became a panacea for improving access and equity.

e) Demand Side Financing Schemes

Inequity in maternal healthcare use was a major impediment to making progress in maternal health. Economic barriers have been seen as a main determinant in accessing facility care. Strategies promoting institutional delivery necessitated the need to provide financial protection to women from rural and poor households with the objective of increasing demand generation for maternal health care use. Therefore, demand - side financing schemes such as Janani Surakshe Yojana (JSY), Chiranjeevi Yojana (CY), JSSK and RSBY were introduced along with NRHM to increase the institutional delivery.

f) Janani Suraksha Yojana (2005) :

JSY centrally sponsored scheme was launched on 12 April 2005 and implemented in all states and union territories (UTs). It is a safe motherhood intervention under the umbrella of NRHM with an objective of reducing maternal and neonatal mortality by promoting institutional delivery among the poor pregnant women belonging to the BPL households and of the age 19 years or above for up to two live births. Janani Suraksha Yojana is a conditional cash transfer under the Demand Side Financing Scheme and part of the safe motherhood initiative. JSY, introduced in 2005, is a centrally sponsored scheme for promoting institutional delivery among poor women. ASHAs play as an effective link between the government and the poor pregnant women.

g) NFHS - 1, NFHS - 2 and NFHS - 3

Like NFHS - 1 and NFHS - 2, NFHS - 3 also had the important goal of educating people about the use of public and private safe maternity services. Pregnancy complictions, prenatal and postnatal care, delivery characteristics, location and assistance during delivery, and postpartum complications are among the topics covered under NFHS data.

h) Balsakha Yojana (2009) :

Under this scheme, child health care is provided, and the pediatrician attends all newborns at the place of birth, ensuring their survival by providing early neonatal care, including immunization at birth, feeding advice and so on. The gynecologist advices and ensures 2 days stay of mother and baby after delivery to cover dangers of the immediate post - partum period. The maternity services are offered for up to 42 days to the mother and newborn care for up to 30 days to all, irrespective of the economic status the beneficiaries. If ASHA worker brings a mother from a tribal block and stays with her during delivery for 48 hours, she gets additional Rs. 200 under this scheme.

i) Child Health Programme under National Rural Health Mission :

The child health programme under National Rural Health Mission (NRHM) comprehensively aims to improve maternal and child health by focusing on maternal mortality, infant and under - five mortality with linked health of mothers.

Following programmes are implemented

a) Newborn and Child Health Interventions : to improve the status of newborn health.

b) Home Based Newborn Care Scheme (HBCN) : for reduction of neonatal mortality.

c) Infant and Young Child Feeding : promotion of breastfeeding.

d) Nutritional Rehabilitation Centres (NRC) : Related to nutrition

e) Supplementation with Micronutrients to reduce anemia.

f) Reduction in Morbidity and Mortality Due to Acute Respiratory Infections (ARI) and diarrheal diseases

g) Rashtriya Bal Swasthya Karyakram (RBSK) - Health screening and Early Intervention Services

j) Universal Immunisation Programme (UIP) :

In India, the Immunization Programme began as the Expanded Programme of Immunization in 1978 and gained momentum in 1985, becoming the Universal Immunization Programme (UIP), which was phased in to cover all districts by 1989 - 1990. In 1992, the UIP became part of the Child Survival and Safe Motherhood Programme, and since then, immunization activites have been a major part of the National Reproductive and Child Health Programme. Since 1997, immunization activities have been a major part of the National Reproductive and Child Health Programme. In 2005, the National Rural Health Mission (NRHM) was launched, and as of today, immunization is one of the main areas under the National Health Mission (NHM).

k) The Integrated Child Development Service (ICDS) Scheme :

This plan is well - known. The ICDS is a federally - sponsored program run by the union and state governments that offers children pre - school education, immunizations, and extra nourishment. It is one of the biggest programs in the world, offering a comprehensive range of services for a child's whole development.

IV) Comparison of Maternal Child Health Care Initiatives Comparison of Maternal Child

Colonial Period	**After Independence**
More individual voluntary efforts	Where state is most responsible

Lack of organized planning	Policies and programmes are in organized Way
Fund was initiated	State had taken liability of finance
Women Missionaries play important role	Government play important role
Encourage of institutional delivery through hospital and dispensaries	Something has been carried by many maternal child health, program maternity
Services provided through charityorganizations catered to the needs of the upper - middle - class women and majority marginalized women left	But the after independence many maternal and child health programmes cover all women form all strata and more focused on the marginalized groups.
In the colonial period maternity practices and frames programmes are based on British curricula.	This was also seen after independence also.
MCH initiatives were not specific, systematic and target - oriented.	But after independence, these initiatives were specific systematic and target - oriented.

Conclusion

Maternal health is a key indicator of women's health and status, and it is a major public issue and an important indicator showing the level of social development also. The definition of women's health differed along with variations of policies. Historically, it was the State's emphasis on maternity health that focused attention on women's hea;th issues. Maternal and Child

health refers to the health of women during pregnancy, childbirth and the postpartum period.

The colonial era was marked by more individual voluntary efforts that lacked organized planning pertaining to MCH. India, on attaining independence, embarked upon the 'socialist pattern' of planned development and the health services, as 'the foundation of all things' found key attention for the socio - economic development process.

On the basis of the recommendations and suggestions, different programmes and policies were framed through five - year plans. These five - year plans help for the development of the health of its citizens. Many different initiatives were taken with respect to mother and child health. Ms. Rani Laxmibai Rajwade one of the committee members in charge of different aspects of maternal and child welfare services claimed that in case of health, maternal and child health should be given first preference and funds should be allotted for this, major Health committees such as Sokhey committee, Bhore committee, Das Gupta committee, Model Public Health Act Committee, Mudaliar committee, Shah committee, etc. constituted to address the MCH and direct and indirect suggestions for improvement of maternal and child hea;th programme.

Inititally, the first and second five - year plans had addressed maternal and child health indirectly but nothing was done in the third and fourth. But, the fifth five - year plan made the efforts to integrate FPP & MCH and nutrition services. So maternal health was seen as an essential component of child development in the fifth plan. The sixth plan gave more importance to maternal and child health rather earlier plans. The Eighth five - year plan gave importance to reproductive health.

Overall, five - year plans, directly and indirectly, are related to maternal and child health programmes. These programmes gave

much importance to mother and child health. It is a one - way process in case of the gender process, but make participation is also very important.

After the independence period, India became a World Leader in medical advancement due to its incredible medical education. Many committees have constituted suggestions for the improvement of the health of the citizens. Maternal and child health is also given importance through implementation programmes, policies and initiatives of Five - year plans play a very important role in them. On the basis of the recommendations and suggrstions, different programmes and policies were framed through five - year plans.

Major Health committee had given important suggestions for the improvement of the health of mother and child, directly and indirectly. The sixth and seventh plans gave more importance to maternal and child health rather than the other plans. Millennium Development Goals also focus on improvement in maternal and child health and reducing infant and maternal mortality. Family planning Programme and National Health Policies also focuses on maternal and child health.

Major maternal and child health programmes play important roles in reducing maternal, infant, and child morbidity and mortality in the population. NRHM programme is one of the important which focuses basically on maternal and child health. Overall, since independence, many programmes have been implemented towards improving the health status of mothers and children.

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Accredited Social Health Activist (ASHA) and Covid-19 Pandemic: A Case Study on the Roles and Challenges of ASHA Workers of Kottukal Primary Health Centre, Thiruvananthapuram

Greeshma T.K.* &
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Abstract

Accredited Social Activists (ASHA) represent Kerala's rural health structure. When the COVID-19 outbreak hit Kerala, ASHA staff were at the forefront of defending the state from its spread. They conducted house inspections, COVID surveillance, immunization programs, preventative medicine distribution, early disease diagnosis, and patient quarantine etc. ASHA workers are successful as health practitioners who may address socio-cultural

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issues at the community level during a pandemic. They generally represent the primary healthcare system's public face. In addition to these responsibilities, they are coping with a variety of personal and professional issues. They receive the lowest payment among all healthcare professionals. They worked in unsafe and difficult environments during the pandemic. ASHA is improving our society's health-care system, and despite the hardships they confront, the vast majority of them continue to work without complaint.

Keywords: *ASHA workers, COVID-19, Challenges, Role, Primary Health Centre, MGNREGS, Outreach Programmes, Monitoring, Surveillance, Contact Tracing.*

Introduction

The Alma-Ata Declaration (1978) established a significant milestone in the field of public health and gave rise to the global notion of "health for all." In order to fulfill the objectives of Alma-Ata, several nations, including India, implemented health policies and initiatives from the grassroots level. Following this as a part of the National Rural Health Mission, India started the ASHA program in 2005–06 to ensure primary health care provision in rural areas. In India ASHA program were firstly introduced in 18 high focused states and eight north eastern states. In Kerala the ASHA programme has been in existence since 2007, with the goal of enhancing basic health care (Sankar Hari et al, 2024,). Kerala has long suffered from a wide range of infectious and noncommunicable diseases, but it has also been successful in controlling many of them in their early stages of development. such as Chikungunya, H1NI, dengue, malaria, and other vector-borne illnesses etc. (Government of India 2022). In light of this, on 30January 2020, medical experts, including ASHA employees, have been working to eradicate the corona virus ever since it first reported in Kerala (Datt, 2023). Particularly the emergency

preparedness of Kerala's health sector during the NIPHA, helped to control the spread of the Corona virus in the first lap through the use of already prepared protocols. The health sector began active surveillance, opened control rooms right away under the supervision of district collector, and began monitoring patients and their medical histories. This proactive public health approach and decentralized healthcare system, which includes CHC (Community Health Centre) and PHC (Primary Health Centre) involvement in the fight against virus spread the state were able to minimize the transmission of viruses at the first and second levels of infection. particularly through the work of dynamic professional network of ASHA staff members. They received training on COVID-19 and post-COVID-19 clinic diseases. Thus, as part of the surveillance plan, PHCs (Primary Health Centers) assessed symptomatic individuals and promptly took further steps to prevent the spread.

Accredited Social Health Activist (ASHA)

Accredited Social Health Activists (ASHA) were first established under the National Rural Health Mission's (NRHM) flagship scheme, which was introduced in 2005 (Patley et al,.2021). ASHA has been deployed for every 1000 people in rural areas and for every 700 people in mountainous and tribal areas (Swathi.et al, 2018). More than 20,000 persons in Kerala hold this position. They are voluntary employees who receive performance-based payments. They serve as an intermediary between the public and the medical system. They primarily supervise the outreach initiatives of primary health facilities and make sure patients have access to these services. Home visits, vaccination campaigns, promoting family planning, holding health education classes, dispensing preventive medication, and gathering health records for the community are just a few of the key duties performed by ASHA employees. They act as the health educators for the neighborhood on matters of public health.

(Vayalil Khadeeja, 2021). ASHA workers are selected from their village community itself. ASHA must primarily be a married, divorced, or widowed female villager. preferably between the age of 25 and 45. She should be literate, and those who meet up to 10 qualifications should be given preference when hiring (National Rural Health Mission, 2014). Although in Kerala ASHA program has been began later than in other states but the plan has made great progress in the last two years. The major role played by ASHA workers in a PHC is to act as a link between a community and a local health institution and ensure primary health care service in their locality. They also make sure of maternal care, child immunization, new-born care, and the prevention of communicable diseases in their locality. They also work against TB and the core monitoring with regard to health promotion, sanitation, and hygiene and make the community a healthy living place. Up until July 2009, in Kerala there are 30909 ASHAs have been chosen, and 27904 of those had received field introduction training. The National Health Mission states that rural areas require 30927 ASHA staff. Based on data from 2019, 26057 ASHA workers are employed throughout Kerala's rural districts, helping to improve the health of the residents (National Health Mission, 2019).

According to Government of India regulations, drug kits are given to ASHA, containing a set of drugs and equipment's and various products enable her for basic level care of the community (National Rural Health Mission). Two districts of the state have started a specific pilot programme on managing non-communicable diseases where ASHA staff members have received the in-depth training and tools necessary to manage NCDs (Non-Communicable Disease) at the community level. Likewise, ASHA has helped in creating a network of community volunteers and NGOs (Non-Governmental Organizations) in awareness campaigns, early detection, follow-up, and palliative care activities

as part of a comprehensive decentralized cancer care program (Arogyakeralam, 2022).

Relevance of the study

ASHA workers' contribution to Kerala's health during the pandemic is greatly valued. During the period when someone sneezes in their neighborhood, ASHA employees should be the first to call; if one enters the ward, she will be the first to know. They monitor persons who exhibit early symptoms, collect health data, inspect residences, assist the department in identifying infectious patients, and maintain home quarantine facilities in such locations. They also prepare daily reports on the state of local health and submit them to higher officials, which aids in monitoring the local health situation. She now plays a significant role in the Rapid Response team as an information provider. However, they do not receive adequate compensation for their work and are not acknowledged as holding a regular post in the health department. The majority of them struggle to gather information from their communities, and the lack of vehicle service makes things even more difficult for them. However, they are still working because the majority of them see this as a service as well. But they weren't paid fairly for the labor they perform. Beyond words, ASHA employees in rural regions have made an essential contribution to improved health care utilization and women's and children's health care development. In their communities, ASHA successfully carried out her role as health educators, counsellors, and promoters. The present study attempts to evaluate the role of ASHA workers and access their activities to understand how much their work is helpful in controlling the Corona virus in their localities. Thiruvananthapuram is one of the places in Kerala where repeatedly various virus clusters forming, reporting of West Nile fever, dengue, Zika cluster, and Omicron virus detection have been made so far. ASHA employees are providing various support to combat against this infectious

disease in every community. These services they offer are for the general public's social security. Their societal responsibility extends beyond COVID-19 preventative initiatives.

Research Questions

1. What are the range and scope of the activities of Accredited Social Health Activists in Kottukal Primary Health Centre.
2. How ASHA employees enacted throughout the pandemic and whether their remarkable field experiences have enabled them?
3. What were the main obstacles that ASHA employees had to overcome throughout the COVID-19 era

Study and Context

A qualitative study was conducted at Kottukal Coastal PHC in Thiruvananthapuram district. The main information was gathered in February 2022 over the first and second weeks. primary sample was obtained using an interview schedule from eight of the thirty-two ASHA workers at Kottukal PHC.

Life and Work of ASHA workers

Kottukal is a coastal PHC (primary Health Centers) that was founded in 1994 in Thiruvananthapuram district. It has since been upgraded from PHC to FHC. The population of the panchayat is approximately 35480. The OP (Outpatient) consultation of this PHC is start from 8 a.m. to 6 p.m. There are three consulting doctors in the PHC, along with 32 ASHA employees and 11 JPHN employees. Among these 32 ASHA employees, eight AHSA employees who are willing to engage in the study were chosen from among the ASHA employees who have been doing their duties in the outside field since the start of the Covid preventative duty. Particularly those who have been employing since the initial

recruitment period, which occurred from 2005 to 2012. The ASHA employees who took part in this study are: *Lekha* began working as an ASHA in 2008, and *Punnakkulam* is her ward. ASHA employee *Ambili* started working in 2008. She representing *Maruthoorkkonam* ward. *Sajothakumari* representing '*Thekkekonam*' ward and she entered in job 2010.The ASHA employee *Sreekala* is in charge of the *Payattuvila*. She began her career in 2010. '*Manakkad*' is overseen by *Sheela*, an ASHA employee. She began her career in 2011.The ASHA worker *shibi* is positioned in the *Chovvara*. Field work for the *Office ward* is handling by ASHA employee *Kala*, who began employment in 2010. *Mannottukonam* ward is under ASHA worker *Latha*. The health seekers acknowledge that ASHA, who periodically check about their health status through home visit, is the visible and main health worker in their locality. Kottukal PHC is located close to the seaside regions of Poovar and Vizhinjam and has 19 wards. There are two ASHA employees per ward. They go to a minimum of 25 and a maximum of 50 residences each day. ASHA workers' primary responsibility is to check on their patients' health status on a regular basis through home visits. During the epidemic, they visited one residence more than twice a month. They also conduct health awareness programs at Kudumbasree meetings place and at the Anganawadi Centers, MGNREGE employees work site, Gram Sabha meetings. They provide nutrition education, Corona virus classes, preventative medicine distribution, environmental cleaning, special care for the elderly and young, prenatal vaccine coordination and delivering special attention for children and mothers in the locality.

The Role Played By ASHA Workers In The Locality During Covid 19

Role of a General Health Worker

ASHA staff are both frontline healthcare professionals and COVID-19 fighters. People were concerned about an

unanticipated pandemic outbreak and the resulting lockdown. But medical professionals, including ASHA, worked day and night to treat the sick patient and preventing the infection from spreading. Throughout the pandemic, ASHA workers go out into the fieldwork and every day to home visit. They also worked on PHC health initiatives and coordinated Panchayat health services.

"*Those were really difficult times, with the pandemic spreading quickly. Health professionals ought to lead the campaign to end it. Our surroundings are coastal areas where sickness can spread quickly. I considered how to manage marketplaces, businesses, and seaside locations where people are constantly interacting. Alongside this, standard outreach home care for obstructions, NCD patients, immunization, post-natal care, etc. were also handled."* Lekha, ASHA coordinator remembering those days. (Field work, 22 February 2022)

Throughout the COVID-19 era, front-line healthcare providers encountered a range of situations. Impacts of anxiety and depression are documented globally. due to the variety of harsh experiences, they had with COVID-19, the risk of infection, having few resources, stress at work, etc. (Fernandez Ritin et al, 2021).

Role of a Health care 'Warrior' during Covid 19

During the pandemic time the Medical Officer of PHC provides ASHA staff with a list of COVID-19 patients, including those in quarantine, primary stage patients, and recovery stage patients in their ward. Therefore, in addition to keeping in touch directly through house visits, they also contact each family to query about their health status at different phases of the disease. ASHA workers were aware of the physical and mental trauma and suffering in their people in the communities, they communicated with the families frequently about the people's health activities as well as how they cared for the family members

as if they were their own. To prevent the disease from spreading on a large scale, they were regularly conducting contact tracing, early disease surveillance, collecting data on quarantine people, patient follow up, cleaning the environment, attending meetings, coordinating efforts with Anganwadi and self-help groups. They also provided routine care to the new born and mother, during the pandemic period.

Ambili (ASHA worker) remembering *"It was extremely difficult for us to work both inside and outside of PHC during the COVID period because we have never performed this much clinical work before, even though we have basic training in medical services. It is also a new experience to have to comfort patients in panic situations in addition to adhering to standardized protocols and precautions"*.

In the initial stages of COVID-19, healthcare professionals are not aware of the virus, have minimal understanding of how it spreads, and are not as knowledgeable about its variations or preventative measures. Every day, their workload increased more and more. Concern about whether it has infected them has also grown. They therefore needed additional financial, technical, and training help, (Salve p Cited in Krisna Sneha, 2022*).*

ASHA worker lekhha says "We took self-precautions during the first wave to prevent the spread of disease through bodily fluids, broken skin, blood, etc. but we also had to perform activities like cleaning the needle, sanitizing the area, making sure that safe anti-management was in place, and also done chlorinating the well during that time. Since we are the only medical professionals that visit patients in quarantine, we were forced to take up these tasks once more during home visits. "

Latha explains, *"The continuous usage of personal protective equipment (PPE) put us in a difficult situation because many of us were using PPE kits for the first time, which was*

unsettling and suffocating. Managing patients in this tight scenario is a herculean undertaking, and many of our colleagues had suffer".

Role as an outreach Service Provider

The outreach initiatives that ASHA staff members carried out in the wards during COVID-19 were especially noteworthy. During that time, ASHA workers were also responsible for locating those who were likely to have positive cases through active local visits, ensuring quarantine activities and active regular surveillance of patients and their families, and updating the department head's daily information. Through the Chief Minister Pinarayi Vijayan's press conference, people frequently saw the results of this procedure. Since camp activities have already stopped, their normal patients received their medication and check-ups through ASHA workers home visits. Preventive medication distribution was ASHA done with the help of self-help organizations. ASHA employees were routinely ensured ward-based announcements and home-to-home notice delivery for COVID-19 actions. At that point, health officials ceased inspecting the local marketplaces and shops, so local self-government sanitized the areas with the assistance of ASHA workers. In certain wards, ASHA workers were able to influence people's attitudes towards patients during the initial phase of the virus's spread. Especially service providers like milk suppliers and newspaper distributors, neighbor's non cooperative attitude towards patients. Then ASHA workers acted as a bridge between those families' problems and those of outsiders.

Sheela detailed the days of her outreach initiatives. "*Many times, I need to buy food for various patients, prepare meals for them, and counsel patients and their families. Patients periodically provide me with copies of their ration cards over the phone so that I can purchase commodities and groceries for them. Home*

visits help us to give better care, particularly for the elderly and youngsters under the age of 10".

ASHA workers have played a number of roles in COVID-19. In particular, tracking down contacts, gathering data on the people under quarantine, supplying necessary medications and other services, setting up a food facility, etc., (Vayalil Khadeeja, 2021.

Role of ASHA inside Primary Health Centre (PHC)

Like outer locality management, their internal PHC work is remarkable. Even if fewer patients were coming PHC directly for consultations, it was extremely challenging to manage them during that time. The patients were anxious and concerned about how the diseases would affect them; they had to wait a long time for consultation; they were unable to speak adequately with medical professionals due to contact avoidance, and so on. At the time, there were many doubts and confusions, particularly among the elderly. They continuously check the availability of their medication; if there is a delay or unavailability, the ASHA is responsible for getting and delivering the medications. Along with this ASHA also paid special attention to pregnant women and postnatal care. When PHC's vaccination drive is in action, ASHA regularly contacts those folks to remind them to get their vaccines. They specifically gave nutrition education classes in these homes, as well as information about the benefits of breastfeeding. They also accompany nursing experts when they providing palliative care services, patient wounds dressing, conducting health examinations, and so on. ASHA personnel are also responsible for collecting e-health information from individuals on behalf of the health department. Newborn registration, health updates of COVID patients, and surveillance information's are also collected and reported to their head authority, which allowing the

department to quickly reach individuals who require medical attention the most.

Sreekala stated, "We are very disappointed in the way people behaved when we first started the covid clinic at PHC. There was no communication at times since everyone was in a hurry, both of us were unable to spend time, could not renew the acquaintance, and some patients resisted our touch out of fear. However, some patients were willing to work with us and adapt to any situation."

Activities through Social Media

The role played by social media with these times is priceless. Regardless of having limited digital literacy, ASHA workers used their smartphones to handle a lot of the PHC activities at the time. They visit patients' homes and assist them in contacting doctors as necessary. They buy medical data from labs and send them on social media. Help patients who require online medical appointments from medical colleges. Send surveillance report and patient data to the medical department at the required times etc. They solved numerous medical problems by using social media local groups, self-help groups, and kudumbasree media groups in their community.

Chovvara ward ASHA workers Shibi says, "At the span of time, our MO (PHC Medical Officer) was quite helpful. She used to consult elderly patients via video call and prescribe medications by phone; we sent lab and test results over WhatsApp, and she checked and provided information via phone conversations. Phone contacts were useful in situations of emergency for calling an ambulance, arranging patient shifts, scheduling visits at higher medical institutions and using video chats to contact covid patients and monitor their medical levels throughout the day and night. Without mobile phones and social media, I don't think this kind of management was conceivable at the time".

Social media was crucial in supplying accurate, reliable information that assisted in combating false information and rumors. updated monitoring of social media through data collection and sharing facilitates timely and appropriate government and health agency intervention. (Tsao Shu-Feng et al, 2021).

Health Care Activities through Self-help Groups and other Organizations

Anganwadi workers helped to coordinate the health care service of pregnant ladies. They visit pregnant women's homes every few weeks to check their blood pressure, blood sugar, and high stress, give out iron supplements, and conduct regular health classes. They also organized family planning education sessions for married girls and adult clinics for girl children. Classes on exercise for normal menstruation, personal cleanliness and eating habits, and marital counselling are also provided to single girls, however, class time is reduced during pandemics. One of the most important aspects in assisting the health department means help to track down the history of patients under quarantine in every community through health registration. They helped us collect those data. They coordinated Covid prevention activities with NSS organizations and resident associations. Self-help groups cooperated in the placement of notices on school walls, conduct neighborhood interactions, and the coordination of covid prevention actions with other organizations.

ASHA worker Sajitha Kumari spoke more clearly on the collaborative activities with MGNREG and Anganawadi workers. She remarked, "*We all work in the same ward, and our friendship helps a lot. They contribute to environmental cleanup, participate in seasonal health activities, and assist in the implementation of women and child programs. They can swiftly gather data since there is a significant self-help group chain in the area, making it*

easier to provide health classes, these contacts helped collect quarantine details, information was efficiently passed through self-help groups, preventive medicine was distributed, and so on."

Self-help groups in India, such as Kudumbasree in Kerala, have also been more prominent after COVID-19. They assist impoverished communities by offering funds and supplies banking services and by filling the need for masks, hand sanitizers, and protective gear like PPE kits. They efficiently manage community kitchens. Their contribution is therefore noteworthy, (World bank feature story, 2020)

Role of a Health Supervisor in Events

Another important role they performed during that period was to visit places, to coordinate preventive activities where large crowds could gather for private meetings or where social events, like weddings, have occurred. Before beginning the function, ASHA workers visit these areas to provide critical health advise and preventative measures, Covid instructions, protocol compliance, and sanitation facilities. ASHA workers must visit households as a preventative measure during a pandemic, regardless of time of day or night, especially in cases of reported deaths. They ensure that people keep a social distance and decrease the risk of virus transmission. According to COVID policy, they can leave the region only after completing all COVID 19 formalities linked to the case.

"People management is a challenging task in "Kalyanaveedu" at that time. People are never aware of the restrictions and laws that have been put in place when they are experiencing happiness and delight. Because of this, we have to keep them distance, remind the use sanitizer, monitor the whole area etc.". Latha added

Activities through Local Self-Government

At this time, ASHA workers never skipped their home-to-home visits, despite the high danger involved. During the visit, youngsters under the age of ten and seniors over the age of sixty were given particular attention. At that point, the PHC physician and nurses would check in with the patients to see whether ASHA saw any unusual changes in their condition. In addition, they ensure that elderly people living alone have access to food and notify the Panchayat of any problems. In an effort to monitor the health of the community and stop the coronavirus from spreading, Panchayath also assisted ASHA in compiling thorough COVID data for every house she visited during the home visit. During every house visit, they take care of cleaning the surroundings, especially removing standing water. In collaboration with ASHA staff, panchayaths took the lead in sanitizing homes and outer places.

Kala opens up "When we complete all of our reports and get to Panchayat It is evident that they are making a concerted effort to stop the infection; they accompany us on house visits and ask about people's needs. They provided thoughtful support during that period". Shibi ASHA worker remembers. *"They supported us against every challenge, including political pressure, party differences, governance, and authority structures. We're still preserving those relationships."*

Research has showcased how every Asha employee concurred that they coordinate and communicate well with Panchayath. They also assisted in inspiring the locals and raising awareness of hygiene, cleanliness, and sanitation (Meena Sadhana, 2020).

The Challenges faced by ASHA Workers During the Covid-19 Period

Economic Difficulties

The main problem that ASHA workers face is that they are still not "recognized" as health department employees. The majority of people earn only 5,000 each month from this life-challenging and priceless job. This is also paid from the NHRM fund; however, it may take some time for them to receive it. They do not have a separate budget or savings fund; therefore, these kinds of discrimination affect their self-esteem.

"*At times, we work long shifts, both day and night, quarantine visits, follow up with patients, gather surveys, and review their health reports. At other times, we have to spend money on groceries and medicine for underprivileged patients. We also struggle, but our pay is extremely low, and the honorarium is arriving much later than expected. I'm not knowing how we managed those difficult times with insufficient money";* Ambilli ASHA worker says.

In a 2022 Rajya Sabha question answer session report on the subject of improving the pay of health care providers, it was said that various policies and government incentives had been approved after covid for ASHA to provide better financial security and a good wage (Ministry of Health and Family Welfare. 2022).

Geographical difficulties

During the period, fieldwork is a risky task. Each ward has a distinct geography. Despite the fact that the location is on the coastal area. There are difficult uphill terrains, wide outlying fields, and uninhabitable areas. During lockdowns, without the support of personnel or vehicles, ASHA worked alone in such areas. Another concern about ASHA is that they are confronted with

animal and reptile problems on a daily basis as they pass many residences and go through many areas and geographical locations.

Jasminlatha complained that "*We did not have transportation service during this time, so we walked to ensure home visit service. We faced with periodic physical tiredness, menstruation troubles, and dietary issues. However, we continued our efforts to prevent the dangerous virus from spreading. I believed that my society responsibilities were far more essential than my own difficulties."*

Health professionals are vital to the health system as a whole, but they also confront a variety of challenges, such as unsafe patient management, occupational danger, psychological risks, violence, harassment, and injuries, as well as limited access to safe drinking water, sanitation, and hygiene difficulties (World Health Organisation, 2022).

Difficulties faced by ASHA's Family

The sacrifices made by ASHA personnel during that period will never be forgotten. Most ASHA personnel are part of a nuclear or extended family. During lockdown, children stay at home, older parents demand support, and some breadwinners in ASHA workers' families lost their jobs, among other things. ASHA workers had no specified or fixed shifts at that time. As a result, they are forced to work both inside and outside PHC day and night, without regard for their families. They never had leisure time or spent meaningful time with their families because they were constantly working. They were exposed to COVID from the workplace more than once. Families were also affected by this.

Ambili, with tears in her eyes, said, "*My son helped me to travel to the fieldwork by using his two-wheeler. He escorted me to the wards and quarantine homes*". Sreekala, an ASHA

employee, went on to explain, "*My 'ettan' (husband) takes care of the housework while I'm away. He accompanied me at places where individuals were cremated, places where weddings were held, and gathering places,"* she smiled.

Even if their earnings are lower and they must balance personal household responsibilities with PHC's healthcare service activities. Nonetheless, they were very satisfied with their outcomes of the work (Mascarenhas Anuradha, 2021).

Safety concern

ASHA workers view their work as social labor done for the benefit of society. Only a small honorarium they received for working day and night during COVID 19. During the outbreak, the Panchayat primarily provide masks, gloves, and hand Sanitizer as safety amenities from the PHC, or health department. Later on, they didn't get these materials on time, and the number of materials become decreased. They have worked at times in the fieldwork with no facilities.

"When others began to live together during the lockdown, we sent our family members to relatives home due to safety concerns". Latha says

Resistance of Individuals

The refusal of local residents to cooperate is another issue they experienced during COVID-19. ASHA employees always advise individuals of the precautions to take in order to avoid the sickness as well as the directions provided to them to notify them if any signs are noticed. If people are not properly informed or do not follow their recommendations, they may only then approach them as soon as possible and take all applicable measures regarding this. which, in some instances, the dismissive attitude of people results in positive cases, this causes authorities to lose assurance about the contributions made by health professionals.

During this period, MGNREGS employees also failed to follow health specialists' recommended care requirements.

"Prior to the epidemic, house visits were a source of great joy for us, aside from being a duty. But throughout the pandemic, I felt alienated from the rest of the population during field work. There are no crowds or people on the pathways, which occasionally generated fear in me." Sheela said.

ASHA employees had to deal with social, economic, and personal obstacles in their daily lives. They are still driven to work. However, there are a few things that demotivate them at work: remote locations, a lack of roads, and inadequate transportation systems etc (Bist Rani Rekha et al., 2023).

The Challenges of Workload

Their workload was still an issue at that time. ASHA employees says that they must carry all stationery alone when they visit schools, neighborhoods of homes, offices, and residence-association offices to post notifications or pamphlets concerning COVID health care activities. Nobody else PHC representatives accompanied her. But the community aided them in putting out notices, and banners. pamphlets in various places. They had to undertake house visits, report preparations, enquire about patient quarantine actions, conduct monitoring, and promote health activities on their own, with no additional aid. They have also been assigned nighttime responsibilities. If any reported deaths occur, they use their families' aid to get there. They organize all the legalities and sometime are stuck in such locations on their own, yet they complete all of the responsibilities and submit the reports the next day without complaint.

Sreekala says "*It's our duty and responsibility, but in the midst of an epidemic like this, I understand that social bonds and responsibilities can often outweigh material success and*

prosperity. These days, it's more than just a job I can see a commitment to society as well."

ASHA representative brings a diverse societal group together under a single component of health care. Even though there are people facing numerous disparities in society. ASHA never permitted them to experience both health and social inequalities, at least during the pandemic.

Conclusion

ASHA workers provide essential support to India's public health system. ASHA workers are the primary healthcare providers at the community level. They worked consistently to ensure the safety and health of Kerala residents during the COVID-19 pandemic. They are skilled in contact tracing, monitoring, and surveillance processes, which aid in the prevention of disease spread, particularly during pandemics such as COVID-19, NIPHA, and ZIKA. As a result, ASHA staff were acknowledged at the 75th World Health Assembly for their vital role in ensuring everyone has access to basic primary care services and connecting communities with the health system. They were also recognized as one of six recipients of the 2022 WHO Director General's Global Health Leaders Award for Health Protection and Promotion (WHO, 2022). The contributions they made to the health division during the COVID-19 period are endless.

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Kerala During the Pandemic Times of NIPAH: A Case Study

Anishia Jayadev *

Abstract

Every societal distress, be it environmental, social, political or health, comes with a great opportunity to devise a solid strategy to contain or take care of future instances of occurrence. Education and scientific priming of the community and conscience building which is replicable will not only help that society but other societies as well. The only effort to be exerted is to extrapolate and customize the available model. Kerala, the state under discussion was thrown into the mouth of health and natural disasters, with public health dimensions for the past 5 years continuously. Still fighting with Covid 19 and the whole world, Kerala has developed

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its model of recouping from the disaster. Fourth time, the state again managed comfortably, the threat of Nipah and dealt with it phenomenally well.

Keywords: *Social Activism, Volunteerism, Surveillance and Contact Tracing, Societal Grouping, Social Network Theory*

Introduction

Kerala, the state under discussion was thrown into the mouth of health and natural disasters, with public health dimensions for the past 5 years continuously. Still fighting with Covid 19 and the whole world, Kerala has developed its model of recouping from the disaster. Fourth time, the state again managed comfortably, the threat of Nipah.

The state of India with the highest Literacy rate, the lowest rate of committing 'Violent crimes', of lowest Infant mortality, the best health care facility, the highest Average life expectancy, good Transportation faculties and good religious harmony, it excels in disaster management also. An attempt is made to analyse how Kerala as a unit of administration and governance faced three disasters, an epidemic of highly infectious lethal disease, in its unique way and ponder possibilities of scalability and reliability.

Methodology

The present study is qualitative, considering the state of Kerala as a case, based on secondary resources, and aims to analyse the various trajectories of Kerala's battle against the NIPAH. The study primarily aims to make solid inferences about the social, economic, political and physical impacts made by the above-mentioned natural calamities and diseases in the state. The study also tries to document how the Kerala state was able to survive in those challenging conditions.

The present study also focuses on the social and economic impact of the disasters and various political, administrative and social

responses to them. The researchers have adopted case study and content analysis methods to make inferences and conclusions from the data collected through various secondary resources. It also highlights the social network theory, and how networks aid in appropriate governance strengthening.

The secondary data were collected from various resources such as books, online offline journals, newspapers, government websites and health reports from WHO and other governmental and non-governmental organizations.

The Case of Nipah

Nipah virus (NiV) infection is a newly emerging zoonosis that causes severe clinical manifestations and high mortality. The Bangladesh strain of NiV infection in humans usually leads to acute respiratory syndrome and fatal encephalitis, even if asymptomatic infections are also reported. The Malaysian strain of the virus has comparatively low mortality rates. Several factors are responsible for zoonotic outbreaks, such as intensive livestock farming and agriculture, using wildlife as food sources, clearing land for farming and grazing, human encroachment on wildlife habitats, international trading of exotic animals and urbanization, leading to more human–animal and environmental interactions.

Nipah took away seventeen lives in its first appearance in May 2018. The entire public healthcare system of the state got stuck for a while because, until that day, the system had no idea of the origin and ways of the strange, fatal disease. Soon the entire system initiated effective steps to prevent and control the outbreak. Initially, the healthcare professionals and personnel were completely in the dark. They took some time to confirm and find the disease and its origin. All the reported, confirmed and casualties were from Kozhikode and Malappuram districts of the state (PIB, 2018).

The health department of the state was able to confirm the disease in close contact with the suspected primary case, within two weeks of the demise of the primary case (suspected). The virus detected was a deadly variant of the Bangladesh strain of Nipah. The experience of Kerala was one of the few instances Nipah was diagnosed in a very short time, during the growth of the outbreak itself. The entire healthcare system of the state was thrown under immense pressure following the diagnosis of Nipah, but the system responded to the crisis well. The various documentation of Kerala's fight against the debut Nipah infection is there in the public domain. Exactly one year later the Nipah virus had claimed seventeen lives back in May 2018 the virus has re-emerged once again in the state.

A Twenty-three-year-old student who was from Ernakulam district was being diagnosed with the Nipah virus and had been hospitalized in May 2019 (Varma Vishnu et.al, 2019). The student was admitted to a private hospital on 30th May 2019 and his samples (throat swabs, blood and urine) had been sent to the National Institute of Virology Pune and tested positive for the virus on June 4. Soon after the confirmation of the disease in the virus-infected patient as a precautionary measure, the authorities kept 311 people who were suspected to have come in contact with the index case (first infected patient) under medical observation to prevent the spread of the virus. The state government put four districts such as Ernakulam, Thrissur, Kollam, and Idukki on high alert as the student (index case) had reportedly travelled through the region recently. Apart from the student (index case), four people were admitted to the Government Medical College Ernakulam with symptoms like fever, cough, and headache, and later tested negative. Since the confirmation came from the NIV Pune the state government has taken effective precautionary measures to prevent the virus from further expansion by tracing the contact, setting up isolation wards and enhancing the medical infrastructure facilities at major medical colleges in the state.

Two healthcare personnel who had a history of contact with the infected patient exhibited symptoms and they had been given proper treatment and kept under surveillance. Containing the spread of the Nipah virus is very crucial to limit the casualties. As in the case of most Nipah outbreaks all over the world, the source of virus infection in the index case remains unknown in the state. However, it's been found that the growth of the outbreak through secondary cases is via human-to-human transmission. The state feared the spread of infection to other districts. So samples of seven suspected patients including healthcare personnel admitted at the isolation ward of medical college Ernakulam and their samples were sent to the National Institute of Virology Pune for examination. As a huge relief for the state, the blood samples from the suspected Nipah patients have tested negative, the Minister for Health, the government of Kerala had officially announced the report from NIV Pune at a press conference. Along with the strategies to control the spread, a special medical team was constituted and they lead the management of suspected/confirmed cases to ensure zero causality. The medical team had formed a protocol to curb the disease from its initial stage and decided to keep vigil for a while. An expert medical team from AIIMS (All India Institute of Medical Sciences) arrived at the state and conducted an in-depth scientific investigation at various locations to find out from where the index patient was infected with the Nipah virus. The special medical team constituted by the state government also conducted various inspections at different locations to identify the source of the virus and its reservoirs. Intensive investigation revealed the presence of the virus in fruit-eating bats even if the exact mechanism of spillover is not known.

Once the disease was confirmed, the health care department had taken effective measures to restrain the virus infection from further expansions. The effective and well-coordinated efforts of healthcare institutions from both the public and private sectors propelled the mission of preventing the Nipah virus. Healthcare professionals and personnel from both the private and public sectors organized together

in every phase such as planning, implementation, and monitoring of actions about the alleviation of disease and treatment of the Nipah-afflicted patients. The state government sought advice and instructions from medical experts both from inside and outside the state and country to frame strategies to prevent the disease and transmission of the virus. The state got help from the union government and other national and international organizations such as the World Health Organization in the form of instructions, equipment, and instruments for the mission Nipah virus.

Precautions, Prevention, Care, And Control of Nipah- A Customizable Model Put Forth

The people were conscientious to

¬ Avoid eating fruits which had been bitten by birds and other creatures

¬ Avoid natural drinks such as toddy which are taken directly from natural resources like trees and others, if not pasteurized

¬ Those who show symptoms like fever, cough, breathlessness and headache keep distance and avoid physical contact with family members, friends, and others.

¬ Those who had symptoms were advised to seek medical attention as soon as possible

¬ Those who attended the patients, the familial care providers and healthcare personnel were supported psychologically and asked to stay at their respective residences and be vigilant about the development of symptoms, and they were under surveillance

¬ Things used by patients were kept separately and safely (food items, clothes etc,)

¬ Ensured the protection and safety of the water resources from the excreta and flux of bats

¬ Keep away from the pet animals and such animals should be secluded away from physical contact with fruit bats

The virus-afflicted patients' needs for intense care and treatment had to be addressed and they must be kept away from others to prevent the spread of disease. Apart from the patients, those who contacted with the infected people in the past and those who are still in contact with the patients will be under meticulous observation and surveillance. In the hospitals where Nipah patients are kept under treatment, other patients are allowed because the possibility of spreading infection is very high. There were separate isolated units would be arranged to provide treatment for Nipah patients. The visitors are completely prohibited from visiting Nipah patients. The healthcare personnel who are involved in the treatment process of Nipah patients will be equipped with high security and safety measures. Specific protocols were devised by the department concerning disease diagnosis, prognosis, treatment and pre-cautionary methods.

Societal and Stakeholder Response

An in-depth study conducted by Chandrasekharan, et al., (2020) reveals that public response towards this virus/virus-infected people was a mixture of fear, anger conflicting ideas, a sense of responsibility and humanitarian concerns. The unknown disease carried death with it. This induced in people, a fear psychosis. Dead bodies were not sent back home but were decided to be cremated by the Government. But electric crematoriums refused to cremate the bodies. Media added to the pandemic fear by exaggerating the news.

According to available information, the most appropriate intervention to control the spread of disease was to burn the body of the departed. Certain communities, which had beliefs regarding life after death, opposed the idea of cremation. The district administration in consultation with people responsible and religious leaders made some consensus like deep burial without compromising religious belief

and this was agreed upon. Religious sentiments were put aside by religious leaders and scientific vision and humanitarianism gained importance. When certain people turned hostile, like crematorium staff, many others stretched out their hands for rescue. The health staff, a couple of ambulance drivers, and sanitary workers chose humanity in front of fear. Their foremost concern was to prevent the spread of infection to others. They refrained from using public transport isolated themselves, from family and stayed alone.

Social activism and volunteerism emerged as a part of the mitigation of a contagious disease.

Governance.

Governance was most effective. Decision-making by the health care system was swift. To reduce spread a protocol was developed which could be implemented globally if such outbreaks emerge.

Body bags, N95 masks, personal protective equipment kits, etc. which were in shortage were procured. The shortage of human resources was managed by recruiting temporary employees and promoting volunteerism.

Funeral

Disposal of body safe is one of the most important steps to prevent a mass spread. In most other countries where such diseases broke out, due to social, cultural and religious reasons, people refrained from obeying the health system and governance instructions of safe burial. This led to harmful consequences (both for Nipah in Bangladesh and the Ebola in Africa) In Kerala religions give the funeral a sacred significance and for some funeral is a window to the spiritual world, for some it is reincarnation etc. This was compromised by the public after the decision and conscience building by Govt. The funeral was conducted in the district of Kozhikode itself. The agitations that arose were managed effectively. This was because of the proper

communication between Govt., religious leaders, local leaders and the public. People vote for the scientific approach. Thus, the Kerala model becomes a replicable one and suggests winning the confidence of the community and engaging and trusting them.

The system dealing with culturally acceptable scientific protocol gets accepted even by religious groups.

From September 12 to September 15, 2023, the Kozhikode district of Kerala experienced six laboratory-confirmed Nipah virus cases, including two fatalities, according to the Ministry of Health and Family Welfare of the Government of India. The other individuals were relatives and hospital contacts of the first case, whose source of infection is unknown. As of September 27, 2023, 1288 confirmed case contacts had been located, including high-risk contacts and healthcare professionals who are now subject to a 21-day quarantine and surveillance period. Six instances were positive for Nipah virus infection out of 387 samples examined since September 12; all other samples tested negative. No additional cases have been found since September 15th. Since 2001, there have been six outbreaks of the Nipah virus in India.

Enhanced surveillance and contact tracing, laboratory testing of suspected cases and high-risk contacts, hospital readiness for case management, infection prevention and control (IPC), risk communication, and community engagement are just a few of the multisectoral coordination and response mechanisms that state and national authorities activated to stop the spread of the outbreak.

The current outbreak of the Nipah virus is the third to occur in the Kerala district of Kozhikode, the fourth to occur in the state of Kerala since 2018, and the sixth to occur in India. This outbreak began with the initial case, followed by a clustering of cases in family contacts and possible nosocomial transmission in hospitals, similar to the previous outbreak in Kerala in 2018. Only Bangladesh and India

have reported Nipah virus outbreaks in the WHO South-East Asia Region.

Coordination: To assist the State and District administration in containment and mitigation efforts, the Departments of Health & Family Welfare, Health Research, and Animal Husbandry summoned numerous central multidisciplinary teams. There were established 19 core committees, each of which was given responsibility for a different aspect of the response, such as surveillance, sample testing, contact tracing, patient transportation, case management, logistics and supplies, training and capacity building, risk communication and community engagement, psychosocial support, and animal husbandry. To organize the reaction actions, the district's control room and phone centre were activated.

Surveillance and contact tracing: Active house-to-house monitoring was conducted by the district health authority in the specified containment zones as part of community-based surveillance efforts. As of September 27, 2023, 53,708 homes had been surveyed in total. As of September 27th, 1288 contacts, including high-risk contacts, had been discovered, quarantined, and are still being monitored. Every high-risk contact underwent testing. In nine villages in the Kozhikode district, containment zones with movement limitations, social segregation, and a requirement to wear a mask in public places were announced. Up until October 1, 2023, the government has prohibited large-scale public events in the Kozhikode district. States and districts nearby have received alerts for increased surveillance.

The Theory Behind Societal Grouping Against Nipah: The Social Network Theory

The focus of social network theory is on how social ties function as channels for information transmission, sources for media or personal influence, and facilitators of attitude or behaviour change. With the growing use of network analytic techniques in diverse empirical situations, social network theory has greatly broadened the scope of

media effects research since the 1960s. Three prominent theoretical frameworks that use network principles in explaining the flow of mediated information and its impacts are the theory of weak ties, the theory of the two-step flow of communication, and the theory of diffusion of innovations. All these are seen in containing the disaster.

Conclusion: This is why we say there is a Kerala model of healthcare

In any society, fear-related behaviour arises at an outbreak of a novel infectious disease. This is a normal adaptive social process. It may protect people from getting infected as they will opt to stay away from those who are infected. It is also common to get grapevine spreads of rumours when the disease is uncommon even to the healthcare systems. But, here, the concern and fear become advantageous to the system because people willingly kept social distancing and started self-reporting (Chandrasekharan, et al., 2020).

The breakout of the NIPAH virus in Kerala had its peculiarities which were unprecedented. Usually, the Nipah outbreak spread by human-human contact will not last long. The period of the Nipah outbreak will be for a few weeks or so. The issue is that it will be very difficult to diagnose the diseases during the outbreak. The disease will be revealed only in a later phase, though already collected and kept samples (Nikolay, B., & et al. 2019). By that time there would have occurred a greater causality. But in the case of Kerala, one of the very second cases, that is a person who contracted the virus from the first patient was identified, as a member of the family. At that time a few people who had been infected had met with death and the rest of them were hospitalized. The most positive thing was that the health services could trace out very early. This was a reflection of the robust healthcare system of Kerala. It is to be reckoned that the first case was identified in a private hospital, by a few doctors who suspected the possibility of the rare infection, Nipah. This shows the ability of the doctors to probe in-depth a clinical case by the doctors and health

workers and the system. The system in due course could trace out every individual infected with the virus or was having the symptoms of the disease, right before they reached the hospital, wherever they went, trace out the possible contacts, trace out places where the dead persons were cremated and a list was drawn upon. Even the timeline was charted.

With the help of the citizens, media and hospital records, the healthcare system could draw out the list of infected people and people who had the possibility of infection. Such an activity was done for the first time in the history of health care in the state of Kerala. For this, a method called SPACE TIME MATRIX was used (Patch JR, 2018).

In Kerala, the Nipah virus emerged in 2018 as a new threat to the health system and alarmed the state with consecutive appearances in the subsequent years. When the Nipah virus had its first outbreak visit, it accounted for seventeen casualties. It created absolute panic among the public and caused an imbalance in the healthcare system of the state. The later outbreaks were identified by the system on time. The authorities had taken effective precautionary measures and implemented efficient strategies with extraordinarily coordinated efforts to restrain the Nipah virus. Through well-coordinated and organized efforts, the health department of the state ensured the least casualties of the Nipah virus this year.

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Accredited Social Health Activist (ASHA) and Covid-19 Pandemic: A Case Study on the Roles and Challenges of ASHA Workers of Kottukal Primary Health Centre, Thiruvananthapuram

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Abstract

Accredited Social Activists (ASHA) represent Kerala's rural health structure. When the COVID-19 outbreak hit Kerala, ASHA staff were at the forefront of defending the state from its spread. They conducted house inspections, COVID surveillance, immunization programs, preventative medicine distribution, early disease diagnosis, and patient quarantine etc. ASHA workers are successful as health practitioners who may address socio-cultural

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issues at the community level during a pandemic. They generally represent the primary healthcare system's public face. In addition to these responsibilities, they are coping with a variety of personal and professional issues. They receive the lowest payment among all healthcare professionals. They worked in unsafe and difficult environments during the pandemic. ASHA is improving our society's health-care system, and despite the hardships they confront, the vast majority of them continue to work without complaint.

Keywords: *ASHA workers, COVID-19, Challenges, Role, Primary Health Centre, MGNREGS, Outreach Programmes, Monitoring, Surveillance, Contact Tracing.*

Introduction

The Alma-Ata Declaration (1978) established a significant milestone in the field of public health and gave rise to the global notion of "health for all." In order to fulfill the objectives of Alma-Ata, several nations, including India, implemented health policies and initiatives from the grassroots level. Following this as a part of the National Rural Health Mission, India started the ASHA program in 2005–06 to ensure primary health care provision in rural areas. In India ASHA program were firstly introduced in 18 high focused states and eight north eastern states. In Kerala the ASHA programme has been in existence since 2007, with the goal of enhancing basic health care (Sankar Hari et al, 2024,). Kerala has long suffered from a wide range of infectious and noncommunicable diseases, but it has also been successful in controlling many of them in their early stages of development. such as Chikungunya, H1NI, dengue, malaria, and other vector-borne illnesses etc. (Government of India 2022). In light of this, on 30January 2020, medical experts, including ASHA employees, have been working to eradicate the corona virus ever since it first reported in Kerala (Datt, 2023). Particularly the emergency

preparedness of Kerala's health sector during the NIPHA, helped to control the spread of the Corona virus in the first lap through the use of already prepared protocols. The health sector began active surveillance, opened control rooms right away under the supervision of district collector, and began monitoring patients and their medical histories. This proactive public health approach and decentralized healthcare system, which includes CHC (Community Health Centre) and PHC (Primary Health Centre) involvement in the fight against virus spread the state were able to minimize the transmission of viruses at the first and second levels of infection. particularly through the work of dynamic professional network of ASHA staff members. They received training on COVID-19 and post-COVID-19 clinic diseases. Thus, as part of the surveillance plan, PHCs (Primary Health Centers) assessed symptomatic individuals and promptly took further steps to prevent the spread.

Accredited Social Health Activist (ASHA)

Accredited Social Health Activists (ASHA) were first established under the National Rural Health Mission's (NRHM) flagship scheme, which was introduced in 2005 (Patley et al,.2021). ASHA has been deployed for every 1000 people in rural areas and for every 700 people in mountainous and tribal areas (Swathi.et al, 2018). More than 20,000 persons in Kerala hold this position. They are voluntary employees who receive performance-based payments. They serve as an intermediary between the public and the medical system. They primarily supervise the outreach initiatives of primary health facilities and make sure patients have access to these services. Home visits, vaccination campaigns, promoting family planning, holding health education classes, dispensing preventive medication, and gathering health records for the community are just a few of the key duties performed by ASHA employees. They act as the health educators for the neighborhood on matters of public health.

(Vayalil Khadeeja, 2021). ASHA workers are selected from their village community itself. ASHA must primarily be a married, divorced, or widowed female villager. preferably between the age of 25 and 45. She should be literate, and those who meet up to 10 qualifications should be given preference when hiring (National Rural Health Mission, 2014). Although in Kerala ASHA program has been began later than in other states but the plan has made great progress in the last two years. The major role played by ASHA workers in a PHC is to act as a link between a community and a local health institution and ensure primary health care service in their locality. They also make sure of maternal care, child immunization, new-born care, and the prevention of communicable diseases in their locality. They also work against TB and the core monitoring with regard to health promotion, sanitation, and hygiene and make the community a healthy living place. Up until July 2009, in Kerala there are 30909 ASHAs have been chosen, and 27904 of those had received field introduction training. The National Health Mission states that rural areas require 30927 ASHA staff. Based on data from 2019, 26057 ASHA workers are employed throughout Kerala's rural districts, helping to improve the health of the residents (National Health Mission, 2019).

According to Government of India regulations, drug kits are given to ASHA, containing a set of drugs and equipment's and various products enable her for basic level care of the community (National Rural Health Mission). Two districts of the state have started a specific pilot programme on managing non-communicable diseases where ASHA staff members have received the in-depth training and tools necessary to manage NCDs (Non-Communicable Disease) at the community level. Likewise, ASHA has helped in creating a network of community volunteers and NGOs (Non-Governmental Organizations) in awareness campaigns, early detection, follow-up, and palliative care activities

as part of a comprehensive decentralized cancer care program (Arogyakeralam, 2022).

Relevance of the study

ASHA workers' contribution to Kerala's health during the pandemic is greatly valued. During the period when someone sneezes in their neighborhood, ASHA employees should be the first to call; if one enters the ward, she will be the first to know. They monitor persons who exhibit early symptoms, collect health data, inspect residences, assist the department in identifying infectious patients, and maintain home quarantine facilities in such locations. They also prepare daily reports on the state of local health and submit them to higher officials, which aids in monitoring the local health situation. She now plays a significant role in the Rapid Response team as an information provider. However, they do not receive adequate compensation for their work and are not acknowledged as holding a regular post in the health department. The majority of them struggle to gather information from their communities, and the lack of vehicle service makes things even more difficult for them. However, they are still working because the majority of them see this as a service as well. But they weren't paid fairly for the labor they perform. Beyond words, ASHA employees in rural regions have made an essential contribution to improved health care utilization and women's and children's health care development. In their communities, ASHA successfully carried out her role as health educators, counsellors, and promoters. The present study attempts to evaluate the role of ASHA workers and access their activities to understand how much their work is helpful in controlling the Corona virus in their localities. Thiruvananthapuram is one of the places in Kerala where repeatedly various virus clusters forming, reporting of West Nile fever, dengue, Zika cluster, and Omicron virus detection have been made so far. ASHA employees are providing various support to combat against this infectious

disease in every community. These services they offer are for the general public's social security. Their societal responsibility extends beyond COVID-19 preventative initiatives.

Research Questions

1. What are the range and scope of the activities of Accredited Social Health Activists in Kottukal Primary Health Centre.
2. How ASHA employees enacted throughout the pandemic and whether their remarkable field experiences have enabled them?
3. What were the main obstacles that ASHA employees had to overcome throughout the COVID-19 era

Study and Context

A qualitative study was conducted at Kottukal Coastal PHC in Thiruvananthapuram district. The main information was gathered in February 2022 over the first and second weeks. primary sample was obtained using an interview schedule from eight of the thirty-two ASHA workers at Kottukal PHC.

Life and Work of ASHA workers

Kottukal is a coastal PHC (primary Health Centers) that was founded in 1994 in Thiruvananthapuram district. It has since been upgraded from PHC to FHC. The population of the panchayat is approximately 35480. The OP (Outpatient) consultation of this PHC is start from 8 a.m. to 6 p.m. There are three consulting doctors in the PHC, along with 32 ASHA employees and 11 JPHN employees. Among these 32 ASHA employees, eight AHSA employees who are willing to engage in the study were chosen from among the ASHA employees who have been doing their duties in the outside field since the start of the Covid preventative duty. Particularly those who have been employing since the initial

recruitment period, which occurred from 2005 to 2012. The ASHA employees who took part in this study are: *Lekha* began working as an ASHA in 2008, and *Punnakkulam* is her ward. ASHA employee *Ambili* started working in 2008. She representing *Maruthoorkkonam* ward. *Sajothakumari* representing '*Thekkekonam*' ward and she entered in job 2010.The ASHA employee *Sreekala* is in charge of the *Payattuvila*. She began her career in 2010. '*Manakkad*' is overseen by *Sheela*, an ASHA employee. She began her career in 2011.The ASHA worker *shibi* is positioned in the *Chovvara*. Field work for the *Office ward* is handling by ASHA employee *Kala*, who began employment in 2010. *Mannottukonam* ward is under ASHA worker *Latha*. The health seekers acknowledge that ASHA, who periodically check about their health status through home visit, is the visible and main health worker in their locality. Kottukal PHC is located close to the seaside regions of Poovar and Vizhinjam and has 19 wards. There are two ASHA employees per ward. They go to a minimum of 25 and a maximum of 50 residences each day. ASHA workers' primary responsibility is to check on their patients' health status on a regular basis through home visits. During the epidemic, they visited one residence more than twice a month. They also conduct health awareness programs at Kudumbasree meetings place and at the Anganawadi Centers, MGNREGE employees work site, Gram Sabha meetings. They provide nutrition education, Corona virus classes, preventative medicine distribution, environmental cleaning, special care for the elderly and young, prenatal vaccine coordination and delivering special attention for children and mothers in the locality.

The Role Played By ASHA Workers In The Locality During Covid 19

Role of a General Health Worker

ASHA staff are both frontline healthcare professionals and COVID-19 fighters. People were concerned about an

unanticipated pandemic outbreak and the resulting lockdown. But medical professionals, including ASHA, worked day and night to treat the sick patient and preventing the infection from spreading. Throughout the pandemic, ASHA workers go out into the fieldwork and every day to home visit. They also worked on PHC health initiatives and coordinated Panchayat health services.

"*Those were really difficult times, with the pandemic spreading quickly. Health professionals ought to lead the campaign to end it. Our surroundings are coastal areas where sickness can spread quickly. I considered how to manage marketplaces, businesses, and seaside locations where people are constantly interacting. Alongside this, standard outreach home care for obstructions, NCD patients, immunization, post-natal care, etc. were also handled."* Lekha, ASHA coordinator remembering those days. (Field work, 22 February 2022)

Throughout the COVID-19 era, front-line healthcare providers encountered a range of situations. Impacts of anxiety and depression are documented globally. due to the variety of harsh experiences, they had with COVID-19, the risk of infection, having few resources, stress at work, etc. (Fernandez Ritin et al, 2021).

Role of a Health care 'Warrior' during Covid 19

During the pandemic time the Medical Officer of PHC provides ASHA staff with a list of COVID-19 patients, including those in quarantine, primary stage patients, and recovery stage patients in their ward. Therefore, in addition to keeping in touch directly through house visits, they also contact each family to query about their health status at different phases of the disease. ASHA workers were aware of the physical and mental trauma and suffering in their people in the communities, they communicated with the families frequently about the people's health activities as well as how they cared for the family members

as if they were their own. To prevent the disease from spreading on a large scale, they were regularly conducting contact tracing, early disease surveillance, collecting data on quarantine people, patient follow up, cleaning the environment, attending meetings, coordinating efforts with Anganwadi and self-help groups. They also provided routine care to the new born and mother, during the pandemic period.

Ambili (ASHA worker) remembering *"It was extremely difficult for us to work both inside and outside of PHC during the COVID period because we have never performed this much clinical work before, even though we have basic training in medical services. It is also a new experience to have to comfort patients in panic situations in addition to adhering to standardized protocols and precautions"*.

In the initial stages of COVID-19, healthcare professionals are not aware of the virus, have minimal understanding of how it spreads, and are not as knowledgeable about its variations or preventative measures. Every day, their workload increased more and more. Concern about whether it has infected them has also grown. They therefore needed additional financial, technical, and training help, (Salve p Cited in Krisna Sneha, 2022*).*

ASHA worker lekhha says "We took self-precautions during the first wave to prevent the spread of disease through bodily fluids, broken skin, blood, etc. but we also had to perform activities like cleaning the needle, sanitizing the area, making sure that safe anti-management was in place, and also done chlorinating the well during that time. Since we are the only medical professionals that visit patients in quarantine, we were forced to take up these tasks once more during home visits. "

Latha explains, *"The continuous usage of personal protective equipment (PPE) put us in a difficult situation because many of us were using PPE kits for the first time, which was*

unsettling and suffocating. Managing patients in this tight scenario is a herculean undertaking, and many of our colleagues had suffer".

Role as an outreach Service Provider

The outreach initiatives that ASHA staff members carried out in the wards during COVID-19 were especially noteworthy. During that time, ASHA workers were also responsible for locating those who were likely to have positive cases through active local visits, ensuring quarantine activities and active regular surveillance of patients and their families, and updating the department head's daily information. Through the Chief Minister Pinarayi Vijayan's press conference, people frequently saw the results of this procedure. Since camp activities have already stopped, their normal patients received their medication and check-ups through ASHA workers home visits. Preventive medication distribution was ASHA done with the help of self-help organizations. ASHA employees were routinely ensured ward-based announcements and home-to-home notice delivery for COVID-19 actions. At that point, health officials ceased inspecting the local marketplaces and shops, so local self-government sanitized the areas with the assistance of ASHA workers. In certain wards, ASHA workers were able to influence people's attitudes towards patients during the initial phase of the virus's spread. Especially service providers like milk suppliers and newspaper distributors, neighbor's non cooperative attitude towards patients. Then ASHA workers acted as a bridge between those families' problems and those of outsiders.

Sheela detailed the days of her outreach initiatives. "*Many times, I need to buy food for various patients, prepare meals for them, and counsel patients and their families. Patients periodically provide me with copies of their ration cards over the phone so that I can purchase commodities and groceries for them. Home*

visits help us to give better care, particularly for the elderly and youngsters under the age of 10".

ASHA workers have played a number of roles in COVID-19. In particular, tracking down contacts, gathering data on the people under quarantine, supplying necessary medications and other services, setting up a food facility, etc., (Vayalil Khadeeja, 2021.

Role of ASHA inside Primary Health Centre (PHC)

Like outer locality management, their internal PHC work is remarkable. Even if fewer patients were coming PHC directly for consultations, it was extremely challenging to manage them during that time. The patients were anxious and concerned about how the diseases would affect them; they had to wait a long time for consultation; they were unable to speak adequately with medical professionals due to contact avoidance, and so on. At the time, there were many doubts and confusions, particularly among the elderly. They continuously check the availability of their medication; if there is a delay or unavailability, the ASHA is responsible for getting and delivering the medications. Along with this ASHA also paid special attention to pregnant women and postnatal care. When PHC's vaccination drive is in action, ASHA regularly contacts those folks to remind them to get their vaccines. They specifically gave nutrition education classes in these homes, as well as information about the benefits of breastfeeding. They also accompany nursing experts when they providing palliative care services, patient wounds dressing, conducting health examinations, and so on. ASHA personnel are also responsible for collecting e-health information from individuals on behalf of the health department. Newborn registration, health updates of COVID patients, and surveillance information's are also collected and reported to their head authority, which allowing the

department to quickly reach individuals who require medical attention the most.

Sreekala stated, "We are very disappointed in the way people behaved when we first started the covid clinic at PHC. There was no communication at times since everyone was in a hurry, both of us were unable to spend time, could not renew the acquaintance, and some patients resisted our touch out of fear. However, some patients were willing to work with us and adapt to any situation."

Activities through Social Media

The role played by social media with these times is priceless. Regardless of having limited digital literacy, ASHA workers used their smartphones to handle a lot of the PHC activities at the time. They visit patients' homes and assist them in contacting doctors as necessary. They buy medical data from labs and send them on social media. Help patients who require online medical appointments from medical colleges. Send surveillance report and patient data to the medical department at the required times etc. They solved numerous medical problems by using social media local groups, self-help groups, and kudumbasree media groups in their community.

Chovvara ward ASHA workers Shibi says, "At the span of time, our MO (PHC Medical Officer) was quite helpful. She used to consult elderly patients via video call and prescribe medications by phone; we sent lab and test results over WhatsApp, and she checked and provided information via phone conversations. Phone contacts were useful in situations of emergency for calling an ambulance, arranging patient shifts, scheduling visits at higher medical institutions and using video chats to contact covid patients and monitor their medical levels throughout the day and night. Without mobile phones and social media, I don't think this kind of management was conceivable at the time".

Social media was crucial in supplying accurate, reliable information that assisted in combating false information and rumors. updated monitoring of social media through data collection and sharing facilitates timely and appropriate government and health agency intervention. (Tsao Shu-Feng et al, 2021).

Health Care Activities through Self-help Groups and other Organizations

Anganwadi workers helped to coordinate the health care service of pregnant ladies. They visit pregnant women's homes every few weeks to check their blood pressure, blood sugar, and high stress, give out iron supplements, and conduct regular health classes. They also organized family planning education sessions for married girls and adult clinics for girl children. Classes on exercise for normal menstruation, personal cleanliness and eating habits, and marital counselling are also provided to single girls, however, class time is reduced during pandemics. One of the most important aspects in assisting the health department means help to track down the history of patients under quarantine in every community through health registration. They helped us collect those data. They coordinated Covid prevention activities with NSS organizations and resident associations. Self-help groups cooperated in the placement of notices on school walls, conduct neighborhood interactions, and the coordination of covid prevention actions with other organizations.

ASHA worker Sajitha Kumari spoke more clearly on the collaborative activities with MGNREG and Anganawadi workers. She remarked, "*We all work in the same ward, and our friendship helps a lot. They contribute to environmental cleanup, participate in seasonal health activities, and assist in the implementation of women and child programs. They can swiftly gather data since there is a significant self-help group chain in the area, making it*

easier to provide health classes, these contacts helped collect quarantine details, information was efficiently passed through self-help groups, preventive medicine was distributed, and so on."

Self-help groups in India, such as Kudumbasree in Kerala, have also been more prominent after COVID-19. They assist impoverished communities by offering funds and supplies banking services and by filling the need for masks, hand sanitizers, and protective gear like PPE kits. They efficiently manage community kitchens. Their contribution is therefore noteworthy, (World bank feature story, 2020)

Role of a Health Supervisor in Events

Another important role they performed during that period was to visit places, to coordinate preventive activities where large crowds could gather for private meetings or where social events, like weddings, have occurred. Before beginning the function, ASHA workers visit these areas to provide critical health advise and preventative measures, Covid instructions, protocol compliance, and sanitation facilities. ASHA workers must visit households as a preventative measure during a pandemic, regardless of time of day or night, especially in cases of reported deaths. They ensure that people keep a social distance and decrease the risk of virus transmission. According to COVID policy, they can leave the region only after completing all COVID 19 formalities linked to the case.

"People management is a challenging task in "Kalyanaveedu" at that time. People are never aware of the restrictions and laws that have been put in place when they are experiencing happiness and delight. Because of this, we have to keep them distance, remind the use sanitizer, monitor the whole area etc.". Latha added

Activities through Local Self-Government

At this time, ASHA workers never skipped their home-to-home visits, despite the high danger involved. During the visit, youngsters under the age of ten and seniors over the age of sixty were given particular attention. At that point, the PHC physician and nurses would check in with the patients to see whether ASHA saw any unusual changes in their condition. In addition, they ensure that elderly people living alone have access to food and notify the Panchayat of any problems. In an effort to monitor the health of the community and stop the coronavirus from spreading, Panchayath also assisted ASHA in compiling thorough COVID data for every house she visited during the home visit. During every house visit, they take care of cleaning the surroundings, especially removing standing water. In collaboration with ASHA staff, panchayaths took the lead in sanitizing homes and outer places.

Kala opens up "When we complete all of our reports and get to Panchayat It is evident that they are making a concerted effort to stop the infection; they accompany us on house visits and ask about people's needs. They provided thoughtful support during that period". Shibi ASHA worker remembers. *"They supported us against every challenge, including political pressure, party differences, governance, and authority structures. We're still preserving those relationships."*

Research has showcased how every Asha employee concurred that they coordinate and communicate well with Panchayath. They also assisted in inspiring the locals and raising awareness of hygiene, cleanliness, and sanitation (Meena Sadhana, 2020).

The Challenges faced by ASHA Workers During the Covid-19 Period

Economic Difficulties

The main problem that ASHA workers face is that they are still not "recognized" as health department employees. The majority of people earn only 5,000 each month from this life-challenging and priceless job. This is also paid from the NHRM fund; however, it may take some time for them to receive it. They do not have a separate budget or savings fund; therefore, these kinds of discrimination affect their self-esteem.

"*At times, we work long shifts, both day and night, quarantine visits, follow up with patients, gather surveys, and review their health reports. At other times, we have to spend money on groceries and medicine for underprivileged patients. We also struggle, but our pay is extremely low, and the honorarium is arriving much later than expected. I'm not knowing how we managed those difficult times with insufficient money";* Ambilli ASHA worker says.

In a 2022 Rajya Sabha question answer session report on the subject of improving the pay of health care providers, it was said that various policies and government incentives had been approved after covid for ASHA to provide better financial security and a good wage (Ministry of Health and Family Welfare. 2022).

Geographical difficulties

During the period, fieldwork is a risky task. Each ward has a distinct geography. Despite the fact that the location is on the coastal area. There are difficult uphill terrains, wide outlying fields, and uninhabitable areas. During lockdowns, without the support of personnel or vehicles, ASHA worked alone in such areas. Another concern about ASHA is that they are confronted with

animal and reptile problems on a daily basis as they pass many residences and go through many areas and geographical locations.

Jasminlatha complained that "*We did not have transportation service during this time, so we walked to ensure home visit service. We faced with periodic physical tiredness, menstruation troubles, and dietary issues. However, we continued our efforts to prevent the dangerous virus from spreading. I believed that my society responsibilities were far more essential than my own difficulties."*

Health professionals are vital to the health system as a whole, but they also confront a variety of challenges, such as unsafe patient management, occupational danger, psychological risks, violence, harassment, and injuries, as well as limited access to safe drinking water, sanitation, and hygiene difficulties (World Health Organisation, 2022).

Difficulties faced by ASHA's Family

The sacrifices made by ASHA personnel during that period will never be forgotten. Most ASHA personnel are part of a nuclear or extended family. During lockdown, children stay at home, older parents demand support, and some breadwinners in ASHA workers' families lost their jobs, among other things. ASHA workers had no specified or fixed shifts at that time. As a result, they are forced to work both inside and outside PHC day and night, without regard for their families. They never had leisure time or spent meaningful time with their families because they were constantly working. They were exposed to COVID from the workplace more than once. Families were also affected by this.

Ambili, with tears in her eyes, said, "*My son helped me to travel to the fieldwork by using his two-wheeler. He escorted me to the wards and quarantine homes*". Sreekala, an ASHA

employee, went on to explain, "*My 'ettan' (husband) takes care of the housework while I'm away. He accompanied me at places where individuals were cremated, places where weddings were held, and gathering places,"* she smiled.

Even if their earnings are lower and they must balance personal household responsibilities with PHC's healthcare service activities. Nonetheless, they were very satisfied with their outcomes of the work (Mascarenhas Anuradha, 2021).

Safety concern

ASHA workers view their work as social labor done for the benefit of society. Only a small honorarium they received for working day and night during COVID 19. During the outbreak, the Panchayat primarily provide masks, gloves, and hand Sanitizer as safety amenities from the PHC, or health department. Later on, they didn't get these materials on time, and the number of materials become decreased. They have worked at times in the fieldwork with no facilities.

"When others began to live together during the lockdown, we sent our family members to relatives home due to safety concerns". Latha says

Resistance of Individuals

The refusal of local residents to cooperate is another issue they experienced during COVID-19. ASHA employees always advise individuals of the precautions to take in order to avoid the sickness as well as the directions provided to them to notify them if any signs are noticed. If people are not properly informed or do not follow their recommendations, they may only then approach them as soon as possible and take all applicable measures regarding this. which, in some instances, the dismissive attitude of people results in positive cases, this causes authorities to lose assurance about the contributions made by health professionals.

During this period, MGNREGS employees also failed to follow health specialists' recommended care requirements.

"Prior to the epidemic, house visits were a source of great joy for us, aside from being a duty. But throughout the pandemic, I felt alienated from the rest of the population during field work. There are no crowds or people on the pathways, which occasionally generated fear in me." Sheela said.

ASHA employees had to deal with social, economic, and personal obstacles in their daily lives. They are still driven to work. However, there are a few things that demotivate them at work: remote locations, a lack of roads, and inadequate transportation systems etc (Bist Rani Rekha et al., 2023).

The Challenges of Workload

Their workload was still an issue at that time. ASHA employees says that they must carry all stationery alone when they visit schools, neighborhoods of homes, offices, and residence-association offices to post notifications or pamphlets concerning COVID health care activities. Nobody else PHC representatives accompanied her. But the community aided them in putting out notices, and banners. pamphlets in various places. They had to undertake house visits, report preparations, enquire about patient quarantine actions, conduct monitoring, and promote health activities on their own, with no additional aid. They have also been assigned nighttime responsibilities. If any reported deaths occur, they use their families' aid to get there. They organize all the legalities and sometime are stuck in such locations on their own, yet they complete all of the responsibilities and submit the reports the next day without complaint.

Sreekala says "*It's our duty and responsibility, but in the midst of an epidemic like this, I understand that social bonds and responsibilities can often outweigh material success and*

prosperity. These days, it's more than just a job I can see a commitment to society as well."

ASHA representative brings a diverse societal group together under a single component of health care. Even though there are people facing numerous disparities in society. ASHA never permitted them to experience both health and social inequalities, at least during the pandemic.

Conclusion

ASHA workers provide essential support to India's public health system. ASHA workers are the primary healthcare providers at the community level. They worked consistently to ensure the safety and health of Kerala residents during the COVID-19 pandemic. They are skilled in contact tracing, monitoring, and surveillance processes, which aid in the prevention of disease spread, particularly during pandemics such as COVID-19, NIPHA, and ZIKA. As a result, ASHA staff were acknowledged at the 75th World Health Assembly for their vital role in ensuring everyone has access to basic primary care services and connecting communities with the health system. They were also recognized as one of six recipients of the 2022 WHO Director General's Global Health Leaders Award for Health Protection and Promotion (WHO, 2022). The contributions they made to the health division during the COVID-19 period are endless.

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Kerala During the Pandemic Times of NIPAH: A Case Study

Anishia Jayadev *

Abstract

Every societal distress, be it environmental, social, political or health, comes with a great opportunity to devise a solid strategy to contain or take care of future instances of occurrence. Education and scientific priming of the community and conscience building which is replicable will not only help that society but other societies as well. The only effort to be exerted is to extrapolate and customize the available model. Kerala, the state under discussion was thrown into the mouth of health and natural disasters, with public health dimensions for the past 5 years continuously. Still fighting with Covid 19 and the whole world, Kerala has developed

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its model of recouping from the disaster. Fourth time, the state again managed comfortably, the threat of Nipah and dealt with it phenomenally well.

Keywords: *Social Activism, Volunteerism, Surveillance and Contact Tracing, Societal Grouping, Social Network Theory*

Introduction

Kerala, the state under discussion was thrown into the mouth of health and natural disasters, with public health dimensions for the past 5 years continuously. Still fighting with Covid 19 and the whole world, Kerala has developed its model of recouping from the disaster. Fourth time, the state again managed comfortably, the threat of Nipah.

The state of India with the highest Literacy rate, the lowest rate of committing 'Violent crimes', of lowest Infant mortality, the best health care facility, the highest Average life expectancy, good Transportation faculties and good religious harmony, it excels in disaster management also. An attempt is made to analyse how Kerala as a unit of administration and governance faced three disasters, an epidemic of highly infectious lethal disease, in its unique way and ponder possibilities of scalability and reliability.

Methodology

The present study is qualitative, considering the state of Kerala as a case, based on secondary resources, and aims to analyse the various trajectories of Kerala's battle against the NIPAH. The study primarily aims to make solid inferences about the social, economic, political and physical impacts made by the above-mentioned natural calamities and diseases in the state. The study also tries to document how the Kerala state was able to survive in those challenging conditions.

The present study also focuses on the social and economic impact of the disasters and various political, administrative and social

responses to them. The researchers have adopted case study and content analysis methods to make inferences and conclusions from the data collected through various secondary resources. It also highlights the social network theory, and how networks aid in appropriate governance strengthening.

The secondary data were collected from various resources such as books, online offline journals, newspapers, government websites and health reports from WHO and other governmental and non-governmental organizations.

The Case of Nipah

Nipah virus (NiV) infection is a newly emerging zoonosis that causes severe clinical manifestations and high mortality. The Bangladesh strain of NiV infection in humans usually leads to acute respiratory syndrome and fatal encephalitis, even if asymptomatic infections are also reported. The Malaysian strain of the virus has comparatively low mortality rates. Several factors are responsible for zoonotic outbreaks, such as intensive livestock farming and agriculture, using wildlife as food sources, clearing land for farming and grazing, human encroachment on wildlife habitats, international trading of exotic animals and urbanization, leading to more human–animal and environmental interactions.

Nipah took away seventeen lives in its first appearance in May 2018. The entire public healthcare system of the state got stuck for a while because, until that day, the system had no idea of the origin and ways of the strange, fatal disease. Soon the entire system initiated effective steps to prevent and control the outbreak. Initially, the healthcare professionals and personnel were completely in the dark. They took some time to confirm and find the disease and its origin. All the reported, confirmed and casualties were from Kozhikode and Malappuram districts of the state (PIB, 2018).

The health department of the state was able to confirm the disease in close contact with the suspected primary case, within two weeks of the demise of the primary case (suspected). The virus detected was a deadly variant of the Bangladesh strain of Nipah. The experience of Kerala was one of the few instances Nipah was diagnosed in a very short time, during the growth of the outbreak itself. The entire healthcare system of the state was thrown under immense pressure following the diagnosis of Nipah, but the system responded to the crisis well. The various documentation of Kerala's fight against the debut Nipah infection is there in the public domain. Exactly one year later the Nipah virus had claimed seventeen lives back in May 2018 the virus has re-emerged once again in the state.

A Twenty-three-year-old student who was from Ernakulam district was being diagnosed with the Nipah virus and had been hospitalized in May 2019 (Varma Vishnu et.al, 2019). The student was admitted to a private hospital on 30th May 2019 and his samples (throat swabs, blood and urine) had been sent to the National Institute of Virology Pune and tested positive for the virus on June 4. Soon after the confirmation of the disease in the virus-infected patient as a precautionary measure, the authorities kept 311 people who were suspected to have come in contact with the index case (first infected patient) under medical observation to prevent the spread of the virus. The state government put four districts such as Ernakulam, Thrissur, Kollam, and Idukki on high alert as the student (index case) had reportedly travelled through the region recently. Apart from the student (index case), four people were admitted to the Government Medical College Ernakulam with symptoms like fever, cough, and headache, and later tested negative. Since the confirmation came from the NIV Pune the state government has taken effective precautionary measures to prevent the virus from further expansion by tracing the contact, setting up isolation wards and enhancing the medical infrastructure facilities at major medical colleges in the state.

Two healthcare personnel who had a history of contact with the infected patient exhibited symptoms and they had been given proper treatment and kept under surveillance. Containing the spread of the Nipah virus is very crucial to limit the casualties. As in the case of most Nipah outbreaks all over the world, the source of virus infection in the index case remains unknown in the state. However, it's been found that the growth of the outbreak through secondary cases is via human-to-human transmission. The state feared the spread of infection to other districts. So samples of seven suspected patients including healthcare personnel admitted at the isolation ward of medical college Ernakulam and their samples were sent to the National Institute of Virology Pune for examination. As a huge relief for the state, the blood samples from the suspected Nipah patients have tested negative, the Minister for Health, the government of Kerala had officially announced the report from NIV Pune at a press conference. Along with the strategies to control the spread, a special medical team was constituted and they lead the management of suspected/confirmed cases to ensure zero causality. The medical team had formed a protocol to curb the disease from its initial stage and decided to keep vigil for a while. An expert medical team from AIIMS (All India Institute of Medical Sciences) arrived at the state and conducted an in-depth scientific investigation at various locations to find out from where the index patient was infected with the Nipah virus. The special medical team constituted by the state government also conducted various inspections at different locations to identify the source of the virus and its reservoirs. Intensive investigation revealed the presence of the virus in fruit-eating bats even if the exact mechanism of spillover is not known.

Once the disease was confirmed, the health care department had taken effective measures to restrain the virus infection from further expansions. The effective and well-coordinated efforts of healthcare institutions from both the public and private sectors propelled the mission of preventing the Nipah virus. Healthcare professionals and personnel from both the private and public sectors organized together

in every phase such as planning, implementation, and monitoring of actions about the alleviation of disease and treatment of the Nipah-afflicted patients. The state government sought advice and instructions from medical experts both from inside and outside the state and country to frame strategies to prevent the disease and transmission of the virus. The state got help from the union government and other national and international organizations such as the World Health Organization in the form of instructions, equipment, and instruments for the mission Nipah virus.

Precautions, Prevention, Care, And Control of Nipah- A Customizable Model Put Forth

The people were conscientious to

¬ Avoid eating fruits which had been bitten by birds and other creatures

¬ Avoid natural drinks such as toddy which are taken directly from natural resources like trees and others, if not pasteurized

¬ Those who show symptoms like fever, cough, breathlessness and headache keep distance and avoid physical contact with family members, friends, and others.

¬ Those who had symptoms were advised to seek medical attention as soon as possible

¬ Those who attended the patients, the familial care providers and healthcare personnel were supported psychologically and asked to stay at their respective residences and be vigilant about the development of symptoms, and they were under surveillance

¬ Things used by patients were kept separately and safely (food items, clothes etc,)

¬ Ensured the protection and safety of the water resources from the excreta and flux of bats

¬ Keep away from the pet animals and such animals should be secluded away from physical contact with fruit bats

The virus-afflicted patients' needs for intense care and treatment had to be addressed and they must be kept away from others to prevent the spread of disease. Apart from the patients, those who contacted with the infected people in the past and those who are still in contact with the patients will be under meticulous observation and surveillance. In the hospitals where Nipah patients are kept under treatment, other patients are allowed because the possibility of spreading infection is very high. There were separate isolated units would be arranged to provide treatment for Nipah patients. The visitors are completely prohibited from visiting Nipah patients. The healthcare personnel who are involved in the treatment process of Nipah patients will be equipped with high security and safety measures. Specific protocols were devised by the department concerning disease diagnosis, prognosis, treatment and pre-cautionary methods.

Societal and Stakeholder Response

An in-depth study conducted by Chandrasekharan, et al., (2020) reveals that public response towards this virus/virus-infected people was a mixture of fear, anger conflicting ideas, a sense of responsibility and humanitarian concerns. The unknown disease carried death with it. This induced in people, a fear psychosis. Dead bodies were not sent back home but were decided to be cremated by the Government. But electric crematoriums refused to cremate the bodies. Media added to the pandemic fear by exaggerating the news.

According to available information, the most appropriate intervention to control the spread of disease was to burn the body of the departed. Certain communities, which had beliefs regarding life after death, opposed the idea of cremation. The district administration in consultation with people responsible and religious leaders made some consensus like deep burial without compromising religious belief

and this was agreed upon. Religious sentiments were put aside by religious leaders and scientific vision and humanitarianism gained importance. When certain people turned hostile, like crematorium staff, many others stretched out their hands for rescue. The health staff, a couple of ambulance drivers, and sanitary workers chose humanity in front of fear. Their foremost concern was to prevent the spread of infection to others. They refrained from using public transport isolated themselves, from family and stayed alone.

Social activism and volunteerism emerged as a part of the mitigation of a contagious disease.

Governance.

Governance was most effective. Decision-making by the health care system was swift. To reduce spread a protocol was developed which could be implemented globally if such outbreaks emerge.

Body bags, N95 masks, personal protective equipment kits, etc. which were in shortage were procured. The shortage of human resources was managed by recruiting temporary employees and promoting volunteerism.

Funeral

Disposal of body safe is one of the most important steps to prevent a mass spread. In most other countries where such diseases broke out, due to social, cultural and religious reasons, people refrained from obeying the health system and governance instructions of safe burial. This led to harmful consequences (both for Nipah in Bangladesh and the Ebola in Africa) In Kerala religions give the funeral a sacred significance and for some funeral is a window to the spiritual world, for some it is reincarnation etc. This was compromised by the public after the decision and conscience building by Govt. The funeral was conducted in the district of Kozhikode itself. The agitations that arose were managed effectively. This was because of the proper

communication between Govt., religious leaders, local leaders and the public. People vote for the scientific approach. Thus, the Kerala model becomes a replicable one and suggests winning the confidence of the community and engaging and trusting them.

The system dealing with culturally acceptable scientific protocol gets accepted even by religious groups.

From September 12 to September 15, 2023, the Kozhikode district of Kerala experienced six laboratory-confirmed Nipah virus cases, including two fatalities, according to the Ministry of Health and Family Welfare of the Government of India. The other individuals were relatives and hospital contacts of the first case, whose source of infection is unknown. As of September 27, 2023, 1288 confirmed case contacts had been located, including high-risk contacts and healthcare professionals who are now subject to a 21-day quarantine and surveillance period. Six instances were positive for Nipah virus infection out of 387 samples examined since September 12; all other samples tested negative. No additional cases have been found since September 15th. Since 2001, there have been six outbreaks of the Nipah virus in India.

Enhanced surveillance and contact tracing, laboratory testing of suspected cases and high-risk contacts, hospital readiness for case management, infection prevention and control (IPC), risk communication, and community engagement are just a few of the multisectoral coordination and response mechanisms that state and national authorities activated to stop the spread of the outbreak.

The current outbreak of the Nipah virus is the third to occur in the Kerala district of Kozhikode, the fourth to occur in the state of Kerala since 2018, and the sixth to occur in India. This outbreak began with the initial case, followed by a clustering of cases in family contacts and possible nosocomial transmission in hospitals, similar to the previous outbreak in Kerala in 2018. Only Bangladesh and India

have reported Nipah virus outbreaks in the WHO South-East Asia Region.

Coordination: To assist the State and District administration in containment and mitigation efforts, the Departments of Health & Family Welfare, Health Research, and Animal Husbandry summoned numerous central multidisciplinary teams. There were established 19 core committees, each of which was given responsibility for a different aspect of the response, such as surveillance, sample testing, contact tracing, patient transportation, case management, logistics and supplies, training and capacity building, risk communication and community engagement, psychosocial support, and animal husbandry. To organize the reaction actions, the district's control room and phone centre were activated.

Surveillance and contact tracing: Active house-to-house monitoring was conducted by the district health authority in the specified containment zones as part of community-based surveillance efforts. As of September 27, 2023, 53,708 homes had been surveyed in total. As of September 27th, 1288 contacts, including high-risk contacts, had been discovered, quarantined, and are still being monitored. Every high-risk contact underwent testing. In nine villages in the Kozhikode district, containment zones with movement limitations, social segregation, and a requirement to wear a mask in public places were announced. Up until October 1, 2023, the government has prohibited large-scale public events in the Kozhikode district. States and districts nearby have received alerts for increased surveillance.

The Theory Behind Societal Grouping Against Nipah: The Social Network Theory

The focus of social network theory is on how social ties function as channels for information transmission, sources for media or personal influence, and facilitators of attitude or behaviour change. With the growing use of network analytic techniques in diverse empirical situations, social network theory has greatly broadened the scope of

media effects research since the 1960s. Three prominent theoretical frameworks that use network principles in explaining the flow of mediated information and its impacts are the theory of weak ties, the theory of the two-step flow of communication, and the theory of diffusion of innovations. All these are seen in containing the disaster.

Conclusion: This is why we say there is a Kerala model of healthcare

In any society, fear-related behaviour arises at an outbreak of a novel infectious disease. This is a normal adaptive social process. It may protect people from getting infected as they will opt to stay away from those who are infected. It is also common to get grapevine spreads of rumours when the disease is uncommon even to the healthcare systems. But, here, the concern and fear become advantageous to the system because people willingly kept social distancing and started self-reporting (Chandrasekharan, et al., 2020).

The breakout of the NIPAH virus in Kerala had its peculiarities which were unprecedented. Usually, the Nipah outbreak spread by human-human contact will not last long. The period of the Nipah outbreak will be for a few weeks or so. The issue is that it will be very difficult to diagnose the diseases during the outbreak. The disease will be revealed only in a later phase, though already collected and kept samples (Nikolay, B., & et al. 2019). By that time there would have occurred a greater causality. But in the case of Kerala, one of the very second cases, that is a person who contracted the virus from the first patient was identified, as a member of the family. At that time a few people who had been infected had met with death and the rest of them were hospitalized. The most positive thing was that the health services could trace out very early. This was a reflection of the robust healthcare system of Kerala. It is to be reckoned that the first case was identified in a private hospital, by a few doctors who suspected the possibility of the rare infection, Nipah. This shows the ability of the doctors to probe in-depth a clinical case by the doctors and health

workers and the system. The system in due course could trace out every individual infected with the virus or was having the symptoms of the disease, right before they reached the hospital, wherever they went, trace out the possible contacts, trace out places where the dead persons were cremated and a list was drawn upon. Even the timeline was charted.

With the help of the citizens, media and hospital records, the healthcare system could draw out the list of infected people and people who had the possibility of infection. Such an activity was done for the first time in the history of health care in the state of Kerala. For this, a method called SPACE TIME MATRIX was used (Patch JR, 2018).

In Kerala, the Nipah virus emerged in 2018 as a new threat to the health system and alarmed the state with consecutive appearances in the subsequent years. When the Nipah virus had its first outbreak visit, it accounted for seventeen casualties. It created absolute panic among the public and caused an imbalance in the healthcare system of the state. The later outbreaks were identified by the system on time. The authorities had taken effective precautionary measures and implemented efficient strategies with extraordinarily coordinated efforts to restrain the Nipah virus. Through well-coordinated and organized efforts, the health department of the state ensured the least casualties of the Nipah virus this year.

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2. The word count should be **4,000–6,000,** including a 200–250 word abstract, 5–6 keywords, references and endnotes (if any).
3. The manuscript should be typed in Times New Roman, Font Size 12 and double-spaced.
4. The journal follows the Publication Manual of the American Psychological Association -7th edition (**APA 7th edition**). The reference and in-text citation must strictly follow this guideline.
5. Each citation in the reference list should have a corresponding in-text citation and each in-text citation should have a corresponding citation in the reference list.
6. Notes, if any, should be indicated by serial numbers as superscripts in the text. The detailed explanations should be provided as endnotes, corresponding to the numbers, and placed just before the references.
7. Tables, charts, diagrams, and maps if any, should be placed within the text and should be aligned center and should have the source.
8. The language and spellings used should be British (UK) English, with 's' variant
   (e.g. 'modernisation ' for 'modernization'; 'colour' for 'color').
9. Non-English or uncommon words should be italicized, with meanings in parentheses or as notes when first used.
10. Manuscript should use non-sexist and non-racist language.
11. Use 'per cent' instead of '%' in the text. '%' can be used in tables, graphs etc.
12. Write numerals between one and ninety-nine, and 100 and above in figures. However, the following are to be in figures only: distance: 5km, age: 35 years old; percentage: 72 percent; and years: 1990s.
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