Networking Event & Workshop

on

Exploring Link between Female Empowerment and Child Health

(March 18, 2019)

PROCEEDING

Rajeev Kamal Kumar

Organized by

School of Medicine, University of Nottingham, UK

&

A N Sinha Institute of Social Studies, Patna

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A. N. Sinha Institute of Social Studies

Proceeding

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Printed at: Patna Offset Press, Naya Tola, Patna

Background

Women empowerment is one of the most important factors in improving the overall growth of children, including their health and education. According to Kofi Annan, when women are empowered, children thrive, and the countries flourish reaping a double dividend for women and children. The issue of women empowerment and child health have become a serious concern for researchers, academicians and policy makers and it has also received due attention especially in context of developing countries like India. Within India, in some of the backward states the situation is more discouraging. This is a highly relevant subject especially in context of Bihar where status of child health remains a concern and women's empowerment in terms of education, health and awareness remains low- despite several initiatives taken by the government in this regard. According to NFHS4, around 48.3 percent children are stunted in Bihar. At the same time female literacy remains low. Prevalence of under nutrition, anaemia and related deficiency are among the highest in Bihar among the states of India. This is quite grim, since children are our future and also the core of country's human capital resources. No country or region can succeed if its children are not able to attain their full potential. Poor health is a foremost constraint in this regard. There is a need for aggressive campaign for spreading awareness on this issue among policy makers as well as all other sections of the society.

School of Medicine, University of Nottingham, UK has been conducting a research on the effects of Rojiroti microfinance programme on nutrition among children under five years of age in Patna district for last few years. It has also tried to investigate the link between women's empowerment and child health. A N Sinha Institute of Social Studies (ANSISS), Patna has been engaged in later stage of this research as local research partner. It is in this context a one-day networking event-cum-workshop titled *'exploring link between female empowerment and child health'* has been organized at the A N Sinha Institute of Social Studies, Patna in collaboration with the School of Medicine, University of Nottingham, UK. The purpose of this workshop is to build on the research work undertaken in Patna district (Bihar), which was initiated by University of Nottingham, UK.

The workshop dealt with some of the important questions around the theme, such as, how progress might be accelerated towards three of the UN Sustainable Goals (SDGs): Gender equality (goal 5); child nutrition (goal 2); and no poverty (goal 1). Rojiroti microfinance's intervention might impact upon each of these SDGs. Rojiroti microfinance is being implemented by the centre for Promoting Sustainable Livelihood (CPSL). CPSL works through self-help groups (SHGs), set up by poor women living in 'tolas' (hamlets or small communities within a village). Rojiroti has developed organically in Bihar over last 17 years. There are now approximately 31000 members in 3,100 SHGs in Bihar.

The workshop inaugurated formally by the chief guest and other dignitaries present in the event just after the registration of the delegates. The workshop was conducted in two main sessions, i.e. plenary session after the formal inauguration and five parallel technical sessions. After the technical session, the chairpersons of all the five technical sessions presented the summary and findings. The workshop in its inaugural session introduced the workshop agenda and address by the guest of honour N. Vijaya Lakshmi, Managing Director, Women Development Corporation, Bihar. During the plenary, the

findings of the research project undertaken so far have been presented. Along with this, one of the key speakers also shared the observations from a similar study on 'the effect of participatory women's groups and counselling through home visits on children's linear growth in rural eastern India (CARING trial): a cluster-randomised controlled trial', carried out in Jharkhand and Odisha.

In the next session of the workshop, five parallel panels have been organized on similar themes, where the panellists have shared their research experiences and ideas. The first parallel session titled 'Anthropological and Sociological Perspective of Women Empowerment & Child Health' was chaired by A K Kapoor, former Professor and Head, Department of Anthropology, University of Delhi. Second session titled 'Socio-Cultural and Economic Perspective of Women Empowerment and Child Health' was chaired by D.M. Diwakar, former Director of ANSISS and present Head of the Economics Division. Third session on 'Public Health Perspective of Women Empowerment and Child Health' was chaired by Barun Kanjilal, Health Economist and Former Dean and Professor, IIHMR, Jaipur. Fourth session titled 'Structural Constraints of Women Empowerment in India: Historical Trajectory and Emerging Paradigm' was chaired by B. N. Prasad, Prof and Head, Division of Sociology and Social Anthropology, ANSISS. The last session titled 'Economic Perspective of

Women Empowerment and Child Health' was chaired by Sankar Majumder, Professor at Visva-Bharati, Sriniketan, West Bengal.

The deliberations made by the delegates during the workshop were very insightful and also helpful for the Indo-UK team to build a consortium for further research. The delegates came from different disciplines and consisted of researchers, academicians, social scientists, Public Health experts, and programme implementers, who shared their experiences and research on these topics and also discussed avenues for wider collaborations and research in the area of maternal and child health. The key speakers and chairpersons of this networking workshop included Alan Smyth (Professor of Child Health, University of Nottingham, UK), Suchitra Rath (Ekjut, Jharkhand), DM Diwakar, A K Kapoor, Barun Kanjilal, Gil Yuron (Director, GY Associates, UK), Shalini Ojha (Clinical Associate Prof. of Neonatology, Univ. of Nottingham, UK), Esther Butt (Senior Lecturer, Univ. of Nottingham), Sankar Majumder, Subir Biswas, P.K. Patra, and others. Closing remarks and vote of thanks were given by Rajeev Kumar Kumar, Asst. Prof. AN Sinha Institute of Social Studies, Patna, who has also coordinated the workshop along with Alan Smyth.

Inaugural & Plenary sessions

Inaugural Address:	D M Diwakar, Former Director of ANSISS, Professor & Head, Division of Economics & Agricultural Economics, ANSISS
Welcome Address:	Nil Ratan, Registrar In-charge, ANSISS
Guest of Honour:	N. Vijaya Lakshmi, MD, WDC, Govt. of Bihar

D M Diwakar, former Director of the Institute chaired the inaugural session and introduced the theme of the workshop. He also welcomed the delegates and acknowledged the support of School of Medicine, University of Nottingham, UK for collaborating the research with the Institute.

Nil Ratan, Registrar In-charge of the Institute formally welcomed the guests and delegates of the workshop. He also shared his experiences and laid emphasis on

the relevance of the subject. In his address, Nil Ratan said child health remains a concern in the state and women's empowerment in terms of education, health and awareness remains low- despite several initiatives taken by the government in this regard. Prevalence of under nutrition, anaemia and related deficiency are among the highest in Bihar. He emphasized the need for spreading awareness on this issue among policy makers as well as all other sections of society. He expected the insights from such a diverse community is obviously going to widen the horizon of our understanding of the subject and leave a vibrant imprint on the minds of all those who are participating in the workshop today. He thanked the team from University of Nottingham for extending an opportunity to the Institute to collaborate for the excellent work and extend a warm welcome to all of them. He also welcomed other participants including the panellists and panel chairs.

The guest of honour for of the workshop, Dr. N. Vijaya Lakshmi, Managing Director of Women Development Corporation, Govt. of Bihar, gave governmental perspectives on the issue. She shared her experiences of the projects undertaken by Women Development Corporation, Govt. of Bihar. She also shown her concern on the poor nutritional status of children in Bihar and mentioned a few initiatives undertaken by the Govt. At the end of her address, she appreciated the efforts of the organizers for convening a workshop on such a pertinent topic. She said the deliberations on the issue of women and child health will not only useful for the state, but its recommendations may also be utilized by other parts of the country.

Plenary session started with the presentations made by Gil Yaron and Sunil Choudhary who explained about the functioning of Rojiroti microfinance on which the present research has been carried out. Rojiroti microfinance is

working through self help groups (SHG) in Patna district by Centre for Promoting Sustainable Livelihood (CPSL), a local collaborating partner. This scheme has been implemented by female SHG and local women coordinators. Rojiroti manages to serve the poorest of the poor, mainly women belonging to Scheduled Caste communities through unrestricted use and size of loan. They further exhorted that these SHGs had strengthened female empowerment in the area through disbursal of small loans to the women members on time. What makes the Rojiroti unique and different from other MF schemes is the size of loan, repayment conditions, participation of community, women's reach, federation of SHGs, low rate of interest, incentives for community women, social and economic empowerment of women and community, impact of its work etc. Women SHG members are seen as income earners, bringing low-cost loans to the household. As women have to make the case for loans to their group their husbands are incentivised to start discussing household income and expenditure. Women use the SHG to discuss issues of concern. Local female coordinators are role models and act as facilitator for other members, who also enable access to existing government programmes that are meant to benefit the poor, e.g., PDS and JSY.

Shalini Ojha and Alan Smyth in their joint presentation on '*Microfinance interventions, women's empowerment and children's health*' said that the MF interventions can result into increased use of contraceptives by the women, their empowerment and children's nutrition. Women who are members of the SHGs are also able to report any kind of violence, i.e. physical, psychological, or sexual violence by their intimate partners. It has also encouraged them to take independent decisions related to the family and they also believe that it has increased their mobility and exposures to the meetings. They concluded that there is limited evidence of MF intervention and women empowerment and children health but in the present study there is a positive relation between the two.

Esther Bott presented a paper on '*Rojiroti, children's health and women's empowerment*' which is result of a pilot study to qualitatively explore the impact of Rojiroti loans on families, particularly on women and children's

welfare. Connections between microfinance loans and empowerment of women are poorly understood. This research recognizes the difficulty of measuring empowerment since it is a partially subjective, complex and fluid notion. It aims to explore empowerment through the voices of the women loan recipients, thereby addressing gaps in knowledge about the qualitative, nuanced factors behind the experiences of mothers and the improved health of their children. The study reveals that this scheme of loan is more beneficial in emergencies, helpful in availing medical facilities and empowerment of women. The women said that the loans are also helpful in small business and agricultural work. The study also reveals that loan is not a solution to any problem, repaying the loan amount and interest rate is a big burden to the poor people. She considered that it is not only beneficial in difficult situations, but also one of the best alternatives of any other loan scheme.

The next speaker, Suchitra Ruth presented a paper on '*Participatory groups and home visits to improve children's growth in rural India: challenges and solutions from rural Eastern India*'. The CARING (Community Action Research to Improve Nutrition and Growth) study was done in two eastern Indian states of Jharkhand and Odisha. It was a Cluster-randomized controlled trial with 120 villages randomly allocated to 60 intervention and 60 control villages. During this three years of intervention followed a cohort of 2520 mothers at seven different time points starting from their third trimester of

pregnancy, at birth, and when the child was 3 months, 6 months, 9 months, 12 months, and 18 months of age to see the impact of intervention on children's growth. An economic evaluation was done to see the cost effectiveness of this intervention. Communities have a critical role to play in helping children thrive. Combining interventions for IYCF (Infant and Young Child Feeding), infection control and stimulation effectively is not easy: food and illness are often higher up in parents' priorities than stimulation. In rural India, there are 2-3 community health workers involved in promoting health, nutrition and stimulation in the 1000 days, which can lead to poor integration of activities there is reluctance to introduce new frontline workers. Demand-side

interventions like PLA and home visits can benefit children's diets, weight and survival, but to reduce stunting measurably, more intense supply-side interventions (like crèches) are probably required. More tools to measure child development reliably in large community-based studies are needed.

In the post lunch session, five technical sessions were conducted. All the technical sessions were organized in five different parallel panels, chaired by the expert and facilitated by the project team members. These sessions were based on different themes. The following section presents a succinct account of the proceeding of the parallel sessions.

Panel-I: Anthropological and Sociological Perspective of Women Empowerment & Child Health

Chairperson: A K Kapoor, Former Vice Chancellor, Jiwaji Univ & Prof & Head, Department of Anthropology, Univ. of Delhi.

Speakers

1. Subir Biswas & Chitradip Bhattacherjee, Professor, West Bengal State University, Barasat, West Bengal
2. P K Patro, Associate Professor, Dept. of Anthropology, Utkal University Odisha
3. Rajesh K Gautam, Associate Professor, Dept. of Anthropology, Dr. H S Gaur University, Sagar, Madhya Pradesh
4. Ganganath Jha, Assistant Professor, Dept. of Anthropology, V.B. Univ., Jharkhand
5. Debendra Biswal, Assistant Professor, Central University of Jharkhand, Ranchi
6. Papia Raj, Assistant Professor, IIT Patna, Bihar

This session was chaired by A.K. Kapoor. A team member, Esther Bott, from the organizing committee of the workshop, also sat in the deliberations to facilitate the discussion. At the outset, the chairperson briefed the theme of the session. The first presenter of the panel Subir Biswas tried to redefine the

relations among gender equality, equity and child health in his paper titled '*exploring links between gender equity and child health among Muslims: the West Bengal scenario*' He emphasized on the fact that gender discrimination remains a major barrier to human development. However in his study of 2000 Muslim pre-school children (1000 of each sex) in five blocks of district North 24 Parganas, he found that children of both sexes are getting equal health care from their parents and there is no significant discrimination statistically present regarding health care practices between boys and girls. Thus the study depicts the fact that though gender discrimination evidenced from different regions of Bengal as well as India, but the present area of study offers both boys and girls the equal rights to survive from health perspective. There is no gender discrimination in upbringing of children among the studied community.

The second speaker Prasana Kumar Patra presented his paper on '*women empowerment and reproductive child health status among the tribal communities of Odisha: an Anthropological reflection*', which is based on ethnographic study among six scheduled tribal communities of Keonjhar, Mayurbhanj and Nawarangpur districts of Odisha. He outlined the fact that empowerment of women is about the process by which those who have been denied the ability to make strategic life choices acquire such an ability and their choices have also yielded positive health outcomes for their children. He found in his ethnographic study that raised standards of educational attainment and economic standard of mothers have positive impact on child's immunization status and child's nutritional status (stunting status). This has also positive impact on other demographic indicators such as institutional delivery, infant mortality rate, ANC and PNC check-ups. Women become more independent to take decisions for health and education for themselves and for their children.

The Next speaker of the panel Rajesh K. Gautam presented a paper related to 'maternal and child health with reference to the tribal women'. He said women are more susceptible to various diseases as they have to perform major role in reproduction. But our health systems are neither having any assessment nor any planning to combat with the problems of future. To ensure women empowerment, it is essential that they must enjoy a healthy life with confidence that they will get all kind of public health care services. The situation is further worst in Tribal areas, as they have multifaceted problems. At one hand, they are always struggling for basic civil amenities and on the other hand they have extreme poverty, illiteracy, unemployment, debts, usury, exploitation, corruption, etc. In this precarious situation, it is difficult to think empowerment of women.

Fourth presenter of the session, Ganganath Jha discussed about the general socio-economic and development status of tribals in his paper '*PVTG women*

and their empowerment: special reference to Birhor of Hazaribagh, Jharkhand'. Birhor belongs to the particularly vulnerable tribal group (PVTG) and they are known for their nomadic way of life. This study was conducted in Hazaribagh district of Jharkhand. He said that the government has been implementing PVTGs specific schemes to raise their socio-economic status, but despite the efforts of the government, there have not been substantial improvements in their socio-economic status, even in comparison to other scheduled tribes or PVTGs of the state. He also tried to present the major changes occurred in the socio-economic life of Birhors in recent times and their struggle to cope-up with the present situation. He further mentioned about the changes in their child rearing practices owing to the influence of outer world.

Another speaker, Debendra Biswal presented a paper titled '*maternal health care needs private sector initiatives: case of community participation in Janani Suraksha Yojana (JSY) in the tribal areas of Jharkhand'*. He said that JSY has not much accommodated the primary health care approach (Alma-Ata Declaration in 1978), which recognises community participation as a complement to any facility-based component to improve maternal and child health. It is evident more in the tribal areas, which shows that there is a huge gap between its normative and praxis level; lack in considerations of socio-economic, geographical and cultural values of tribals, lack of epidemiological logic reflected in its investment pattern, and appropriation of technology and decentralization of the programmes. He emphasized that since public sector health care is unable to improve the situation, private sector health care providers may be involved in the line of PPP for effective implementation of JSY among tribals of Jharkhand.

The last presenter of the panel Papia Raj discussed the issue of '*health technologies for empowerment of women in Bihar*'. She said that the women are facing more difficult situations in the backward states, such as Bihar because of poor health status and low literacy level. The literacy level of women is even poor in the state. She tried to explore the role of health informatics tools, such as, mobile phone, also known as *mHealth*, in improving maternal and child health scenario of Bihar. This will obviously lead to the women empowerment in the state. In developing countries like India, mobile phones are serving as an excellent medium for establishing health communication. Most importantly, literacy does not seem to be a barrier in the use of mobile phone. So it has the potential to address the issue of health inequalities in remote locations where there is shortage of medical resources. The technological intervention in public health care may be a better way to improve the health of mother and child.

Panel-II: Socio-Cultural & Economic Perspective of Women Empowerment & Child Health

Chairperson: D. M. Diwakar, Former Director, Professor & Head. Division of Economics & Agricultural Economics, ANSISS, Patna.

Speakers

1. Rajiv R Thakur. Dean & Professor, BIMTECH, Greater NOIDA. Uttar Pradesh
2. Dilip Kumar, Joint Director, Population Research Center, Patna University, Bihar
3. C S Verma, Associate Professor & Coordinator, GIDS, Lucknow, UP
4. Ajit Kumar Singh, State Facilitator-Bihar, NHSRC, Patna
5. Brajeshwar Prasad Mishra, Programme Officer, Save the Children, Patna

Panel-II on Socio-Cultural and Economic Perspective of Women Empowerment & Child Health was chaired by D.M. Diwakar. The chairperson

briefed the presenters about the session. He also put forth the theme of the session, in which he highlighted the main concern of the session. Dr. Shalini Ojha, one of the organizing committee members of the workshop facilitated the discussion. Altogether five presentations were made in the session.

R R Thakur, the first speaker in the panel, presented a model titled *'SE 9D NUT+ GEN- A Suggestive model'* to improve the malnutrition status of children and empowerment of women in the state. He underscored that healthy nutrition is a critical input for ensuring good child health. He explained the background and meaning, size and impact of malnutrition in any society, which is quite significant requiring a holistic approach for its eradication. With the objective of eradication of malnutrition in the society to ensure good child health, he has proposed a suggestive model drawing cues from real life cases and

mythological beliefs prevalent in our society. The model advocates 'Hygiene in addition to Nutrition' to beneficiaries, assured through an integrated approach around a given ecosystem focusing on Empowering women and Genuity.

Second speaker Dilip Kumar talked on relationship between women empowerment and child health and said that the women empowerment may create a range of health benefits to the women and children. He has taken the data from secondary sources, such as census, 2011 and NFHS-4. Based on this analysis, he observed that the state has shown improvement in many health and socio economic indicators, such as decrease in TFR, increase in life expectancy, literacy rate, decrease in gender gap in literacy, decrease in malnutrition, less spousal violence, etc. The percentage of women owning a house or land alone or jointly is more than national average. Similarly, the state has also witnessed increase in household decision making by women, women representation in PRI, having saving account, etc. On the basis of the data, the overall condition of women has been improved in the state, but, we still need to find out the actual situation at the grass root level, whether the women are actually empowered and exercising her authority achieved over the years.

Third speaker of the panel C S Verma presented a paper on '*Impact of women empowerment on health of under-5 children: a case study from Uttar Pradesh*'. He emphasized the fact that the women cannot contribute meaningfully in the process of development, until their own development is taken care of. However, there is enough evidence to show that empowered women contribute significantly to better development indicators including nutrition and health of children. He discussed about intervention programmes in three blocks of Raebareli district of Uttar Pradesh for accessing the public health services by women. The three years intervention programmes on 210 women belonging to the SHG had been conducted. Results show direct relationship between empowered women and nutritional intake, immunization and visits to health Sub Centre, PHCs and other public health institutions. Different indicators of nutritional intake in the form of colostrums feeding, immunization and weight of children, improved satisfactorily during the period. Empowerment of women SHG members also witnessed qualitative change from economic empowerment (through livelihood development) to social and political awareness and empowerment through awareness and education.

The next speaker Ajit K Singh discussed '*cultural and economic perspectives of women empowerment and its relation to child health*'. He said that when women are empowered in totality, their children have automatically better health. In India, urban woman are far more educated than rural women due to its socio-economic structure. Quality and continued education and control over resources by women are key elements of empowering women in the country. A supportive legal provision for land rights is also one of the important interventions that will lead to change in status of women. It will

provide social security and opportunity to earn more and take decisions for better health and education for women and their children. He also discussed factors behind high rate of child mortality under the age of five years and major diseases of children, such as, Diarrhoea, Pneumonia, etc. He further discussed about ten strategic interventions to improve child survival like provision of essential care of child, expansion of services for care of sick newborns and home based newborn care, etc

The last speaker of the panel Brajeshwar Prasad Mishra discussed the skill development for the women which may be helpful in empowering the women. Economic empowerment of women will automatically lead to social development and better access to health, nutrition, and education of their children as well. He has taken the reference of one of the ongoing projects of 'Save the Children', where women are being provided skill training. This has positive impact on women and children health as well.

Panel III: Public Health Perspective of Women Empowerment & Child Health

Chairperson: Barun Kanjilal, Health Economist, Former Dean & Professor, IIHMR University, Jaipur

Speakers

1. Santosh Kumar, Public Health Expert, UPHSSP, Lucknow
2. Gowtham Ghosh, Assistant Professor, IIHMR University, Jaipur
3. Dr. Ram Ratan, State Immunization Officer, SHSB, Patna
4. Arvind Kumar, State Data Officer, State Health Society Bihar, Patna

This session tried to explore the role of public health in women empowerment and child health. During the session, four Public health experts and state level health officials presented their papers in the session. The session was chaired by Barun Kanjilal and facilitated by Alan Smyth, main coordinator of the

workshop. The session started with the presentation made by Santosh Kumar on the topic '*women empowerment: use of technology for better motherhood*'. He said, Bihar is one of most populous states in India and has very poor health indices. A variety of socio-economic factors, such as, delivery at home, social restrictions, low expected returns of girls' education, poverty, inequality, poor implementation of programs and schemes etc., are responsible for women's poor health attainment. Mother and Child Health is an area where care giver (ASHA, ANM and AWWs) and care seekers both are primarily woman and hence it was envisaged to use technology which would enable these service providers to provide MCH in a better way and also empower beneficiary-mother and her child to attain a better health outcome. He mentioned about an intervention project, which was carried out in PHC Kanti area of Muzaffarpur (Bihar), where 10 ANMs were provided with mobile and online App. The intervention has shown positive impact on both health seekers as well as providers. The output of ANMs have improved significantly, as now they did not require to carry multiple files to the field, also since data entry in the mobile was menu driven it improved data quality and online reporting of the data. ANMs could now generate due list of beneficiaries she should see on a given month, what would be the supplies required for the months, etc. On beneficiary side, they could have access to pre-recorded messages about different program available to them, mother having mobile phones were able to receive reminders for due services, etc.

The second speaker of the panel, Gowtham Ghosh presented a paper on '*health of disabled women and children in Bihar: an opportunity for inclusion*'. He raised the issue faced by disabled women and their exploitation. He advocated skill development programmes for them. He also said the motive of NFHS does

not match data with the definition of women empowerment. He drew attention towards the condition of disabled children. Out of the total disable population in India, women constituted to 44 percent and children in the age group of 0-6

years 1.24 percent (20.42 lakhs) are disabled. Bihar state has 8.69 percent disabled populations and having highest share (14.24 percent) of disabled children (0-6 years) in the population of disabled persons in India. These figures have wider implications in future. Poverty and disability both are the major concerns for our country. He advocated adding disabled women and children to mainstream programme. The importance of women empowerment and an active political will to achieve it is evident from the fact that there is a whole SDG dedicated to it - SDG 5 - achieve gender equality and empower all women and girls. Gender inequality persists worldwide. Women, across the globe and throughout history, have faced gender-based discrimination. This discrimination is compounded if the woman is disabled. A woman or a girl with disabilities faces discrimination and barriers because she is disabled, because she is a female and because she is a female and disabled.

The next speaker of the panel Ram Ratan has tried to present the government's perspective and discussed about the *"women empowerment through the success of primary health care"*. He said women enjoy the health facilities, empowerment, and reproductive rights. He defined women empowerment in three perspectives; technology/knowledge, service and economic. Under the technology he discussed the eVIN (Electronic Vaccine Intelligence Networking) which was implemented in June 2016. Service providers, such as, ASHA, AWW, ANM, SHGs worked very well for the health of women and children. He also mentioned the *'Janani evam Bal Suraksha Yojana'* (JBSY), through which women of the state have been benefitted and empowered.

The last speaker Arvind Kumar talked about the role of data in successful implementation of public health programmes. He emphasized the fact that for the formulation of policy and successful implementation of any public health program, quality data is required. He especially mentioned about a few important applications of the health department being implemented in state of Bihar, such as, Reproductive and Child Health (RCH) and ANMOL. He underscored the issue of use of data in evidence based decision making, but there are some constraints as well in quality aspects of the routine data generated through these applications.

Panel-IV: Structural Constraints of Women Empowerment in India: Historical Trajectory and Emerging Paradigm

Chairperson: B N Prasad, Professor & Head, Division of Sociology & Social Anthropology, ANSISS, Patna.

Speakers

1. Aditya Raj, Asst. Prof, Humanities and Social Sciences, IIT, Patna.
2. Renu Choudhary, Asst. Prof., Division of Sociology & S. Anthropology, ANSISS, Patna

3 Kaushal Kishore, Asst. Prof., Division of Sociology & S. Anthropology, ANSISS, Patna.

4 Nehit Prasad, Research Officer, Vinoba Bhave University, Hazaribagh

This session was chaired by B.N. Prasad, A team member from the organizing committee of the workshop. Rajeev Kamal Kumar also sat there to facilitate the discussion. The chairperson briefed the presenters about the session. He also put forth the theme of the session, in which he highlighted the main concern of the session is to explore reasons for perpetuation of hitherto patriarchal social structure and consequent gender discrimination: in spite of significant economic transformation, democratic polity, emergence of diversified modern values and infusion of technological growth. One of the plausible reasons is that capitalism which constitutes economic base continuously restructures patriarchal social institutions for its own growth. While doing so, it subsumes the later but allows maintaining; what Althusser argues its 'relative autonomy'.

Aditya Raj, the first speaker of the panel, presented his paper on '*community based education for gender empowerment in Bihar*'. He opined that the attitude of men and the normative practices of the culture, here in the state, have subjected women and girls at the far end of disempowered spectrum. Traditional taboos have found new forms, as lack of freedom for perusal of life

opportunities keeps declining. This has been embedded in the society and culture, which we have been inheriting for long. Most frightening, in the absence of any hope, is the gradual acceptance of disempowered situation by women and girls. This is valid for the women belonging to any class, caste group. More or less, the women are disempowered in every type of societies, but the jeopardy further multiplies for women and girls of lower caste because the hold of caste system is still paramount in Bihar. This can be broken down by a virtuous cycle by understanding women and girls from their perspective and with them at the pivot and by using technologies which facilitate

participation, awareness, autonomy, capacity, and power for their utility. Enabling technologies, with the help of equitable governance, can create processes for vital community based education which may cut across the structural barriers of caste and class.

Renu Choudhary spoke on '*structural constraints and emerging paradigms of empowerment among Dalit women in Bihar*'. She said - Dalit women faces

systematic oppression, social exclusion, direct and structural violence within their own community as well as from other 'upper' caste people. She has taken the data from the secondary sources, such as, Census of India, NFHS-4, etc. The latest data on SC shows some improvement in health and education compared to the past, but the improvement for SC women is very slow than the women belonging to general caste. She argued community exploitation is less than societal exploitation for Dalit women. Women are subjugated in the society even after so much of advancements, mainly because of their economic dependency on their male counterparts. This exploitation is also rooted in long tradition and culture of the communities.

The next presentation was on a primary study on Tharu community entitled '*A socio-economic analysis of women's empowerment and child health*' (in Hindi). The speaker, Kaushal Kishor said the women empowerment is closely linked to the child health as the child is fully dependent on mother well before the birth, and even after the birth, the child remains dependent for nutrition and health on the mother. He also enumerated three basic factors of women empowerment, i.e., social, educational and economic. He further said that the Tharu women who are more educated and socially and economically more empowered can take better care of their children as compared to the other group of women. Tharu women also enjoy more autonomy and freedom in their family and society.

The last presenter of the session Neha Prasad spoke on '*Institutional barriers to women empowerment*'. Her talk was not very specific and well researched, but highlighted a few important issues related to the women in Indian society in general. She has talked about the general issues faced by women in their day-

today lives in the society. The main barriers to the women empowerment, according to the speaker are lack of resources, lack of land ownership, poor access to finance, violence against women, etc. To empower the women, the above issues may be taken care of. The improved status of women in their families will definitely improve the health of women and children.

Panel-V: Economic Perspective of Women Empowerment & Child Health

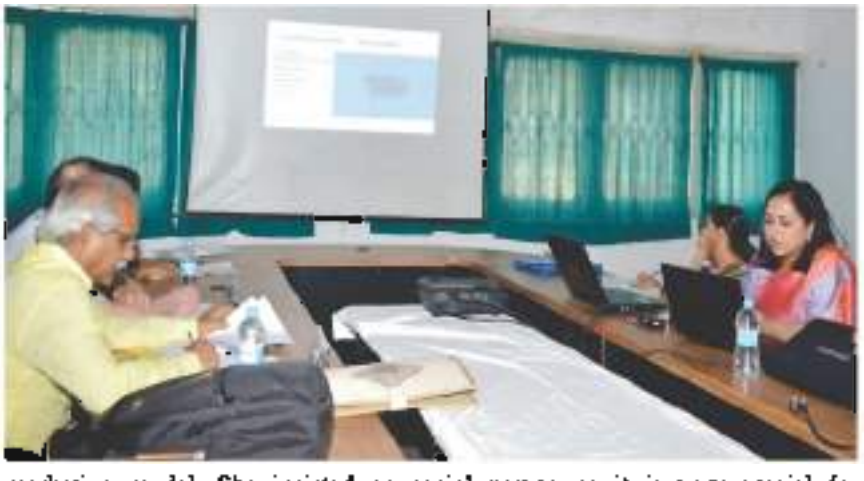
Chairperson: Sankar Majumder, Department of Rural Studies, Institute for Rural Reconstruction, Visva-Bharati, Sriniketan, Birbhum, West Bengal

Speakers

1. Vinita Srivastava, Asst. Professor, JIMS, Delhi
2. Ranjeet Kumar Sinha, Associate Professor, PMCH, Patna
3. Abhijit Ghosh, Asst. Professor, ANSISS, Patna
4. Manish Kumar, Social Development Specialist, IL&FS, NNP, Patna
5. Sanjay Suman, Senior Manager, Global Health Strategies, Bihar

The last parallel technical session of the workshop on economic perspectives of women empowerment and child health was chaired by Sankar Majumder. The chairperson of the session explained the theme and subsequently open the session for presentations by the listed speakers. A total of five speakers presented their work in the session. Gil Yaron was there from the organizing team to moderate the discussion.

Vinita Srivastava, first speaker of the session presented a social marketing model and talked about dimensions of women empowerment through social



marketing model. She insisted on social power, as it is very crucial for

empowering women. She also accepted the fact that the child health is aligned with women empowerment. An empowered woman can take care of her child and her family in a better way. She also tried to establish the link between economic power and women empowerment. Her concern was related to women's ability to make decisions through economic power that will lead to achieve the goal of women empowerment. According to her, social marketing model empowers women and culminates into a better health environment for the future generations. She also discussed about spiritual power, which is interconnected with women empowerment and finally child development.

The next speaker of the session, Ranjeet Kumar was also part of the first phase of the women empowerment project, lead by the Nottingham University. He discussed the '*economic dimension of women empowerment*' through a few case studies. He underscored the importance of literacy and education as education is crucial element in economic and social development, which also leads to a greater level of awareness and improvement in economic condition. It also increases female participation in decision making and pre-requisite for acquiring various skills and better use of health care facilities. Education has inverse relation with fertility as it delays the marriage age of girls. Similarly better economic condition has inverse relationship with fertility, and virtually all well-fed societies have low fertility. He mentioned a study in which it was

found that stunting was more prevalent among children of Eastern India as compared with Bangladesh. Mother's body mass index, mother's age, sub-region, community, religion, wealth quintile and empowerment indicators had significant association with child stunting. He also gave another case in which it was found that there is a strong and positive influence of the active participation of women in making decisions in the household on their children's health status. He concluded that in the present project study, it was also found that the women belonging to marginal section are involved voluntarily in SHGs, run by Roji Roti which has added financial security and women are now able to make important household decisions.

The next paper titled '*exploring the intersection between women empowerment and child health in Bihar: an economic perspective*' was presented by Abhijit Ghosh. He tried to link women employment with women empowerment and underscored the issue of women empowerment as it is a very subjective term, encompassing a set of complex dimensions. He further said that economic independence of a woman forms the base of empowerment and is the most important indicator of development. The participation of women of Bihar in labour market is very low in comparison to all India average. If we look at census data, there are only 13.42 percent main workers for female; while male counterpart is as high as 52.46 percent. The incidents of BMI of girls aged 15 to18 years and women aged 15 to 49 years are 45.2 percent and 30.4 percent respectively. It is also found that there is a direct relationship between under-weight of children and incidents of low BMI, which is significant and positive therefore the children health cannot be separately taken care of without considering improvement of mother. He also talked about the educated women and their employment situation in the state. By providing district level data, he argued that in terms of per capita income, Patna is an outlier. It is much ahead than the other districts of the state. It is found that there is a huge gap among districts in terms of per capita income. This is one of the biggest obstacles in the journey of women empowerment and the overall development of the state.

The next speaker of the session, Manish Kumar shared his first hand experience on the theme. As social development specialist at IL&FS, he worked with the rural women and came across their social problems. He also shared the intervention done by his institution, and the changes brought into women's lives. He said that women empowerment is very essential for improving the child health in India. He emphasized on positive role of SHGs in empowering women and improving child health.

The last speaker of this session, Sanjay Suman has focused more on health aspects, which are essential for women empowerment. The main concern in his presentation was the decision making of a woman especially in the matter of family planning. He emphasized that family planning and focus on improved reproductive health is critical for growth, equality and sustainable development that open the door to several opportunities resulting in prosperity for women and families everywhere. However, every time we fail to identify and address the issues around reproductive health and family planning services, 'women' suffer the consequences in shape of unwanted and unplanned pregnancies. Motherhood by choice is an incredible and rewarding experience in a woman's life. Women empowerment is not possible without first investing in the health of women and children. With better access to family planning, we would see improvements in the health of women, children and entire communities. More women could advance their education, participate in the workforce and contribute to the economy. He also discussed the factors that hindering the proper family planning services. The need of the present day is adoption of a

more holistic approach of ensuring reproductive health and rights for all and not only population control. There is a need to raise awareness on the importance of spacing methods, new contraceptives, common myths/misconceptions, government facilities and schemes, among all sections of the society to ensure an increase in the uptake of family planning services.

Presentation by Panel Chairs

Chairperson: Alan Smyth: Professor of Child Health, University of Nottingham, UK & Shalini Ojha: Clinical Associate Prof. of Neonatology, University of Nottingham, UK

After the completion of parallel sessions, the chairperson of each of the parallel session was requested to present the main findings and issues raised by different speakers in the parallel sessions. The main purpose of this session is to identify the important issues pertaining to the theme of each session, and also to inform all the delegates together about the proceeding of the parallel sessions. This session was chaired by Alan Smyth and Shalini Ojha.

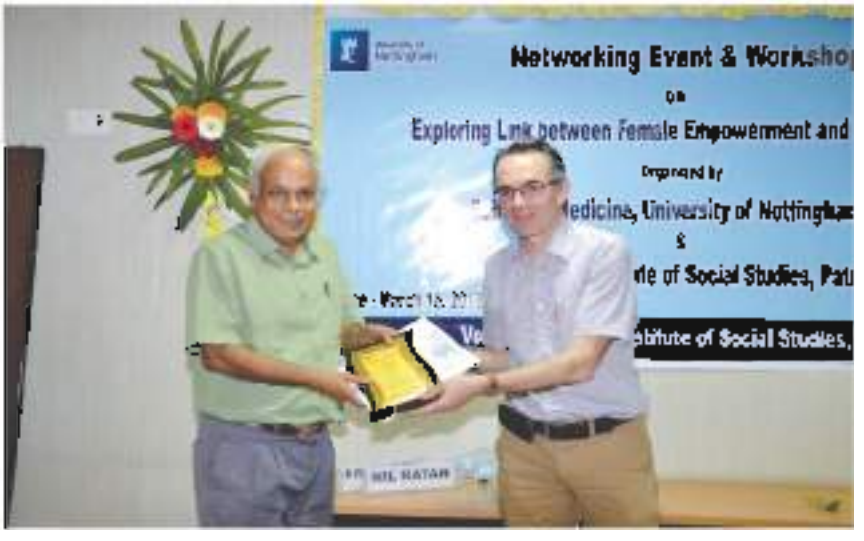
The chairperson of the parallel session-I on Anthropological and Sociological perspective, A K Kapoor presented the summary and main findings of the session. He informed the audience about the presentations being made in all the six presentations. The presenters talked about different categories of women- rural, urban, tribal and Muslim women and RCH issues. Most of the presenters shared their studies which were based on the field study. By way of conclusion, he said we are ignoring the psychological aspect of women empowerment. For the implementation of any development programme, we have to also see the psychological aspect of human, as many studies shown women are controlled by their husbands in Indian society. Women still face domestic violence and liquor is one of the reasons of domestic violence. Women should understand the meaning of empowerment and realize their power. He also referred a study conducted by him, where women became united for their welfare.

The presentation on Parallel Session-II on Socio-Cultural perspective of women empowerment and child health was made by its chairperson D M Diwakar. He described the brief findings of the papers presented in the panel. He said the session dealt with some specific issues pertaining to the women empowerment and child health, such as demographic scenario and gender gaps in the state, role of SHGs in women empowerment and child health, especially children under five years of Uttar Pradesh, women education, etc. It has emerged from the presentations that non economic issues, viz. political awareness and participation of women, awareness to their rights and entitlements, education and health needs of the women, etc., are also important in addressing the women empowerment. Even the households with better economic capacities are behaving in same manners because of the patriarchal nature and they are not different otherwise. Focus on adolescent girls' health and generating awareness among them can also lead to better results in terms of mother and child health in future. He suggested addressing the issue of women empowerment and child health through socio economic perspective. He also said if we have to look into the outcome of the health of children, the issues of education, caste and assets (wealth), nutrition, preventive health care through gender issues, etc., should be taken care of. The other research question comes through the political empowerment and participation through which one can intervene. He also asked, can we think of having redistributive model in terms of utilization of services and spending, and if break the patriarchy, can we go for the public utilization in a better way?

Ramu Kanjilal discussed about the proceeding of Panel-III, chaired by him. There were four presenters in the panel. First two presenters talked about the use of technologies in empowering the women and enhancing the child health, and public health. The third presenter talked about the disabled women and their health. The last presenter put forth the government's perspective with a few examples of the public health schemes. The government has come up with different technologies and web portals related to RCH, vaccinations programmes, and mobile based technologies available. The argument was that these technologies are helpful to the frontline health workers. In addition to technologies there are also some other initiatives for example, the incentives currently given to ASHA/ANM has somehow empowered these providers as well as beneficiaries. He also raised a few pertinent questions in his conclusion - whether recent technologies are helpful in empowering the women and to what extent they contribute in the empowerment of women providers?, can these technological initiatives be a substitute in gaps of service delivery?, and whether the link between women empowerment and child health is linear or by empowering the women it will improve the child health?

Panel-IV on the theme structural constraints of women empowerment in India: historical trajectory and emerging paradigm was chaired by B N Prasad. There were four presenters in the panel. On behalf of the panel chair, one of the

presenters of the panel, Aditya Raj, has briefly presented the proceeding of Panel-IV. He focused on traditional taboos of Bihar, which are the main barriers in the women empowerment. This vicious cycle can be broken by understanding women and girls from their perspective and with them at the pivot and by using technologies which facilitate participation, awareness,



autonomy, capacity, and power for their utility. Enabling technologies, with the help of equitable governance, can create processes for vital community based education, which may cut across the structural barriers of caste and class. If we look at the health status of poor and women belonging to the marginalized caste, studies reveal that individual's poorer health status, including higher morbidity, lower life expectancy and higher rate of infant mortality, are linked to her race, ethnicity and caste, and in certain cases, nationality. Scheduled Caste (SC) women are one of the historically deprived groups, as reflected in poor maternal health outcomes and low utilization of maternal healthcare services. But the situation among the tribal communities is somewhat different from the women belonging to the caste group. Socially and economically empowered women have better health condition of their children.

Towards the end of the workshop, the participants were given a certificate of participation and memento. Rajeev Kamal Kumar, one of the Coordinators of the workshop, presented closing remarks and vote of thanks. He also acknowledged the support of the main coordinator from University of Nottingham, Alan Smyth and other team members. He thanked the delegates who came from different parts of the country and also appreciated the efforts of the faculty members, research scholars and support staffs of the Institute.

Annexure- I: Brief on the theme by Chairpersons of the Panel

Theme: Socio-Cultural & Economic Perspectives of Women Empowerment in Indian

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Place of women in a society reflects the level of progress that a society has attained with respect to a particular time and space. This also reveals about the prospects of future society, as child is the glimpse of a future society. This connection of women and children may be seen with two perspectives. One considers women as an object and the other considers women as a subject. When we consider women as an object, we presume to plan, work and evolve strategies and programmes to address the issues of women empowerment through designated institutions and agencies considering the challenges of mainstreaming women. In this worldview woman is a problem and others have to be sensitive to respond to the problems. We can imagine a huge structure, funds, deliverables, monitoring and evaluations, backward and forward linkages, transparency and governance, etc. Therefore, similar to investment in poor empowerment of women is rooted through investment in women. Here presumption is that women are weak, they need supports, they should be protected, etc., etc. It may or may not be necessary to trust on the wisdom of woman whether she has an insight and she is capable of forwarding solutions to resolve the problems. In such a situation all the ideals and responsibilities are judged through patriarchal mindset. India travelled from welfare to development, empowerment, participatory, inclusive modes of development strategies, it has achieved many of the deliverables also but still much are left much to be desired even at the front of basic needs including, education, sanitations and health

The other world view is to consider women as subject, where women are not just problems; they are the part of solutions too. Therefore, any solution for empowerment of women needs to be reflected through gender's perspective, which necessarily presupposes women leadership for resolutions of problems coming in the way of women empowerment. Be it the questions of empowerment as a concept, mechanisms to address the issues, deciding programmes, strategies, deliverables, monitoring and evaluations, etc., etc. Providing helping hand through requisite logistic support could be a friendly environment for policy and programme implementation. For instance, Global Hunger Index includes indicators such as malnutrition among women and infant mortality rate, which provide a basis to look into the linkages between women and child. There could be many such indicators which need explanation about wasting and stunting of children, despite so many welfare, development,

and participatory inclusive measures of empowerment. This needs structural explanations of the problems.

Theme: Public Health Perspective of Women Empowerment & Child Health

Child health care in female-headed households living in specially disadvantaged areas

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What are the possible implications of changing decision-making structure (in a particular household) on child health? The question is crucial in the context of the rising trend of male migration especially in the specially disadvantaged areas where poorer households face a shrinking scope of livelihood due to rapid and adverse changes in the physical and social environment. The young males in these areas, many of them are married, often leave their families and migrate to the cities for better opportunities. The households, affected by the temporary migration of the earning male members, are headed by their wives, mostly out of compulsion. In such cases, the presence or absence of women's social support systems or social ties with other members of a community stand out as an important criterion of empowered mobilization of resources for health care for women and child health.

The issues related to child health in the female-headed households in India have been gaining attention from the researchers in recent times. Several research issues have emerged although the available scientific evidences are too inadequate to draw specific inferences. The issues primarily centre on the health seeking behaviour of the female-headed families' vis-à-vis their male-headed counterparts. It is important to generate more evidences to explore to what extent the abrupt change in a family's decision making process - after the migration of a key male member (or, husband) and consequently the increasing responsibility of the adult female (or, wife) - affects the health as well as the health seeking behaviour, especially in the context of women and child health care. The issue becomes more complex when the female head is also engaged in new income-generating activities that require her to stay a long time away from home and her children.

For example, a research on the health care system of the Indian Sundarbans, a geo-climatically vulnerable area in Eastern India, has clearly demonstrated the need for better understanding of the concept of 'women empowerment' in the context of health care decisions by female-headed households (http://www.futurehealthsystems.org/india). Being a water-locked area, accessing healthcare facilities for health care is always a challenging task for the women living in the remote islands, more so when there is no adult male

member to escort her during the process. Consequently, as the anecdotal evidences revealed, the women in such cases are compelled to visit the local quacks more often simply because they are within reach. This is clearly a negative effect even though the mother is the sole decision maker in the family.

A social network analysis, conducted under the same research programme, with the women whose husbands have migrated to cities in search of job came up with several findings regarding the role of social support system in this context. For example, a mother whose husband has migrated out of the area for a long period of time may have to seek more support from the social support system compared to another whose husband is regularly available to provide her with the necessary support. The mothers with migrant husband, who had to resolve health problems of their children on their own, have to build a more strong resource mobilizing and leverage network outside the secured boundary of family and kins. As they mostly depend on the wider network for their livelihood and survival, the child care seeking also have to be depending on the decision and process guided by this network.

Theme: Structural Constraints of Women Empowerment in India: Historical Trajectory and Emerging Paradigm

Political economy of women empowerment in India: Structural constraints and emerging paradigm

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Historically speaking; larger the gap between layers in social stratification system, the system is more prone to domination and exploitation. Traditional Indian society has been the most unequal and rigidly patriarchal society, negating thereby any successful representation of gender equality and democratic social order. Gender discrimination is the result of exclusion of females from productive resources. This results into deteriorating health status, limited educational opportunities, poor nutritional condition and increasing female morbidity, lack of hygiene and safe drinking water; to credit and aptitude to exercise one's democratic egalitarian rights. Gender is central consideration of society to assign roles and responsibilities, distribution of resources and rights between male and female. Allocation, distribution, utilization, and control of resources are thus incumbent upon gender relations embedded in both ideology and practice. However; establishment of democratic regime in India has impacted patriarchal institutions. Democratic value system, modernization, rising level of literacy among women have contributed positively towards establishment of little more egalitarian and humane society. With emergence of culture of rising aspiration among Indian women coupled with educational development and capital intensification, human capital content of girls in terms of self assertion, both economically and socially, is opening up

new choices for them. By virtue of being part of labour market and their growing association with mainstream social and economic processes that are integral part of commodification process, seems to be providing more democratic space for women equality. But all engrossing question remains that whose socio-economic space is expanding in a social system where structural differentiation rules the roost of development and social change.

Main concern of this paper is to explore reasons for perpetuation of hitherto patriarchal social structure and consequent gender discrimination; in spite of significant economic transformation, democratic polity, emergence of diversified modern values and infusion of technological growth. One of the plausible reasons is that capitalism which constitutes economic base continuously restructures patriarchal social institutions for its own growth. While doing so, it subsumes the latter but allows maintaining, what Althusser argues its 'relative autonomy.' Paper also tries to locate emerging gender paradigm vis-à-vis patriarchal hegemonic control; with the help of parameters like education, health, work participation, and domestic violence.

Theme: Economic Perspective of Women Empowerment & Child Health

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Concept of women empowerment is multidimensional: expansion of economic, political, social, cultural and familial power of female. Understanding women empowerment demands operationalisation of the concepts of female empowerment from each of these angles. For this, it is necessary to conceptualise their measurements (either quantitatively or qualitatively). Each of these concepts has several dimensions. For example 'Economic Power' may be considered at individual personal level, family level, at group or community or local level, at district level and so on. Again 'Economic Power' may be considered from asset ownership level, from income level, employment level, etc. One may consider any one of these aspects or may calculate index of each aspect and then consider the index of all these aspects by clubbing the indices of these aspects. Similarly, social, political, cultural, familial powers have their respective different levels as well as types. Here also indices may be constructed.

Child Health is a concept. For understanding this concept its operationalisation is also required. Health of a child may be understood by his/her nutritional level. Three commonly used measures to understand level of child nutrition are height for age, weight for age, and weight for height. All these are again dependent on food intake and many other factors like hygiene, sanitation, etc. Child Health of a geographical space or of a social group may be understood by CMR, IMR, level of immunisation, etc. While exploring the links between

women empowerment and child health researchers need to keep in mind that any of the above mentioned aspects of either 'women empowerment' or 'child health' is not dependent on any single factor. Rather each of them is dependent on a large number of factors. For example 'Child Health' as conceived in terms of immunisation is not determined by the income level of the family from where the child comes. Rather it depends on the provision of public health services. Expansion of women empowerment in terms of economic power, specifically personal income definitely contributes to the development of child health. But researchers need to know that development of child health is not simply due to increase in economic power (income) of the family but due to contributions of many other factors like government provisions of health services, awareness level, etc. Another important aspect in this type of research through primary survey is related to the process of data collection. Who are the actual respondents at the time of data collection? Is respondent head of the family? Is respondent a female /male member? Is respondent the person who is supposed to give answer? Or simply the person available in the family at the time of survey? Findings of the research largely depend on all these.

Annexure- II: Abstracts

Participatory women's groups and children's growth: what can we learn from the CARING trial?

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This abstract describes the contents and effects of a community based strategy to improve children's growth in rural India. One third of world's stunted children live in India with highest prevalence in poorest wealth quintile. Stunting is a marker of chronic under nutrition. The underlying causes are linked to maternal under nutrition, early and frequent childbirth, infections and poor nutrition during the first 1000 days. Stunted children tend to receive insufficient stimulation, which further affects their development and are also deprived of their opportunity to develop to their full potential because of poor nutrition and repeated infections in the first 1000 days of life. CARING (Community Action Research to Improve Nutrition and Growth) trial was done in two eastern Indian states of Jharkhand and Odisha. The CARING study was a Cluster-randomized controlled trial with 120 villages randomly allocated to 60 intervention and 60 control villages. During this three year of intervention we followed a cohort of 2520 mothers at seven different time points starting from 3rd trimester of pregnancy, at birth, and when the child was 3 months, 6 months, 9 months, 12 months, and 18 months of age to see the impact of intervention on children's growth and on addressing under nutrition. To understand the impact and mechanisms of the pathways of change we collected process evaluation data using qualitative interviews with mothers and community health workers and document reviews. An economic evaluation was done to see the cost effectiveness of this intervention. The strategy included two interventions: (a) women's groups to promote individual and community action for nutrition; (b) monthly home visits to mothers of children less than two years to support feeding, hygiene, care, and stimulation.

In each intervention cluster a facilitator called the *Su Poshan Karyakarta* (good nutrition worker) conducted at least two to three monthly participatory group meetings in her village and adjacent hamlets using principles of participatory learning and action or PLA. We adopted this approach to tackle under nutrition in the first 1000 days of life by addressing the underlying causes of under nutrition such as birth spacing, nutrition in pregnancy and hygienic practices. The community based worker also carried out home visits to mothers of children less than two years where she asked about current or recent illness, and engaged the mother in a discussion about feeding, hygiene, care practices specifically seeking care for illnesses and feeding more during and after illness, demonstration of recipes and hand washing and stimulation. Age specific colour coded picture cards were developed for the ease of discussion by the *Su Poshan Karyakarta*.

We tested the strategy's effects on children's growth and related outcomes in a cluster RCT with 3001 children in two districts of Jharkhand and Odisha, India. Children's mean length-for-age Z score at 18 months was –2.31 (SD 1.12) in intervention clusters and –2.40 (SD 1.10) in control clusters (p=0.08). In intervention clusters, more children attained minimum dietary diversity, more mothers washed their hands offering food to children, fewer children were underweight, and fewer infants died. We could not measure effects on children's development [Nair et al. *Lancet Global Health 2017*. Further improvements in growth would require addressing low age at first pregnancy, maternal under nutrition, infections in the postnatal period and families' financial barriers to improving children's diets.

Exploring links between gender equity & child health among Muslims: the W Bengal scenario

Subir Biswas & Chitradip Bhattacherjee
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Gender beliefs represent themselves as universal depictions of women and men by a narrow set of features. Gender equity is increasingly cited as a goal of health policy but there is considerable confusion about what this could mean either in theory or in practice. Achieving gender equity is critical to sustainable development. Gender equity is a concept to provide fairness as respected by means of rights, benefits, obligations and opportunities equivalently. Gender discrimination remains a major barrier to human development. Girls and women have made major strides since 1990, but they have not yet gained gender equity. India also experienced same problem found in the works of different scholars. Present study seeks to understand whether children of both sex getting equal health care from their parents and the possible outcomes in their health statuses. The specific objectives are-

(i) Whether children of both sex getting proper care from their parents in respect to breast feeding duration, immunization & health care.
(ii) To find out their nutritional status such as 'height for age', 'weight for age', 'weight for height', 'mid upper arm circumference', that is actually if they are malnourished or obese or normal.
(iii) To understand if gender equity exists in health and care services among children of the reference population.

For the present study five blocks of district North 24 parganas were selected according to Muslim concentration over 50 percent; and field work conducted among 2000 Muslim pre-school children (1000 of each sex). Data were collected from parents about their health care facilities like immunization, breast feeding and disease treatment facilities. Beside this standard

anthropometric measurements were collected from children to understand their health statuses comparing with WHO (2006) standardized reference values. It was observed that no significant discrimination statistically present regarding health care practices between boys and girls. Statistical analysis also showed no significant difference present between boys and girls regarding their health status. Thus the present study depicts the fact that though gender discrimination evidenced from different regions of Bengal as well as India, but the present area of study offers both boys and girls the equal rights to survive from health perspective.

Women Empowerment and Reproductive Child Health Status among the Tribal Communities of Odisha: An Anthropological Reflection

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The premise of this paper is based on the understanding that the empowerment of women is about the process by which those who have been denied the ability to make strategic life choices acquire such an ability and their choices have yield positive health outcomes for their children. Based on ethnography-based empirical work among six scheduled tribal communities of Keonjhar, Mayurbhanj and Nawarangpur districts of Odisha, this paper concludes that; raised standards of educational attainment and economic standard of mothers have positive impact on child's immunization status and child's nutritional status (stunting status). Other demographic and health indicators, such as institutional delivery, infant mortality rate and ANC-PNC check-ups show positive improvement when pitted against raising standard to mother's education and economic standard as measured through the influence of the active participation of women in making decisions in the household.

Issues related to maternal and child health with reference to Tribes

Rajesh K. Gautam, Associate Professor
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goutamraj2006@gmail.com

Globally, epidemiological transition is followed by nutritional transition; but in a country like India we are facing both transitions at the same time, resulting into dual burden of the problem. Women are more prone to such problem. Biologically, the women have to perform major role in reproduction. Hence, they are more susceptible to communicable as well as non-communicable diseases. Again in country like India we are mainly focusing on the problems and issues of today. Our systems are neither having any assessment nor any planning to combat with the problems of tomorrow. To ensure women empowerment, it is essential that they must enjoy healthy life with confidence that they will get all kind of health care. But we know that it is missing everywhere. Neither an urban system nor a rural and tribal are customer

friendly. The situation is further worst in Tribal areas. They have multifaceted problems. At one end, they are always struggling for basic civil amenities like safe drinking water, roads, electricity, education, etc. On the other hand they have extreme poverty, illiteracy, unemployment, debts, usury, exploitation, corruption, etc. This paper highlights different issues of health among the tribal women.

PVTG Women and their Empowerment: Special Reference to Birhor of Hazaribagh, Jharkhand

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Out of 75 PVTGs of India, nine reside in Jharkhand. Among them, Birhor is the most vulnerable tribe. In spite of several efforts by the Government, their total population has restricted to few thousands. Birhors are known for nomadic way of livings, reside in forest and for livings depend on hunting and food gathering. From the very ancient time, Birhor women has been playing very active role in their economy. With shrinking base of forests and substantial changes in their surroundings, the way of livings of Birhor has also been changing. The major changes have been found in their occupational patterns. The government too, has been implementing PVTGs specific schemes to raise their socio-economic status. Despite this, there has not been substantial improvements in their socio-economic status, even in comparison to other scheduled tribes or PVTGs. In the above background, this paper has tried to analyse/explore the major changes occurred in the socio-economic life of Birhors in recent time and their struggle to cope up with the concurrent society. As, women is always center to any social change, both as a driver and as a target, this paper has focused on literacy, awareness and their role in income generation activities specifically. It has also assessed changes in their child rearing practices owing to outer world influences. It has also tried to assess the reach and utility of various governments' programmes meant for PVTGs. It has long been proclaimed that government's schemes have failed to influence the living standard of PVTGs owing to lack of sensitivity to their culture on the part of administrators.

Maternal Health Care needs Private sector initiatives: case of community participation in JSY in the tribal areas of Jhabrkhand

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Janani Suraksha Yojana (JSY) has two major objectives; firstly to increase institutional deliveries in BPL families through establishing a system of co-ordinated care by field level health workers; integrates cash assistance with antenatal care, institutional care during delivery and immediate post-partum

period in a health centre and consequently to reduce Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). However, the experiences show that it has not much accommodated the Primary Health Care approach (Alma-Ata Declaration in 1978), which recognises community participation as a complement to any facility-based component to improve maternal and child health. The strategies and achievements of these programmes in the tribal areas show that there is a huge gap between its normative and praxis level; lack in considerations of socio-economic, geographical and cultural values of tribals, lack of epidemiological logic reflected in its investment pattern, and appropriation of technology and decentralization of the programmes. In an in-depth study in the Tribal areas of Jharkhand, the author found that the public sector health care is unable to strengthen motivation levels of para-medical staff, to empower local community based structures along with community level participatory monitoring, to increase involvement of PRIs, community leaders, women's groups and local NGOs. To fill the gaps, there is an urgent need of involvement of private sector health care providers on the line of PPP to make JSY a success among the tribal populations.

Health Technologies for Empowerment of Women in Bihar

Papia Raj, Assistant Professor
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In an underdeveloped state like Bihar, women face double jeopardy because of poor health status and lower literacy rate. Hence, in this state maternal mortality is very high which affect overall societal status of women. This study focus on exploring the role of health informatics tools such as mobile phone, also known as *mHealth*, in improving maternal and child health scenario of Bihar, which in turn can lead to women empowerment. In developing countries like India, mobile phones are serving as an excellent medium for establishing health communication. Most importantly, literacy does not seem to be a barrier in the use of mobile phone. So it has the potential to address the issue of health inequalities in remote locations where there is shortage of medical resources. Health information propagated through mobile phone can improve knowledge which is an important tool for generating women empowerment.

"5E 9D NUT+ GEN"- A Suggestive model for women empowerment and child health

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Understanding the importance of a good child health for human development especially in a country like India where dividend of healthy human capital is very high for its growth, the theme of the sessions **"Socio- Cultural & Economic perspective of Empowering women and Child Health"** brings about child health into focus. As can be understood, the session through its

deliberations is attempting to explore the assurance of good child health by empowering women as a change agent looking at the socio-cultural & economic perspective of an ecosystem.

The author have tried to bring out healthy nutrition as a critical input for ensuring good child health which has been explained while deliberating in the background the meaning, size and impact of malnutrition in any society, which is quite significant requiring a holistic approach for its eradication. With the objective of eradication of malnutrition in the society to ensure good child health, the authors have proposed a suggestive model drawing cues from real life cases and mythological beliefs in society. The model has key tenets, such as socio-cultural, economic & other context. It reinforces integrated approach including every stakeholder and emphasizes efficiency and effectiveness of the channel, focusing on empowering women (SE9D), nutrition plus hygiene (NUTI+), and genuity (GEN). As is mentioned, the model "SE 9D NUTI+ GEN" advocates of hygiene in addition to nutrition to beneficiaries , assured through an integrated approach around a given ecosystem focusing on empowering women and genuity.

Status of women empowerment and child health in Bihar

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This interdisciplinary review explores linkages between accesses to health services, children health care and women's empowerment. It suggests that improved access to empowerment for women may create a range of benefits for the health care. It is mainly based on the secondary sources of data like Censuses, NFHS etc. As per the Census of India, the young age population (0-14 years) in Bihar has declining from 41.2 percent in 1971 to 29.5 percent in 2011, but the aged persons (60+ years) have increased from 5.3 percent to 8.5 percent. Compared to the major states, the ratio of working population to total population is the lowest in Bihar of about 52 percent. The literacy rate in Bihar increased from 13 percent in 1951 to 64 percent in 2011; while for all India it was 18 percent to 74 percent respectively. The gender gap of literacy in urban areas decreased from 34.5 percent in 1961 to 12.1 percent in 2011 in Bihar. Household population age 6 & above who have completed primary school education increase from 1992-1993 to 2015-16 as per the NFHS results. There is increase in the Percent of female population age 6+ years who ever attended school in Bihar from 30 to 57 from 1992-1993 to 2015-16 as per the NFHS results. Child Development Index is 0.296 which is above the CDI of Uttar Pradesh but below the others states. Percentage of children under 5 years who are underweight in Bihar has decreased from 62.6 percent to 44 percent. Percentage of children under 5 years, who are stunted in Bihar decreased from 60.9 to 48 from NFHS - 1 to NFHS – 4 respectively. Anaemic children in Bihar also decreased from 78 percent to 64 percent as per NFHS -3 to NFHS -4.

Some other indicators related to women development has also shown positive trend. The percentage women age 15-49 years with 10 or more years of schooling in Bihar has substantially increased from 6.6 percent to 23 percent as per NFHS- 1 to NFHS -4. The percentage of currently married women who usually participate in household decisions has increased from 69 to 75 percent from NFHS- 3 to NFHS- 4 respectively. The Percentage of women owning a house and/or land alone or jointly. NFHS-4 (2015-16) in Bihar is 59 percent while for all India is only 38 percent. The percentage of women having a mobile phone that they use themselves is 41 percent (NFHS-4) in Bihar which is lower than that of India (46 percent). There is increase from 8 to 26 percent of women having a bank or savings account that they use themselves in Bihar during NFHS -3 to NFHS -4. The Percentage of ever-married women who have ever experienced spousal violence has decrease from 59 percent to 43 percent in Bihar from NFHS- 3 to NFHS -4. Bihar became the first state to reserve 50 percent seats in PRI for women and currently 54 percent seats of PRI in Bihar are occupied by women. By way of conclusion he said, there seems some improvement in women's status over the period of time, which should be further validated at the grass root level.

Impact of women empowerment on health of under 5 children: a case study from Uttar Pradesh

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Women constituting around half of the population play a distinct role in the development of any society. She contributes in many roles: as a mother, as a housewife, as a woman herself represents a unit of human capital and is therefore capable of contributing to the social, human and economic progress of the nation. It is a fact that women cannot contribute meaningfully in the process of development, until their own development is taken care of. However, there is enough evidence to show that empowered women contribute significantly to better development indicators including nutrition and health of children. A study based on an intervention programme of three years duration on 210 Women SHGs spread across three blocks in Raebareli district of Uttar Pradesh aimed at improving utilization of public health services and other women and child development schemes. First one year was invested in sensitising the SHG members on the issues of health, education, gender, political participation and participation in decision making. A baseline survey of nutritional level of children between 6 months to 5 years, immunisation; colostrums feeding, general utilization of health services was done at the beginning of the programme in 2014. The final survey at the end of the programme was done in December 2017. A survey of non SHG members of 100 household (control group) was also done. Results show direct relationship between empowered women and nutritional intake, immunisation and visits to health Sub Centre,

PHCs and other public health institutions. Different indicators of nutritional intake in the form of colostrums feeding, immunisation and weight of children, improved satisfactorily during the period. Empowerment of women SHG members also witnessed qualitative change from economic empowerment (through livelihood development) to social and political awareness and empowerment through awareness and education. If women are empowered beyond economic livelihood, they can bring multifarious change in behavioural practices of their household members and bring significant change.

Socio-Cultural and Economic perspective of women empowerment & Child Health

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Socio-economic, demographic and political determinants of women's empowerment are important factors of child health. Different researchers believed that the dimension of political and social awareness of women is a part of the empowerment process (Sabharwal, 2000; Kamani, 2007). "The women's empowerment is a process of identifying their inner strength, opportunities for growth, and roles in shaping their own destiny". All the definitions of women's empowerment contain at least a psychological characteristic, besides the social and economic ones that exist (Saraswathy, et al., 2008). What leads to women's empowerment, and its values for growth and poverty reduction? It is imperative like an objective itself because it gives the ways to achieve a better gender equality. Women's empowerment frequently leads to a better spending in education, shelter, and food nutrition for the entire family. Decision making power, mobility and access to resources is strongly related to each other than to child-related decision making, freedom from physical threats and power over resources (Kritz et al., 2000).

The policy prescription is surrounded around the education of women because a high level of female education provides a rock-solid base to resolve major issues related to mother and child. It has been a fundamental issue in India that urban women are far more educated than rural women due to an innate socioeconomic structure. Increase in women literacy rate of the country has significant effect on mean age of marriage. Marriage is a sociological institution and reflects status of women empowerment of the respective culture. Some research have finding that one percent increase in women's income causes a 10 percent increase in their empowerment and women who availed credits are more economically empowered than those who do not. Quality education, continue education and control over resources of women is key elements of empowering women in the country. Supportive legal provision for land rights is also important intervention. It will provide social security and opportunity to earn more and take decisions for better child health.

Women Empowerment: Use of Technology for better Mother and Child Health outcome in Bihar

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Health of women has profound implications for the development and well being of a State and hence nation. Bihar which is one of most populous state in India has very poor health indices. A variety of socio-economic factors are responsible for women's poor health attainment, the important ones are need for female labour at home, low expected returns of girls education, and social restrictions. Mother and Child Health is an area where care giver (ASHA, ANM and Anganwadi workers) and care seeker, both are woman, and hence it was envisaged to use technology which would enable ANMs to provider MCH better and also empower beneficiary mother and her child to attain a better health outcome. Specific objective of the interventions was to 1) Real time data updating of MCH services, 2) Real time, inbuilt and auto generated work plan for MCH services by ANMs, 3) Data utilization to improve quality of MCH services 4) Tracking of mother and child for timely MCH services by ANMs. The project was implemented in PHC Kanti, Muzaffarpur during 2013 -14. A total of 10 ANMs were given mobile app, which was developed by technical support of Dimagi and IIHMR. All other support such as mobile phones and platform (CommCare) were provided by Dimagi. Recurrent Expenses (SIM cards, internet, and refreshments during training) were managed by IIHMR. Three Days Training of the ANMs on the mobile based application was organized at the PHC Kanti. It includes two days classroom orientation and followed by one day field level on-site training with beneficiaries. Trainers included 2 Members from Dimagi and 2 from IIHMR Jaipur.

Analysis of the data has shown that output of ANMs have improved significantly, as now they did not require to carry multiple files to field. also since data entry in the mobile was menu driven it improved data quality and timely reporting of the data. ANMs could now generate due list about which beneficiary she should see on a given month, what would be the supplies required for the months. On beneficiary side, they could have access to pre-recorded messages about different program available to them, mother having mobile phones were able to receive reminders for services due to them, etc. Overall, both ANMs and mothers in subject areas reported to have benefited by the mobile. Piloting of mobile based RCH program has shown encouraging results in improving accessibility and quality of RCH services in target area. Future programs should focus on sufficient training of service providers and 24x7 system supports. Also, indicators should be developed and used to monitor the women empowerment due to use of technology.

Health of disabled women and children in Bihar: An opportunity for inclusion

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Globally, more than one billion people experience some form of disability and the prevalence is higher among women than men (WHO/WB 2011). The 2011 census revealed that 2.68 crore disable population live in India, amounting 2.21% of the total population. The prevalence of disability is more in rural 2.24% than in urban 2.17% area. The percentage of total disable population has increased. Increase in ageing population, chronic health conditions like cardiovascular disease, diabetes, mental health disorders and injuries and fall, which have the condition with disability, will cause the increase in disability prevalence in coming years (WHO 2010). The latest 2016 Act of 'The Rights of Persons with Disabilities' recognizes 21 types of disabilities. This number has increased from seven as mentioned in PWD Act 1995. The total number of disable population in India will also increase as per the new Act. Census is the only reliable source of getting the disability data. The last survey by NSSO (58th round) carried out in 2002 collected information on mental disability, visual, communication and locomotors disability along with socio-economic characteristics (age, literacy, employment and vocational training) were collected. There are no other sources of health status of the disabled population, especially women and children. Out of the total disable population in India, women constituted to 44% and children in the age group of 0-6 years 1.24% are disabled (male children 1.29% and female children 1.19%). These figures have wider implications in future. Bihar state has 8.69% disable population and having highest share (14.24%) of disabled children (0-6 years) in the population of disabled persons in India.

Women with disabilities require protection from abuse and exploitation and the children with disabilities requires special attention as they are the most vulnerable population. The literacy rate of disabled in Bihar is 47.3%, for male 31.4% and female 15.8%. Evidence shows that the prevalence of disability decreases with the increase of literate female population (Nandita Saikia et.al). Disability is often associated with severe socioeconomic disadvantages and poverty (Kandasamudhan M et.al), which leads to poor health among women and children. Women with disabilities experience difficulties in accessing health facilities, education and employment (UN DESA). Only 17% women with disabilities employed compared with 54% men in Bihar, mainly cultivators and agriculture labourers. The poverty and disability go both ways- disability add to the risk of poverty, conditions of poverty add to risk of disability. Poor households do not have adequate food, basic sanitation and access to primary health care. Person born with disability due to lack of accessible health facilities resulting various medical complications for both the pregnant woman and the unborn child often leading to a disability for the child. Even though the

disabled women willing to avail the maternal and other health services, the health care providers lack of knowledge on maternity care needs of the disabled women and the physical infrastructure of the health facility are the major challenges in accessing the services.

The importance of women empowerment and an active political will to achieve it is evident from the fact that there is a whole SDG dedicated to it - SDG 5(achieve gender equality and empower all women and girls). Gender inequality persists worldwide. Women, across the globe and throughout history, have faced gender-based discrimination. This discrimination is compounded if the woman is disabled. A woman or a girl with disabilities faces discrimination and barriers because she is disabled, because she is a female and because she is a female and disabled.

Community Based Education for Gender Empowerment in Bihar

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The lacuna of development can only be addressed by putting women and girls at the center of any comprehension and process outlay especially in an underdeveloped milieu like Bihar which is a land of paradox with rich history but with backward looking social characteristics. The attitude of men and boys- be it elderly or youth- as well as the normative practices of the culture, here, have subjected women and girls at the far end of disempowered spectrum. The jeopardy further multiples for women and girls of lower caste because the hold of caste system is still paramount in Bihar. Traditional taboos here have found new forms as lack of freedom for perusal of life opportunities keeps declining. Most frightening, in the absence of hope, is the gradual acceptance of disempowered situation by women and girls. This can be broken by a virtuous cycle by understanding women and girls from their perspective and with them at the pivot and by using technologies which facilitate participation, awareness, autonomy, capacity, and power for their utility. Enabling technologies, with the help of equitable governance, can create processes for vital community based education which may cut across the structural barriers of caste and class.

Structural constraints and emerging paradigms of empowerment among Dalit women in Bihar

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The caste system is a complex social stratification system which has been abolished, but remains deeply ingrained in India. Women from Dalit community face multiple subalternity - they are subaltern with various level of

subalternity (as Dalits, as poor, and as women). Dalit Women faces systematic oppression, social exclusion, direct and structural violence within their own communities as well as from 'upper' castes. Women from Dalit community in Bihar suffer the same trauma. As per census 2011, Scheduled Castes constitute 16 percent of Bihar's 104 million population and only one-sixth (approx 16 percent) of Bihar's households are in urban areas, and the remaining 84 percent are in rural areas. Literacy rate in Bihar stands at 61.8 percent of which the literacy rate of the scheduled caste and scheduled tribe are 48.65 percent and 51.8 percent respectively. Enrolment rate among SC girls shows an increasing trend both at primary and upper primary level. In 2013-14 enrolment of SC girls was 14.47 percent at primary level while at upper primary level it was 5.11 percent. However it shows an encouraging trend but it is much less than the general population. If we look at the health status, various studies reveal that individuals' poorer health status, including higher morbidity, lower life expectancy and higher rates of infant mortality, is linked to her race, ethnicity and caste, and in certain cases, nationality. Scheduled Caste (SC) women are one of the historically deprived groups, as reflected in poor maternal health outcomes and low utilisation of maternal healthcare services. NFHS 4 data shows some encouraging trend in health status among SC women in Bihar. This paper tries to analyse few aspects of empowerment among dalit women of Bihar.

A socio-economic analysis of women's empowerment and child health (Hindi translated into English)

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The concept of women's empowerment and child health are interlinked with each other, as the child before taking birth remains dependent upon her/his mother. The health of woman is positively related with the outcome of newborn. If the mother remains healthy and fit throughout her pregnancy and after it, the child will also be healthy. The child is fully dependent on mother well before the birth, and even after the birth, the child remains dependent for nutrition and health on the mother. The health of woman is also linked with the empowerment of woman. If the woman is empowered in the family and society, she can make decisions regarding her own health and well being of her children and family. There are three main factors of women empowerment, i.e., social, educational and economic. This paper is based on a study conducted among a Scheduled Tribe, i.e. Tharu of West Champaran of Bihar. The study used mainly qualitative methods of observation and in-depth interview. It has been found that the gender equity is more among the Tharus as compared to the women belonging to caste societies, resulting into more freedom and liberty for Tharu women in the society. It is further observed that those Tharu women who are more educated and socially and economically more empowered can take better care of their children as compared to the other group of women.

Institutional Barriers to Women Empowerment

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There has been much proof that gender equality and women empowerment has direct impact on better child health. The Indian Constitution does not discriminate among its citizens on the basis of sex. The government has been implementing a number of schemes for women empowerment since independence. Despite this, gender inequality is a harsh reality of Indian society, as the efforts of the government are either half-hearted or have very poor implementation. In reality most of the provisions for women exist only on the paper. There are a number of institutional barriers, which hinder not only their personal growth but also the proper implementation of the government initiatives. The government must identify institutional barriers and remove them. Gender inequalities are deep-rooted in our society and there are a number of reasons behind it. These inequalities are influenced by region, caste, class, income and education level of the women, which should be addressed separately. At the same time, there are few other institutional barriers which are common in nature and faced by every women irrespective of caste, class and income and education level. This paper has explained some of the institutional barriers, and advocates for specific intervention by the government. Without removal of these barriers, the efforts of government will be wasted. Lack of land ownership, limited access to institutional finances, immobility resultant from fear of violence in public places, prevalence of gender stereotyped role for women even in the public sector are few specific barriers faced by every women and are major hindrance in the way of women empowerment and gender equality.

Social Marketing Model for Behaviour Change

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Women in India make up almost 50 percent of population (48.53%, 2011 census) and the child health is aligned to mother's socio-economic status (Allin S, and Stabile M 2012). World has witnessed that communities with economically empowered women have ensured a conducive environment for sound child health. Marketing is essentially a branch of economics (Kotler 2016). The author has attempted to understand the dimensions of empowering women with the help of 'Social Marketing Model'. It also deals in studying the linkage between economic status of mother and mortality rate of child, which gives some insight to the concept. With the objective of making a better society and a more empowered future society, it is must that we focus on change of mental perspective of women and attempt to make her more empowered.

Behaviour, intervention and marketing mix and audience segmentation are the three components of key triad of the social marketing model for behaviour change. According to Tulchinsky and Varavikova (2009), social marketing is systematic application of marketing concepts and techniques to achieve specific behavioral goals for social and public good. Social marketing model empowers women and culminates into a better health environment for the future generation

Women Empowerment and Child Health: Economic Perspective of Rojiroti women

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The paper discusses the economic dimension of women empowerment through a few case studies. Education of the woman is a crucial element in economic and social development, which also leads to a greater level of awareness and improvement in economic condition. It also increases female participation in decision making and pre-requisite for acquiring various skills and better use of health care facilities. Education has inverse relation with fertility as it delays the marriage age of girls. Similarly better economic condition has inverse relationship with fertility, and virtually all well-fed societies have low fertility.

Exploring the Intersection between Women Empowerment and Child Health in Bihar: An Economic Perspective

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Women empowerment is a very subjective term, encompassing a set of complex dimensions. However, economic independence of a woman forms the base of empowerment and is the most important indicator. This paper examines the intersection between women empowerment and child health in Bihar from economic perspective. The participation of women of Bihar in labour market is very low. The engagement of women in labour market is considerably low (13.42 percent main worker); while male counterpart is as high as 52.46 percent (Census, 2011). In case of marginal workers, the gap between male-female has been reduced. This implies that female workforce of Bihar is not engaged in stable job. NSSO 68th round data reveals that female engagement in usual status activity are 8.7 percent while the all India average stands at 31.2 percent. However, during last decade Bihar attains satisfactory economic growth. This is even reflected in the substantial increase in male usual status activity. However, there is meagre enhancement in female activity. The female unemployment rate of age group 15 to 59 years is 11.9 percent in Bihar while all India average is 3.9 percent. Bihar is one of the most mal-nourished states with 48.3 percent stunting rate of children. The incidents of BMI of girls aged

15 to18 years and women aged 15 to 49 years are 45.2 percent and 30.4 percent respectively. There is a direct relationship between under-weight children and incidents of low BMI, which is significant and positive therefore the children health cannot be separately taken care of without considering mother. The literacy rate of Bihar is lowest in India with considerable gender gap. The existing institutional structure deserves special attention. The effective implementation of the specific programmes meant for mother and children requires a sound and robust institution, particularly local administration.

Exploring links between Women Empowerment and Child Health

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Family planning and focus on improved reproductive health is critical for our country's development and a big step towards growth, equality and sustainable development that opens the door to several opportunities resulting in prosperity for women and families everywhere. However, every time we fail to identify and address the issues around reproductive health and family planning services, 'women' suffer the consequences in shape of unwanted and unplanned pregnancies. Motherhood by choice is an incredible and rewarding experience in a woman's life. But it is not surprising that pregnancies still go unplanned. It is disheartening that even today in India, every 12 minutes a precious life of a women is lost due to pregnancy or childbirth related complications[3]. With better access to family planning, many of these deaths can be averted resulting into improvements in women's and children's health. More women could advance their education, participate in the workforce and contribute to the economy. Family planning also slows down population growth, decreases the stress on natural and public resources, and results in an overall improvement in the quality of life. For decades, India's family planning program was focused on population control. Over the years, that focus rightly shifted to a more holistic approach of ensuring reproductive health and rights for all. Despite this progress, many women in India still don't have access to contraceptives or the awareness to make informed choices about family planning. Women are excluded from decision-making because of dominant social norms i.e., patriarchy and other social norms such as son preference, early marriage and pregnancy, pressure to prove fertility right after marriage, myths and misconceptions regarding contraceptive methods and gender disparity restrict uptake of family planning services. Female sterilisation in Bihar remains the predominant contraceptive method (21%)[4]. Lack of education and knowledge around reproductive health and hygiene aggravates the problem. There is an urgent need to educate couples about the benefits of family planning, improve

[3]Annual Report 2016-17, Ministry of Health & Family Welfare, Government of India.
[4]National Family Health Survey (NFHS-4) 2015-16

access to contraceptives and family planning services and to promote voluntary and informed choice among women in India, especially in Bihar.

Global Health Strategies (GHS) use advocacy, communications and policy analysis to improve health and wellbeing around the world. GHS works on key health issues including Family Planning, Tuberculosis (TB), Immunisation, Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) and Lymphatic Filariasis (LF), among several others. In Bihar, GHS works closely with a network of 34 CSOs and leverages a community champion-based strategy by engaging with 142 community champions who elevate voices from the ground. These community champions are the foremost important cornerstone of this project as they voluntarily help generate awareness on family planning methods and encourage uptake of its services by providing correct and consistent information on family planning. They are individuals from various walks of life i.e., ASHA, ANM and Anganwadi worker, members of women's group, Village Health Sanitation & Nutrition Committee (VHSNC), Panchayati Raj Institution (PRIs), religious leaders among others, who believe in the efficacy of family planning.

Family planning is a human right and a joint responsibility of both husband and wife. Couples should discuss when they want to have children and adopt contraception to ensure that they avoid unplanned pregnancies as it not only affects the health of mothers but also children. Accesses to the family planning choices are the right of every woman and they should be able to make informed family planning decisions. There is a need to raise awareness on the importance of spacing methods, new contraceptives, common myths/misconceptions, government facilities and schemes, among all sections of the society to ensure an increase in the uptake of family planning services. We must work together to ensure that women and men have access to family planning services, and most importantly, that women are empowered to make reproductive health decisions.

Annexure- III: Programme Schedule

10.00-10.30	Registration	
10.30-10.45	Inaugural session Welcome Address	Chairperson: D M Diwakar, former Director and Professor, ANSISS Registrar I/C, ANSISS
10.45-11.00	Address by Guest of Honour	N. Vijaya Lakshmi, *IAS*, MD, Women Development Corporation, Bihar
11.00-11.15	Setting the Scene: How does Rojiroti Microfinance work?	Gil Yaron & Sunil Choudhary
11.15-11.45	Rojiroti microfinance: effects of children's nutrition in a cluster randomised trial	Alan Smyth & Shalini Ojha
11.45-12.00	**Tea Break**	
12.00-12.30	Rojiroti microfinance and its impact on women empowerment: Insights from qualitative interviews	Esther Bott
12.30-13.00	Participatory women's groups and children's growth: what can we learn from the CARING trial?	Suchitra Rath
13.00-14.00	**Lunch Break**	

Parallel sessions 14.00-15.00

Panels	**Chairperson & Speakers**
Panel-I: Anthropological & Sociological Perspective of Women Empowerment & Child Health	A K Kapoor (Chair) Subir Biswas, Prof., WB State Univ. PK Patra, Head, Anthropology, Utkal Univ., Odisha Rajesh Gautam, HS Gaur Univ. Sagar Ganganath Jha, Asst. Prof. VBU, Hazaribagh Debendra Biswal, Asst. Prof., CUJ, Ranchi Papia Raj, Asst. Prof., IIT, Patna

Panel-II: Socio-Cultural & Economic Perspective of Women Empowerment & Child Health	D M Diwakar (Chair) R R Thakur, Dean& Prof., BIMTECH, NOIDA Dilip Kumar, Joint Director, PRC, Patna Univ. C S Verma, Associate Prof., GIDS, Lucknow Ajit K. Singh, State Facilitator, NIHSRC-Bihar B P Mishra, Save the Children, Patna
Panel-III: Public Health Perspective of Women Empowerment & Child Health	Barun Kanjilal (Chair) Santosh Kumar, UPIHSSP, Lucknow Gowtham Ghosh, IIHMR, Jaipur Ram Ratan, SHSB, Patna Arvind Kumar, SIHSD, Patna
Panel-IV: Structural Constraints of Women Empowerment in India: Historical Trajectory and Emerging Paradigm	B N Prasad (Chair) Aditya Raj, Asst. Prof., IIT, Patna Renu Choudhary, Asst. Prof. ANSISS, Patna Kaushal Kishore, Asst. Prof. ANSISS, Patna Narendra Deo, Arth Foundation, Patna Neha Prasad, Research Officer, Hazaribagh
Panel-V: Economic Perspective of Women Empowerment & Child Health	Sankar Majumder (Chair) Vinita Srivastava, Asst. Prof, IIM, NOIDA Ranjeet K Sinha, Associate Prof., PMCH, Patna Abhijit Ghosh, Asst. Prof. ANSISS, Patna Manish Kumar, SPMC, Patna Sanjay Suman, Sr. Manager, Global Health Strategies

15.00-15.15	**Tea Break**	
15.15-16.15	Presentation by Panel Chairs	Chairperson: Alan Smyth & Shalini Ojha
16.15-16.30	Closing Remarks & Vote of Thanks	Rajeev Kamal Kumar

Annexure-IV: List of Participants

S.N	Name	Designation\ Affiliation	Address\Email ID\Contact No.
1	Dr. N. Vijay Laxmi	IAS, Managing Director	Women Development Corporation, Patna, Bihar
2	Dr. Esther Rott	Senior Lecturer,	University of Nottingham, UK Esther.Rott@nottingham.ac.uk
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रोजी-रोटी माइक्रो फाइनांस के प्रभावों पर चर्चा, रिसर्चर ने प्रस्तुत किए पेपर

एएन सिन्हा इंस्टीट्यूट में महिला राशक्तीकरण व बाल स्वास्थ्य पर कार्यशाला

Datnik Bhaskar 19.03.2019

RASHTRIYA SAHARA (Hindi Daily) Date 19/03/2019

बाल पोषण व गरीबी उन्मूलन पर विमर्श

Rashtriya Sahara 19.03.2019

महिला सशक्तीकरण और बाल स्वास्थ्य के संबंधों की पर कार्यशाला

AAJ Daily 19.03.2019

स्वयं सहायता समूह से महिलाएं हो रही हैं सशक्त

Prabhat Khabar 19.03.2019

टना | हिन्दुस्तान

...सिन्हा इंस्टीट्यूट में नॉटिंघम यूनिवर्सिटी के स्कूल ऑफ मेडिसिन और अनुग्रह नारायण सिंह समाज अध्ययन संस्थान की सहभागिता से हुई कार्यशाला

महिला सशक्तीकरण और बाल स्वास्थ्य के विकास पर हुई चर्चा

[illegible]

इन्होंने रखे विचार

[illegible]

Hindustan 19.03.2019

THE TIMES OF INDIA, PATNA
TUESDAY, MARCH 19, 2019

'Liquor ban a saviour for women, children'

Dignitaries at a workshop in Patna on Monday

Times News Network

Patna: Liquor ban or prohibition has helped a lot in improving the condition of women ... and children in the state.

[illegible]

The Times of India 19.03.2019

महिला सशक्तीकरण और बाल स्वास्थ्य के संबंधों की पर कार्यशाला

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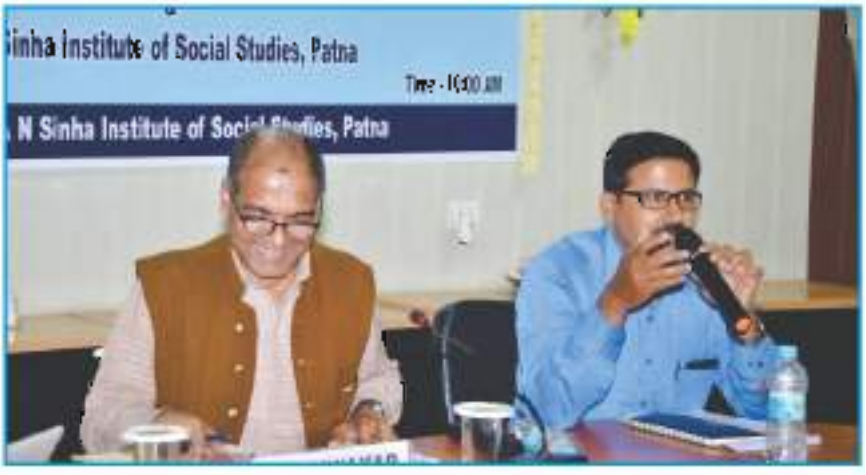
The Times of India 19.03.2019

Annexure- VI: Proceeding through pictures




SANKAR MAJUMDER
GIL YARON


NIL RATAN


A K KAPOOR


Exploring Link between Female Empowerment and Child Health
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Networking Event & Workshop
Exploring Link between Female Empowerment and Child Health

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